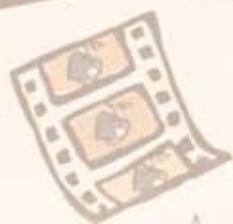


The Adaptation Guide

Adapting HIV Behavior Change Interventions for Gay and Bisexual Latino and Black Men



Healthy Relationships



A small group-level intervention with people living with HIV/AIDS.

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for friendship
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for life

4-UP: DEFEND YOURSELF



BROTHERS KEEