

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



Technical Assistance Guide



2012

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This package has been developed by Cicatelli 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.

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Section 1. Introduction to the Technical Assistance (TA) Guide

What is the purpose of the Focus on the Future (FOF) TA Guide?

The purpose of the TA Guide is to

- Provide additional guidance to agencies that have received the official CDC training, preparing them to implement the intervention with fidelity. The TA Guide includes answers to questions frequently asked by agency staff, and that are in various stages of implementing the intervention.
- Supplement the information found within the various manuals in the intervention package.
 - **FOF Package Content** includes
 - Starter Kit – contains an overview of the intervention and a description of the science behind the intervention. Guidance on how agencies get started (pre-implementation) is also included.
 - Implementation Manual (IM) – contains an overview of the intervention, the science behind the intervention, and guidance on pre-implementation, implementation, maintenance, and monitoring and evaluation of the intervention. A Facilitator’s Guide, which describes step-by-step how the facilitator will conduct the intervention with each client, is also included. The IM also contains planning tools for pre-implementation and implementation, timelines, template materials for delivering the intervention, such as handouts, visuals, and feedback forms, and marketing brochures for both agency staff and potential participants.
 - Training video – A training video depicting a full delivery of the intervention, which can be used as part of the Peer Health Advisor’s (PHA) training or as a tool to introduce and educate agency staff about the intervention.

How to Use this Guide

Icons

- *Questions from the field:* The symbol  indicates questions that came from the case study agencies during the pilot process.

Tables

- The tables included throughout this guide are designed to direct you to where further information on specific topics can be found in the Implementation Manual. Please refer to these tables whenever you need more detailed guidance on a specific topic.

Questions

- Included in this guide are commonly asked questions about implementing **FOF**. These questions typically address issues that are not specifically covered in the other materials provided, but still may be important topics to address as your agency begins implementing the intervention. Many of these questions and answers come directly from agencies who have previously piloted the intervention.

Intended Audience

The **FOF** TA Guide is for intervention facilitators (PHAs), clinic managers, clinic directors, and other staff who are involved with **FOF** at the clinic.

How Do I Obtain Additional Copies of the FOF Package?

Contact your local or state department health department Project Officer, or the Project Officer at the Centers for Disease Control and Prevention (CDC), or visit <http://www.effectiveinterventions.org>.

Section 2. Overview of Focus on the Future

For more comprehensive information on the **FOF** intervention and the science behind it, refer to the “Overview” and “Science Behind the Intervention” sections of the Implementation Manual. There you will find the description of the intervention and the research study, including the theoretical foundation of the intervention and the research outcomes. You will also find the **FOF** Core Elements in both guides and the Behavior Change Logic Model. The tables below are included throughout the TA Guide to direct you to where information can be found in the Implementation Manual. Also included below are commonly asked questions to provide your agency with additional information that is not provided in the guides but may come up while you are implementing this intervention in your specific setting.

For More Information about	See the Implementation Manual
The Intervention	Page 9
Theoretical Foundation	Page 16
Original Research Findings	Page 16
The Core Elements Key Characteristics	Pages 18, 78, 82, 88, 94, 102, 106
The Behavior Change Logic Model	Page 21
The Implementation Summary	Page 52
Facilitating the Intervention	Page 75

Intervention Development Process

- Q. What is the CDC Replicating Effective Programs (REP) Project?
- A. In 1996 the Centers for Disease Control and Prevention (CDC) established a synthesis activity where evidence-based interventions are identified and research translation and packaging activity named the Replicating Effective Programs (REP) Project. The REP Project supports the translation,

packaging, and field testing of evidence-based HIV prevention interventions and other brief tools into everyday practice, by working with the original researchers in developing a user-friendly package of materials designed for prevention providers.

For information about other effective interventions being diffused through CDC, visit the CDC website:

www.cdc.gov/hiv/projects/rep/default.htm

Q. What is the CDC diffusion of effective behavioral interventions (DEBI) Project?

A. The Centers for Disease Control and Prevention (CDC) has a national strategy to provide high quality training and technical assistance to prepare regional and community HIV programs to implement science-based HIV interventions. The CDC is collaborating with the original researchers to make effective interventions available to communities.

For information about other effective interventions being diffused through CDC, visit the CDC website:

www.effectiveinterventions.org

Identifying Eligible Clients

Q. Do all potential clients need to be screened to meet eligibility criteria?

A. Yes. It is important to screen all clients to ensure that they meet the eligibility criteria. This is because the intervention was only tested and proven to be effective among this population. The screening criteria for **FOF** are

- Male,
- African American,
- Ages 18-29,
- Have sex with women (MSW),
- Report STD signs, symptoms, or contact and/or are newly diagnosed with an STD,
- Report their HIV status as negative or unknown,
- Used condoms during vaginal sex with female partner(s) in the past 3 months.



Note: During the case study agency field testing process, clients who met all the eligibility criteria, but who were slightly outside the eligible age range, were permitted to participate in the intervention at one of the four case study agencies. This decision was made based on that agency's policy for receiving clients for the day. In some cases, there were days of the week or periods of time when very few eligible clients attended the clinic and therefore limited the number of those meeting the criteria who could participate in **FOF**. In order to maximize the use of the PHA's time, slightly older or younger men who would likely have similar life experiences and perspectives to those meeting the eligibility criteria were permitted to participate. The PHA who worked with men slightly older (30-35

years old) and slightly younger (16-17 year old) clients found that there were no discernible differences between them and the group tested in the original study (18-29 years old), in that:

- Establishing a rapport with slightly older and younger clients was not any more difficult.
- The information delivered by the PHA during the intervention was equally applicable to the needs of the older and younger clients.

These cases were outside the age range of eligibility used in the original research, and as such, there is no evidence that **FOF** was an effective intervention for these additional clients. It should also be noted that part of the **FOF** implementation planning process includes estimating the number of eligible clients who seek services at the clinic. This includes estimates of the daily volume of clients to be served. As implementation proceeds, if you notice that the PHA is not serving the estimated number of clients, ensure that systems to identify eligible clients are in place and functioning properly prior to expanding age criteria to include younger or older men. Agencies should also consult with their Project Officer before adapting **FOF** for other age groups.



Q. Why can't this intervention be for anyone?

A. This intervention was specifically developed for young African American men who have sex with women who have used condoms in the past. It has only been proven to be effective with this population. Additionally

- The PHA, who facilitates the intervention, possesses characteristics that mirror only this population's characteristics.
- The PHA is trained to specifically have a conversation with this population about barriers to using condoms, specifically with women.
- The HIV rates poster used during the intervention speaks specifically to African Americans.

The Peer Health Advisor

Q. Why is it important for a peer to deliver the intervention?

A. It is essential to have a peer deliver **FOF** for a number of reasons. Clients are often more comfortable discussing sensitive sexual topics and personal experience with a peer instead of a health professional. Many clients are also more likely to accept messages delivered by a peer and practice the information they learn during their session in real life. In addition, building a strong rapport with the client is an integral part of **FOF**, and this will happen much more quickly when a peer is facilitating the session.

Q. How is the role of the PHA different from the role of existing staff at my agency, such as a Disease Intervention Specialist (DIS)?

A. The role of and services provided by the PHA should be balanced with, and compliment, the important supportive and educational services that health educators, social workers, and disease intervention specialists provide in order to reduce the individual-level and community prevalence of

STDs. Pre-Implementation and Implementation planning should ensure that eligible clients have the opportunity to take advantage of the services that the PHA provides, while still maintaining the integrity and availability of other evidence-based services provided at the clinic. That being said, the PHA plays an important and unique role within the care structure of the clinic that serves to optimize the client experience by utilizing a peer to peer approach. By virtue of his position as a peer to the client, the PHA is able to easily facilitate the creation an open, fun, and sex-positive experience for clients that allows them to explore various ways of enhancing their sexual experience while reducing the likelihood of acquiring future STDs through the efficacious use condoms and water-based lubrication.

The Intervention

- Q. Do we have to implement FOF exactly as it was done in the original research? Do we need to deliver all six components to each client? Do clients need to meet all of the original eligibility criteria?
- A. **FOF** was only proven to be effective under the conditions of the original research and every effort should be made to maintain fidelity to the original design of the intervention. The PHA must facilitate the intervention the same way it was originally delivered, covering all six components with each client. Additionally, the Core Elements of the intervention must be maintained during your agency's implementation of **FOF**. While fidelity to the Key Characteristics is recommended, these may be adapted as they are believed to be less critical to the outcomes obtained in the original research. With this in mind, it is understood that clinics use different approaches to manage the volume of persons seeking care and client flow in an effort to maximize the number of persons they see and range of services they provide. Involving clinic administrators and managers early on the process and getting their perspectives on how best to implement **FOF** with men who meet the criteria is strongly encouraged.
- Q. Why is it necessary to cover all of the components?
- A. **FOF** was shown to be effective when all six components were delivered to each client. Omitting any of the six components fundamentally changes the intervention. It is unclear if **FOF** remains effective when any of these six components are omitted.
- Q. Why is there so much repetition among the components?
- A. Throughout **FOF**, the facilitator repeats important messages related to consistent condom use, the benefits of using water-based lubricant and finding a condom with the right fit and feel, erection loss, planning for sex, as well as protecting the African American community from STD and HIV infection. It is important to reinforce these concepts because doing so reinforces the client's knowledge, skills and motivation around effective condom use.
- Q. How is **FOF** different from a group intervention session?

- A. **FOF** is an individual, one-time single-session intervention that lasts 45-60 minutes. During this short amount of time, the PHA delivers a tailored intervention to each client addressing specific questions, issues and problematic experiences with condom use. The one-on-one nature of the session allows the PHA to gather information about the client's specific experiences and needs, and tailor the program to address them.

Section 3. Getting Started, Planning, Implementing and Maintaining Focus on the Future

There are a number of factors to consider prior to implementing **FOF**. For example, how many and what kinds of staff you should hire, and how much time and effort your agency should allocate prior to and during implementation. Below are a number of commonly asked questions agencies preparing to implement **FOF** have asked. For more information already provided in the Pre-Implementation section of the Implementation Manual (IM) please refer to the table below.

For More Information on:	See the Implementation Manual
Improving Agency Readiness Checklist	Page 33
Integrating FOF into existing services	Page 34
Preparing to Manage Staff for FOF	Pages 28, 33
Developing an Evaluation Plan	Page 114
Securing “Buy-in”	Pages 24, 26
Recruiting Eligible Clients	Page 38
Marketing the Intervention	Page 40
Introduction to the Facilitators Guide	Page 76
Session Content/ Implementation Guidelines	Page 76
Managing the Quality Assurance Plan	Page 123
Monitoring the Evaluation Plan and Collecting Data	Page 114

Staffing

- Q. How many fulltime equivalent staff (FTEs) are needed to conduct the intervention, and what experience, skills, or competencies should they have?
- A. **FOF** is facilitated by one individual, a PHA. The PHA needs to be someone who is non-judgmental, has a sex-positive attitude, is able to quickly establish a rapport with each client, and who can create an environment of trust and respect that encourages open and honest communication during each session. PHAs should have the following specific 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.);
 - An 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 PHA 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.

Beyond these attributes, there are no specific skills or competencies that the PHA position requires. The PHA can be supervised by one FTE who is already an employee of your agency. This person should have experience supervising and supporting staff, and be able to add the supervision of an additional staff member to their current workload.

- Q. If I can't locate staff with the skills that are needed, what can I do?
- A. If you are unable to find a suitable candidate for the PHA position, other recruitment avenues should be explored. For example, reaching out to agencies that serve young African American men, placing an advertisement in a local newspaper, distributing flyers, or asking clinic staff if they know of anybody may be necessary to find candidates for the PHA position. If somebody who fulfills all the PHA criteria cannot be located, your agency will not be able to implement the intervention.
- Q. Is it okay to use a fewer number of staff because of budget issues?

A. **FOF** is facilitated by one individual, a PHA. If you are unable to hire a PHA, you will not be able to implement this intervention.

Q. May I use volunteers instead of agency staff?

A. As long as the volunteer you utilize for the PHA has the qualities, skills, and training necessary to implement the intervention and is as reliable as paid agency staff, there is no issue with using a volunteer for this position.

Q. Do the staff who conducts the intervention need to be the same race/ethnicity as the clients?

A. Yes, the PHA's physical attributes need to reflect the target population. This is so the PHA can be viewed as a peer by the clients he works with. Due to this requirement, it is important that the PHA be the same race/ethnicity as the clients.

Q. Do the staffs who conduct the intervention need to be the same gender as the clients?

A. Yes, the PHA's physical attributes need to reflect the target population. This is so the PHA can be viewed as a peer by the clients he works with. Due to this requirement, it is important that the PHA be the same gender as the clients.

Q. Can I use peers to facilitate **FOF**?

A. Yes, utilizing peers to facilitate **FOF** is a requirement of the intervention.

Q. Where do we find people with the skills to be facilitators?

A. PHAs can be recruited from the surrounding community in the following ways

- Contacting local agencies that serve a high proportion of young African American men;
- Placing an advertisement in local newspapers advertisements;
- Creating online advertisements;
- Distributing flyers;
- Word of mouth.

Tools are provided as part of the materials package to help you interview and select a PHA.

Q. If a potential facilitator does not have facilitation experience, how can they get training?

A. Facilitation experience is not a requirement for the PHA position. However, it is essential that all PHAs participate in the **FOF** Training of Facilitator's Program. This is a 3-day training whereby PHAs gain the facilitation skills that they will be using when they deliver **FOF** to clients.

Contact the Project Officer at the Centers for Disease Control and Prevention (CDC) or visit www.effektiveinterventions.org to register for the training.

Q. I have a co-worker who would be a great facilitator for **FOF**. Can he implement the program even if he has not had formal training?

A. One of the Core Elements of **FOF** is that it is facilitated by a peer who has been formally trained in delivering the program. If you are unable to find a peer from the community to fill the PHA position you will not be able to implement this intervention. Additionally, the 3-day Training of Facilitators program is mandatory for all PHAs who facilitate the intervention with clients. If a PHA is unable to attend the Training of Facilitators he will not be able to implement the intervention. Contact the Project Officer at the Centers for Disease Control and Prevention (CDC) to register for the training.

Q. When the PHA is not seeing clients, what should he be doing with this time?

A. On days when a sufficient number of eligible clients are not coming into the clinic, it is important that the PHA is using his time at the clinic productively and towards the goals of **FOF**. PHAs should not be performing duties unrelated to **FOF** (e.g., answering phones, filing, etc.).

During downtime, PHAs 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;
- Offer the intervention to other clients who are 16-17 years old or 30-35 years old. However, evidence of effectiveness with these age groups has not been proven (see the “Adapting Focus on the Future” section for more information around this);
- Call clients who participated in the intervention to see if they have any questions and to get feedback about the intervention.

Supervision and Management

Q. Why must all of the agency’s staff be oriented to the intervention?

A. It is important that all staff are oriented to the intervention prior to the intervention being implemented to ensure

- All staff understand the goal of the intervention;
- All staff understand their role and responsibilities associated with **FOF**;
- That there is “buy-in” among staff, which can motivate staff to fulfill their responsibilities as effectively as possible (e.g., recruitment).

Q. How do we keep staff motivated after the training?

A. Keeping staff motivated is important to the implementation process. Staff motivation impacts the number of clients being recruited for the intervention and fidelity to the intervention, amongst other things. Some of the ways that staff can be motivated include

- During staff meeting
 - Sharing the program's successes.
 - Let staff know how many clients the PHA is seeing on a regular basis.
 - Share any positive feedback you or the PHA receives from clients who have participated.
 - Show the **FOF** video to remind staff of what the PHA is addressing with clients.
 - Brainstorm solutions to issues that the PHA may be having or systems level issues (e.g., recruitment messages, screening for eligibility, the point in clinic flow when clients are recruited, etc.).



Q. How do we maintain staff “buy-in” over time?

A. It is not only important to create staff “buy-in” before implementation of the intervention begins, but it is also important that staff are involved, engaged, and encouraged to provide timely and direct feedback throughout implementation. Ongoing 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 “buy-in” to the intervention, they become a force for driving the intervention's success.

To promote on-going “buy-in” from staff, you can consider the following:

- During development of the **FOF** implementation plan
 - Involve staff in considering the value of **FOF** within their clinic setting as you are making the decision about adopting **FOF**. Some key messages you can include as part of this discussion are
 - Integrating peers into the clinic's services will help clients be more honest about their experiences and accepting of what they learn during their visit;
 - **FOF** is inexpensive to implement;
 - In 2009 **FOF** was proven to be effective when implemented with fidelity;
 - Make copies of the original study (included in the Implementation Manual) available to staff who are interested in reading about the original research;
 - **FOF** is a unique opportunity for clients to have a personalized, one-on-one interaction with someone at the clinic who can address their specific issues with condom use for up to an hour each;
 - Involve staff in developing how clients will be recruited and in thinking about the flow of the client through the system;
 - Involve staff in the development of monitoring and evaluation processes, including collection and sharing of relevant findings.

- 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.



Q.

What do I do if eligible clients are not being recruited by staff whose role it is to recruit clients?

A.

If eligible clients are being missed by staff who are responsible for screening clients, those clients will not be recruited for the intervention. In order to ensure that all eligible clients who come into your clinic are screened and recruited for the intervention, you can

- Address staff “buy-in”. If staff do not have an understanding of the intervention and do not feel involved and engaged throughout implementation, they will not view the intervention as a valuable service to provide to clients and recruitment may suffer as a result. To promote on-going staff “buy-in” that will impact recruitment, you can consider the following:
 - 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, particularly those responsible for screening for eligibility and recruitment;
 - Ask staff to brainstorm solutions to challenges with screening for eligibility and recruitment;
 - 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 and how to screen for eligibility.
 - Place a list with the eligibility criteria for **FOF** in a common area where all staff can see it. This will not only help educate staff on what the target population for the intervention is, but also remind them that the intervention is available as part of the clinic's services.



- Q. How can we ensure that staff do not interrupt the PHA in the middle of conducting sessions?
- A. Having staff interrupting the PHA when facilitating the intervention with the client can be avoided by building sufficient “buy-in” at the beginning of the program. If staff have an understanding of the private nature of the conversation that the PHA is having with clients (e.g., by showing staff the video) and understand the value of the intervention, they will be discouraged from interrupting sessions.

If staff interrupting sessions is an on-going issue, you can place a sign on the PHA’s door that states “Do Not Disturb --- Session in Progress.” Also, asking staff not to interrupt sessions of the intervention or sending a memo-reminder to staff can help alleviate this issue.



- Q. As a female supervisor, I believe sitting in the room to observe the PHA would change the dynamic with the client. How can I still provide feedback to him about his performance with clients without directly observing the implementation?

- A. Supervisors can provide feedback without directly sitting in on sessions in the following ways
- Tape record or video record the PHA facilitating the intervention with a client (Note: You will need to get written or verbal permission from a client before doing so);
 - Tape record or video record the PHA facilitating the intervention with another staff member;
 - Listen to the intervention from outside the door in a way that the PHA and client cannot see you (Note: You will need to get written or verbal permission from a client before doing so);
 - Listen to the intervention from another room (Note: You will need to get written or verbal permission from a client before doing so).



- Q. Our county is implementing **FOF** at multiple sites. How can we promote communication between the PHAs and Supervisors at our different sites?
- A. If possible, plan on having the PHAs and Supervisors at different sites communicate with one another. Conducting a bi-weekly or monthly conference call that is facilitated by a Clinic Manager or Director is a good way to increase support for these staff members, share successes, address challenges and get feedback about **FOF** implementation.

Training and Technical Assistance

- Q. How can I request training for my agency?
- A. Contact the Project Officer at the Centers for Disease Control and Prevention (CDC) to register for the training, or visit www.effectiveinterventions.org
- Q. How can I train staff members who were not able to attend the FOF training?

- A. The 3-day Training of Facilitators program is mandatory for all PHAs who facilitate the intervention with clients. If a PHA is unable to attend the Training of Facilitators he will not be able to implement the intervention.

The Implementation Manual contains materials designed to help clinic managers or supervisors who attend the Training of Facilitators program to train other staff who will be involved in implementing **FOF** around the intervention. It is suggested that supervisors hold an in-service where they share what they learned during the Training of Facilitators. It is important that this in-service focuses on why **FOF** is a valuable intervention for your agency, how **FOF** will be integrated into the clinic's flow, what the PHA talks to clients about, and the roles and responsibilities of all individuals involved.

- Q. How do I obtain Technical Assistance?

- A. Technical Assistance can be requested through your Project Officer. Your Project Officer will work with your agency to deliver Technical Assistance on any issues or questions your agency has with implementing **FOF**. Agencies or clinics directly and indirectly funded by the Centers for Disease Control and Prevention may access assistance from Capacity Building Assistance (CBA) Providers nationwide.

Delivering the Intervention

- Q. Is there a **FOF** attendance policy?

- A. As a single-session intervention, there is no attendance policy for **FOF**. However, clients must complete the entire session (i.e., all 6 components) in order to receive the condoms and water-based lubrication at the end. Clients who leave the session before it is over are ineligible to receive these supplies.

- Q. Is taking 45-60 minutes with each client really necessary?

- A. Yes. It is vital that the PHA take the full amount of time to work through each component and address any condom use issues that the client may have.

- Q. If the session is supposed to last at least 45 minutes, can we consolidate or even eliminate topics to shorten the session so it lasts less than 45 minutes?

- A. No, the session cannot be shortened to less than 45 minutes. Through the original research study, the intervention was found to be effective when facilitated as it is written in the Facilitator's Guide. There is no evidence that the shortened intervention is effective if any topics are consolidated or eliminated.

- Q. If a session is supposed to last for a maximum of 60 minutes, can we make the session longer if clients want to stay?

- A. No, this is not an option that clients will have. Often there will be other clients waiting to receive the intervention or other duties that the PHA has that prevents him from spending any extra time with

specific clients. PHAs should also endeavor to keep themselves available so that if a new client is recruited for the intervention at the clinic, he is available to deliver the intervention in a timely manner.

Q. What if the session runs longer or shorter than the suggested length of time?

A. If a session time is less than 45 minutes, this indicates that either all 6 components are not being completed with fidelity or the clients' issues are not being adequately addressed. In this case, review the Facilitator's Guide to determine which components are not being facilitated with fidelity. For example

- Take more time to build rapport and get to know the client.
- Review and address the client's condom use errors from the Short Condom Use Survey (SCUS) in greater detail.
- Ask more open-ended questions to encourage clients to open up about past condom use experiences.
- Take more time to discuss and present options for condom negotiation strategies.
- Ensure clients are practicing applying the condom to the penile model at least 3 times correctly. This can be done by encouraging clients to practice 1-2 times using the card with the correct steps, and then 1-2 times without using the card (from memory).
- Take more time to discuss erection loss and the importance of having a number of good fitting condoms on hand before sex begins.
- Ensure clients are opening, touching and learning about the different features of all of the different types of condoms and lubricants available.
- Ask the client what he will remember, summarize key messages, and ask him to pass the information he learned onto friends and family.

If a session takes over 60 minutes, review the Facilitator's Guide to gain an understanding of what might have caused the session to last too long. For example, the PHA could be

- Going into too much detail with certain components.
- Addressing issues outside of the goals of **FOF** (e.g., providing more STD information than the intervention requires).
- Having difficulties keeping clients on topic.

The PHA should keep a clock or timer in his office so that he can keep track of how much time a session is taking. While a PHA should never begin to rush through a session if he thinks he is going to go over the allotted amount of time, he should become comfortable keeping track of the time for future sessions.

Q. What are some ways to keep the sessions fun?

A. The success of the session for each client depends on the PHA's ability to build a strong rapport with each client and make the session interesting, personal, and fun. Clients need to feel comfortable and relaxed when discussing sexual issues. Some strategies to achieve a fun session include

- Using a sense of humor to make the session fun.
- Focusing the session on the client and his hopes for the future.
- Building up the baby oil experiment. Clients particularly enjoy this part of the intervention and it is a great tool for lightening the mood.
- Clients are also often very excited to learn about, discuss, and touch the high-end condom brands and models they have not had the chance to see before.

Q. Are people who are not participants allowed to attend the sessions?

A. No, **FOF** is a one-on-one conversation between the client and the PHA. Friends, significant others, family members, and others should not be included in the session. This is to ensure that the client is comfortable sharing his experiences, feels he can be honest, and that all of the client's questions or concerns around condom use are addressed.

Q. Why can't family members (brothers and sisters or husband and wife), couples or close friends participate?

A. It is important that **FOF** is conducted one-on-one with a client in a private setting. Clients may be unwilling to share personal information that is important for the PHA to address in the presence of a third party participant. Clients may also simply feel uncomfortable discussing sexual topics in the presence of a third party participant. In order to ensure that clients feel completely comfortable and are able to share all of their thoughts, experiences, and questions with the PHA, it is mandatory that the session remain one-on-one.

Q. How do clients respond to this intervention?

A. Clients who participate in the intervention respond extremely positively. For many clients, **FOF** is the first time someone has taken the time to explain to them how to properly put on a condom. The baby oil experiment, in which clients learn that oil-based lubricants can cause condoms to break, is an exciting and memorable piece of the intervention. Clients are motivated to consistently use condoms when they are presented with the poster displaying the uneven burden of HIV in the African American community. Clients are also very interested in learning about the different condoms that are available, and many are eager to begin using water-based lubrication.

Q. What are the important points for the PHA to articulate when explaining the "National HIV Rates Pie Charts"?

A. Not all clients will be able to easily interpret information displayed on a pie chart. The main point is not to emphasize the numbers or percentages as much as it is to emphasize the significant impact the epidemic has had on the African American community in the US. In order to ensure that clients understand the important points of the pie charts, PHAs should emphasize

- African Americans are disproportionately affected by AIDS in this country;
- 44% of all new HIV infections among men in the US are acquired by African American men;



- 66% of all new HIV infections among women in the US are acquired by African American women;
- 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;
- Although the pie charts can make it seem like more women are infected than men, in fact 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.



Q. Can we provide additional incentives to clients who participate?

A. Yes, you can provide additional incentives to clients who participate. If your agency is planning on offering clients refreshments (e.g., can of soda, bag of chips, etc.), a gift card, or any other type of incentive, be sure to include the added expense in your budget.

“What If’s” During the Intervention



Q. How can the PHA ensure clients are practicing applying the condom to the penile model three or more times correctly?

A. It is important that clients practice correct condom application skills three times or more during the intervention. This is so they can build their skills and confidence with regards to using condoms and water-based lubricant. Some clients will not want to practice correctly applying the condom more than once. In order to prevent this issue from occurring, it is suggested that PHAs

1. Ask the client to apply the condom to the model correctly at least once using the “8 steps to correct condom use” listed on the back of the contact card;
2. Ask the client to apply the condom to the model correctly at least twice without referring to the “8 steps to correct condom use.”

Another way to ensure clients practice correct condom use three or more times is by encouraging the client to practice with at least three of the different condoms and types of lube on the table.



Q. What should the PHA do if he is asked questions about STDs outside of his scope of knowledge?

A. It is not the role of the PHA to provide clients with in-depth STD information, as the focus of the intervention is correct condom use. If a client asks the PHA a question that he does not know the answer to, he should refer the client to an appropriate person in the clinic who has the information or who can direct the client to the appropriate resources to get the information they seek.

The PHA can record basic STD-related questions that come up frequently with clients. Afterwards, during meetings with his supervisor the PHA can get the answers to these questions. By doing this

the PHA will be able to answer the common basic STD questions as they come up, which will increase his credibility with clients.



Q. How can the PHA make the client feel more comfortable touching the water-based lubricant?

A. Clients may feel uncomfortable touching lubricant and getting their hands messy during the intervention. To make clients feel more comfortable touching the water-based lubricant, PHAs should

- Be comfortable touching the lubricant themselves. When opening the lubricant to show clients, PHAs should empty a liberal amount into their hands. PHAs can also rub the lubricant into their hands afterwards, showing clients that lubricant is a good moisturizer as well.
- Have ample napkins or paper towels and hand sanitizer sitting on the table so the client is able to see that he can clean his hands after touching the lubricant.



Q. What should the PHA do if the client refuses to practice correct condom use on the penile model?

A. The PHA should thank the client for coming in and end the session. The client is not eligible to receive the free condoms and lubricant.



Q. What should the PHA do if the client appears to be very hostile, drunk, high, suicidal or violent?

A. The PHA should thank the client for coming in and end the session. The client is not eligible to receive the free condoms and lubricant.



Q. What should the PHA do if the client discloses that he is HIV-positive during the session?

A. The PHA should thank the client for coming in and end the session. The client is not eligible to receive the free condoms and lubricant. If possible, the PHA should refer the client to someone at the agency who can ensure the client is in medical care or to refer client to a local HIV care clinic.



Q. What should the PHA do if the client discloses that he also has sex with men? Or the PHA suspects the client may have sex with men?

A. **FOF** is an intervention for clients who have sex with women; however, these clients are still eligible to participate if they have sex with men in addition to women. If a client discloses that he has sex with men, the PHA should continue with the session and deliver the intervention in such a way that the information is still relevant to sexual activity with women, but does not exclude sexual activity with men.



Q. What should the PHA do if a client asks him to make a presentation about **FOF** in another setting (e.g., at a community event, local college, etc.)?

A. If a client asks the PHA to make a presentation about the **FOF** intervention in another setting, the PHA should let the client know that he needs to talk to his supervisor first. It is up to each PHA's supervisor and clinic policies whether the PHA is able to present **FOF** in the requested setting.

Settings

Q. What types of agencies have used **FOF**?

A. **FOF** was originally implemented and researched at a public STD clinic in the southern United States from September 2004 to May 2006. The intervention and accompanying materials (Implementation Manual, Starter Kit, etc.) were implemented at four public STD clinics in the northeastern and southeastern United States from August to October 2011.

Q. Can the program be conducted in places other than public STD clinics, such as private health settings or community-based settings?

A. Yes, **FOF** can be implemented in settings other than public STD clinics. It is important that settings where **FOF** is implemented have the ability to test and diagnose clients with STDs. For example, a private health care setting or community health clinic that is able to diagnose and treat STDs would be suitable if it serves a sufficient number of the target population (consult the Planning Tool in the Implementation Manual to determine whether or not your agency serves an adequate number of eligible clients). Places like barber shops, schools, and group homes that are not settings where people can be tested and diagnosed with STDs are not suitable settings to conduct this intervention.

Client Recruitment

Q. What can we do if we are not recruiting enough eligible clients?



A. Before implementing **FOF**, agencies should assess whether or not they serve an adequate number of eligible clients on a weekly basis using the Planning Tools provided in the Implementation Manual. Agencies that offer **FOF** should have enough eligible clients coming into their clinics that the PHA is able to see 4 to 6 clients per day.

If your agency has implemented **FOF** but you are finding that there are not a sufficient number of eligible clients who come into your clinic, in order to recruit more eligible clients you can

- Ensure that all the eligible clients that your agency serves are being identified using your current identification and recruitment model. If you discover that some eligible clients are not being recruited, identify what challenges with screening for eligibility and recruitment exist and brainstorm solutions to these challenges with your staff.
- Address staff “buy-in.” If staff do not have an understanding of the intervention and do not feel involved and engaged throughout implementation, they will not view the intervention as a valuable service to provide to clients and recruitment may suffer as a result. To promote on-going staff “buy-in” that will impact recruitment, you can consider the following:
 - 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, particularly those responsible for screening for eligibility and recruitment;
 - 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 and how to screen for eligibility.
- Make **FOF** part of the standard of care for eligible clients. This means that **FOF** is not an option for eligible clients, but a standard part of their care at your clinic. This will prevent clients from opting out of the program.
- Provide additional training or support to the PHA on rapport building. If clients are successfully recruited but decide to leave once the intervention begins, this could be an issue with the PHA's ability to establish a connection with the client at the beginning of the session and make him feel comfortable.
 - Additionally, you can have the PHA first introduce himself to recruited clients while they are still in the waiting room. Other clients in the waiting room will see this interaction, and may become interested in the opportunity being provided to the original client.
- Secure funds for additional incentives. For example, providing clients with a can of soda and a snack (e.g., bag of chips, granola bar, etc.) may entice more eligible clients to participate in the program.

If there are not enough eligible clients coming into the clinic to receive services, this intervention may not be a good fit for your agency.



Q.

How can we reduce or eliminate the number of clients who want to leave in the middle of a session?

A.

Some clients may want to leave during the middle of the intervention. To prevent this from happening, you can

- Make **FOF** part of the standard of care for eligible clients. This means that **FOF** is not an option for eligible clients, but a standard part of their care at your clinic. This will prevent clients from believing they can leave in the middle of the intervention.
- Provide additional training or support to the PHA on rapport building. If clients are successfully recruited but decide to leave once the intervention begins, this could be an issue with the PHA's ability to establish a connection with the client at the beginning of the session and make him feel comfortable.
- Tell participants that they are not eligible to receive the free condoms and lubricants unless they stay for the entire duration of the intervention.

- Secure funds for additional incentives. For example, providing clients with a can of soda and a snack (e.g., bag of chips, granola bar, etc.) may entice more eligible clients to stay for the duration of the program.



Q. Why might a client not be able to or want to participate in **FOF**?

A. Certain clients may decline participating in **FOF**. This could be because clients have

- Someone in the waiting room waiting for them;
- Other appointments they need to attend;
- To pick up their children at day care;
- To go to work;
- To move their car to ensure that they will not receive a traffic ticket;
- To put more money in the meter to pay for parking.

To address this question more completely, please review the two preceding questions.



Q. What should our agency's recruitment messages include to ensure that we're recruiting the greatest number of eligible clients?

A. The most effective way to successfully recruit eligible clients for the intervention is to make **FOF** a standard of care for eligible clients at the clinic. This means that it is part of the services that have been arranged for them while they are in the clinic (i.e., it is not optional).

Other incentives to highlight when recruiting clients include

- \$50+ in free condoms and lubricants;
- A one-on-one discussion with a peer;
- Learning how to protect oneself from future STDs;
- A way to spend one's time while waiting to see the doctor or nurse (if applicable).

Supply Management



Q. Where should we keep the supplies for the intervention?

A. The great number and variety of high-end and popular condoms and lubricants 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 changing the lock to the closet or room where the supplies will be kept prior to implementing the intervention.



Q. How can we avoid having staff members request or take supplies exclusively for **FOF**?

A. The great number and variety of high-end and popular condoms and lubricants that are associated with **FOF** are appealing to both clients and staff. However, none of the supplies should be taken or used by staff. It should be made clear to all staff that **FOF** is not a program with sample condoms

and lubricant and that the supplies are carefully ordered for the anticipated number of clients who will receive the intervention. It is also important to stress to staff that the supplies used are expensive and not easy to replace, so giving supplies to staff may impact the sustainability of the program at the agency.



- Q. The PHA finds it difficult to quickly set the room up between clients (e.g., restocking the table with condoms, lubricant, bags, copies of survey and posters, etc.). What can he do?
- A. The PHA can create a checklist of all the items that need to be re-stocked for each client. This way he can quickly restock all the items before the next client enters the room. For example

<u>FOF Re-Stocking Checklist</u>	
<ul style="list-style-type: none"> ● Condoms <ul style="list-style-type: none"> <input type="checkbox"/> 15 Trojan Magnum <input type="checkbox"/> 15 Trojan ENZ <input type="checkbox"/> 15 Trojan Ecstasy <input type="checkbox"/> 15 LifeStyles King Size XL <input type="checkbox"/> 15 LifeStyles RoughRider <input type="checkbox"/> 15 Durex Tropical Flavors <input type="checkbox"/> 15 Durex Her Sensation <input type="checkbox"/> 15 Durex Pleasuremax <input type="checkbox"/> 15 Kimono Microthin <input type="checkbox"/> 15 Kimono Aloe <input type="checkbox"/> 15 Beyond 7 	<ul style="list-style-type: none"> <input type="checkbox"/> 1 Lifelike Penile Model <input type="checkbox"/> 1-2 Other Penile Models (e.g. woody) <input type="checkbox"/> 1 Ditty Bag <input type="checkbox"/> 1 Bottle of Baby Oil <input type="checkbox"/> 1-2 Rolls of Paper Towels or Napkins <input type="checkbox"/> 1 Contact card (with 8 Steps to Correct Condom Use and PHA's Contact Info) <input type="checkbox"/> 1 List of Stores Nearby with Condoms and Lubricant <input type="checkbox"/> 1 National HIV Rates Poster <input type="checkbox"/> 1 Short Condom Use Survey <input type="checkbox"/> 1 pen ● Lubricants <ul style="list-style-type: none"> <input type="checkbox"/> 30 ID Juicy Lube <input type="checkbox"/> 30 AstroGlide

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.

Intervention Materials

- Q. We have many kinds of posters and patient educational materials at our agency already. How are your materials different?
- A. The messages and materials referred to during **FOF** are uniquely forward-thinking and “sex-positive.” While many materials that are currently available contain much of the same educational material, **FOF** is positioned to make clients feel good about their sex lives, feel good about practicing safe sex, and feel good about their futures. Clients who participate in **FOF** come away

feeling empowered and motivated after hearing the program’s messages, and are likely to share the lessons they learned during their session with their community.

- Q. If we want to change something in a written handout or a video, how should we go about making those changes?
- A. Agencies are welcome to create additional materials to supplement those provided as part of the intervention package. Also, if agencies feel that there is inaccurate information contained within the materials provided, they can and should contact their Project Officer at the CDC. If the agency is indirectly funded through their health department, they should contact their direct funder to request assistance on adaptation. Otherwise, the materials provided for **FOF** should not be changed.
- Q. Do we need permission to translate the intervention materials into another language?
- A. Yes, you should contact the Project Officer at the Centers for Disease Control and Prevention (CDC) regarding questions about translation. If your agency is indirectly funded through your health department, you should contact your direct funder to request assistance on translation.
- Q. Does someone at CDC need to review or approve changes we want to make to intervention materials?
- A. Yes, you should consult your Project Officer before making any changes to the intervention materials. If you agency is indirectly funded through your state or local health department, you should contact your direct funder to request assistance on adaptation.
- Q. Can we modify and change materials (statistics, video, posters, and handouts) to update the intervention?
- A. Throughout the implementation of **FOF** at your agency, updates may be required to the following materials
- National HIV rates broken down by race;
 - Stores in the area that carry condoms and water-based lubricants.

As new National HIV statistics become available, the pie charts should be updated. As stores in the area open, close, change their condom and lubricant prices, and change their hours, updates to the list of stores in the area should be completed.



- Q. How can we ensure that the “List of Stores” covers a variety of stores and brands of condoms and lubricants that appeal to clients?
- A. It is important that the “List of Stores” given to clients covers a variety of stores where clients can purchase high-end and popular condoms and lubricants used in the intervention in larger quantities (boxes of 12 or more). Throughout the intervention, clients are encouraged to plan ahead by purchasing condoms and always making sure that they have a few accessible to them whenever they might have sex. It is stressed that if they wait until the last minute and have to go to a vending machine or gas station to buy a single condom, it may not be the condom with the right fit and feel

for them. Also, if that one condom breaks, the client will be forced to make a difficult decision (i.e., he will have to either stop having sex, go out and purchase another condom in the middle of sex, or have sex without a condom).

In order to ensure that the list covers a variety of stores where clients can purchase boxes of condoms with the right fit and feel, include

- Stores close to the clinic;
- Popular chains (e.g., Walgreen's, CVS, etc.);
- Stores that clients tell the PHA that they often go to to purchase condoms.



Q.

Can we give clients a copy of the “National HIV Rates Pie Charts” to take home with them?

A.

Yes, PHAs can make copies of the “National HIV Rates Pie Charts” and give a copy to each client. Agencies should account for the added printing expenses (e.g., color cartridge, paper, etc.) when preparing their budgets.

Section 4. Adapting Focus on the Future

Agencies adopting **FOF** should make every effort to deliver the intervention to the target audience for whom it is originally intended and in the way it was originally delivered before considering making changes. Any adaptations to **FOF** should be discussed with your Project Officer, who can provide you with technical assistance. If your agency is indirectly funded through your health department, you should contact your direct funder to request assistance on adaptation. It is also advised that staff who are considering adapting parts of the intervention for their local community's needs carefully review the Behavior Change Logic Model and the intervention's Core Elements and Key Characteristics first in an effort to understand the main features of **FOF** likely to create changes reported in the original research. Some parts of **FOF** may be adapted to better fit the needs of your agency and target population. Doing this means agencies must stay within the guidance of the approved adaptation process. Doing so allows **FOF** to be adapted to a different population or setting, but ensures that the effectiveness of the intervention is maintained by preserving the heart of the intervention. For more information on adaptation of the intervention, please see the Adaptation section of the Implementation Manual (IM).

For More Information on:	See the Implementation Manual
Fidelity to the Intervention	Pages 18, 19, 60
Adaptation of the Intervention	Page 60

Maintaining Fidelity

- Q. What is fidelity and why is fidelity so important to **FOF**?
- A. Fidelity is the ability of the implementing agency to deliver the intervention as closely and as accurately to the original design of the program as possible. This includes adhering to all of the Core Elements and Key Characteristics. This ensures that the intervention is as effective as possible and that each client receives as similar an experience as possible. Implementing staff should strive to implement with fidelity, as every adaptation and diversion from the original design jeopardizes the effectiveness of the program, which was only shown to be effective under the original design.
- Q. What is adaptation of an intervention? When is it appropriate to adapt an intervention?

- A. Adaptation refers to changes that are made to the intervention by implementing agencies based on the unique circumstances and characteristics at each agency that the staff feels cannot be circumvented. Often these issues revolve around clinic flow design, the population the agency serves, or the resources available to implement the intervention. While some adaptations to **FOF** can be made without compromising the effectiveness of the program, there are specific Core Elements that cannot be changed. The Core Elements of Focus on the Future are listed in the Implementation Manual (p. 16). You should consult your Project Officer when considering other adaptations. As a general rule, adaptations should be avoided.

Expanding Client Eligibility

- Q. How do we adapt the intervention to serve other populations that the intervention did not target (persons living with HIV infection, Native Americans, transgender clients, etc.)?
- A. **FOF** should not be adapted for other target populations. This intervention was only shown to be effective with the target population (18-29 year old African American males who have sex with women who are not knowingly HIV+), and there is no evidence showing that adapting it to serve other populations will be beneficial.

- Q. Our client base is diverse. Can we deliver the intervention to a mixed population (age, race/ethnicity, or sexual orientation) instead of to one specific population?
- A. No, a crucial aspect of the intervention is the ability of the PHA to reflect the population he is facilitating the intervention with and to be viewed as a peer by the clients. Expanding the criteria to other populations makes it difficult for the PHA to function and build rapport once he is no longer considered a peer to the client. In addition to this, young African American men who have sex with women are specifically targeted by **FOF** because of the current lack of programs that are catered to them, despite the fact that they carry such an uneven portion of the HIV burden in the US.

- Q. Can we offer **FOF** to clients who meet all of the eligibility criteria but fall slightly outside of the age range?



- A. Yes, your agency can offer **FOF** to clients who fall slightly outside of the age range but meet the rest of the eligibility requirements. During the pilot testing of this intervention, one case study agency adapted the intervention by offering it to clients who were 16-17 and 30-35-years-old on days when there were not a sufficient number of clients who fell within the original eligible age range. The PHA reported that there were no distinguishable factors (e.g., experiences, questions, needs, etc.) between these slightly older and younger clients and the clients who met the original age requirement (18-29-years-old), although there was no evaluation conducted to determine whether or not the intervention was effective for these additional participants. Eventually this adaptation was adopted by other case study agencies, who reported similar results. It is important that the intervention is only adapted for these slightly older or younger clients when there are insufficient numbers of traditionally eligible clients at the clinic. It is also important that slightly older or younger clients are

never prioritized over clients who screen eligible under the original criteria. Finally, only clients who fit the original age requirement (18-29-years-old) should be considered when conducting your Pre-Implementation planning.



Q. Can we offer **FOF** to clients who are not able to stay the day they are recruited for the intervention, but are willing to return to the clinic to participate in **FOF** at a later time?

A. Yes, your agency can offer **FOF** to clients who are not able to stay the day they are recruited for the intervention, but are willing to return to the clinic to participate in **FOF** within a 2-week window. The original developer and researcher of **FOF**, Dr. Richard Crosby, believes that this adaptation will not significantly impact the effectiveness of the intervention. During this short window of time (i.e., 2 weeks), clients will still be feeling vulnerable about their STD status. It is important to understand that this is only a theory, and there has been no research conducted to determine whether or not this is an effective practice. If your agency does make this adaptation, these returning clients should not be prioritized over clients who screen eligible for **FOF** in the clinic that same day.



Q. If a client screens eligible for **FOF** more than once at the same clinic, can he receive **FOF** more than one time?

A. No, it is not recommended that clients receive **FOF** more than once. **FOF** was only evaluated as a single-session, so it is unclear if multiple sessions will benefit clients. If a client has received **FOF** and is still engaging in unsafe sex practices, agency staff should provide the client with condoms and consider referring him to other HIV prevention services. If your agency sees a lot of repeat clients engaging in high risk behaviors, your agency should consider other HIV prevention programs (e.g., condom distribution, more intense HIV risk reduction intervention) to compliment **FOF**.

Intervention Content

Q. Can we add additional topics to cover more information, such as how drug use affects the risk of acquiring HIV?

A. No. Through the original research study, the intervention was found to be effective when facilitated as it is written in the Facilitator's Guide. Any other information your agency would like to provide is separate from **FOF** and should not be provided during the intervention. Doing this potentially compromises the intervention's effectiveness. If your clients have other needs that **FOF** does not address, consider referring them to other HIV prevention services that compliment **FOF**.

Q. Can we add or delete material or topics that do not apply to our target population?

A. No, all of the information that **FOF** is comprised of is specifically designed to apply to the target population.

Q. Can I replace a component or activity within a component that does not appeal to participants with one that accomplishes the same objectives?

A. No. Because the time frame that the PHA has to complete the intervention in is short, and because other activities were not evaluated during the original research, different activities cannot be substituted for those used in the intervention.

Q. Can I add information on diseases besides HIV/AIDS to the intervention?

A. No, the PHA is not trained to be a disease specialist. Any questions clients have about specific diseases need to be referred to the appropriate staff at your agency, and any other information you want to ensure clients receive needs to be presented by those staff members as well.

Q. Can we change the order of the components?

A. Yes, PHAs can change the order of the components, except in three cases.

1. “Component 1: Rapport Building” must be completed first. This is because the client must feel comfortable with the PHA and trust him before any of the goals of the subsequent components can be achieved.
2. “Component 2: Filling in the Gaps” must be completed second. This is because the PHA needs to first assess where the gaps in the client’s knowledge are before he can tailor the rest of the session to the client’s needs.
3. The second half of “Component 6: Fit and Feel” must be completed last. It is important that clients do not get to fill the bag with 25+ condoms and 25+ packets of water-based lubricant until the very end of the intervention. Some clients may ask or demand to leave once they have their bag of free condoms and lubricant. In order to prevent this from happening, clients should not fill up the bag until the end. It is also important that the session is closed in the manner described in the Facilitator’s Guide (i.e., asking the client what he will remember from the session, summarizing key messages, asking the client to pass the information he learned to friends and family).

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. 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. 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 larger group of people.

Q. Can the PHA share relevant local statistics during the intervention (e.g., “40% of all HIV infections in this state are in our city” or “our city has the third highest HIV rates in the country”)?

A. Yes, PHAs can share state or local statistics with clients. This can add to the client’s understanding of their HIV risk and their motivation to use condoms.



Section 5. Monitoring and Evaluation Plan

There are a number of reasons an agency may want to evaluate an intervention. Evaluation ensures accountability to the community, staff, clients, and funding source, and also helps improve the quality and delivery of the intervention. Evaluation helps the agency decipher what strategies worked and did not work, which is important in order to effectively improve and adapt their programs. For more information on the types of evaluation your agency will conduct and why, refer to the “Maintenance” section of the Implementation Manual (IM) or the Monitoring and Evaluation Guide (M&E) in the IM.

For More Information on:	See the Implementation Manual
Managing the Quality Assurance Plan	Page 123
Monitoring the Evaluation Plan and Collecting Data	Page 114
Institutional Review Board Approval	Page 27
Process Data	Page 114, 120, 121
Process Monitoring and Evaluation	Page 114
Process Evaluation	Page 116, 122, 123
Monitoring Intervention Outcomes	Page 114, 118

List of Commonly Asked Questions

- Q. How do I evaluate the program?
- A. The two main methods of evaluation for **FOF** are process monitoring and process evaluation.
- Process monitoring involves recording the number and characteristics of the clients participating in the intervention, keeping track of the resources used, and monitoring the delivery of the intervention itself for consistency and adaptation.

- Process evaluation involves comparing the data collected during process monitoring to the information in your agency’s implementation plan. The goal of this is to see how your implementation of the intervention may have changed over time, and helps to identify any potential areas for improvement in your implementation strategy. This type of evaluation is useful in ensuring that your agency maintains fidelity to the Core Elements of the intervention.

When designing your Monitoring and Evaluation plan, you should aim to write SMART (Specific, Measurable, Appropriate, Realistic and Time-based) process objectives. Refer to the Monitoring and Evaluation section of your Implementation Manual (p. 113) for greater detail on SMART process objectives.

A third type of evaluation, formative evaluation, often takes place during the design and pre-testing of the program in order to assess the feasibility and appropriateness of the intervention for your agency.

Q. Do we have to use all of forms included in the Monitoring and Evaluation Guide?

A. The forms you use when monitoring and evaluating **FOF** will depend on your monitoring and evaluation plan. The forms that have been included in the Monitoring and Evaluation Guide have been provided for your agency to use or for your agency to adapt, however, they are not mandatory to use.

Q. What is the difference between process evaluation and process monitoring? What is the difference between process monitoring and outcome monitoring?

A. Process monitoring involves recording ongoing activities in a setting that indicate how services are being delivered. Data collected to monitor a process typically includes: the number and characteristics of the clients who receive the intervention, the resources used in order to implement the program, and either directly or indirectly monitoring the actual delivery of the intervention. For example, you can record the amount of time each session of **FOF** takes.

Process evaluation involves comparing the data collected during process monitoring to the information in your agency’s program objectives. The goal of this is to see how your implementation of the intervention may have changed over time, and helps to identify any potential areas for improvement in your implementation strategy. This type of evaluation is useful in ensuring that your agency maintains fidelity to the Core Elements of the intervention. For example, you can use your process monitoring data to determine the average amount of time each session of **FOF** takes over a given period of time, and use this number to evaluate whether or not the PHA is spending the appropriate amount of time with each client.

Outcome monitoring refers to 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. While this kind of data may be useful for your agency to collect

for its own purposes, the CDC does not require that you report it as a requirement of being funded to implement **FOF**.

Q. What is the Institutional Review Board (IRB) and is IRB approval required to implement FOF?

A. The IRB is a committee that has been formally designated to approve, monitor, and review biomedical and behavioral research involving humans, with the aim to protect the rights and welfare of the research subjects. An IRB is not required to implement **FOF** as no biomedical or behavioral research will be conducted. **FOF** is not a research project but a service that your agency will be offering clients who screen eligible.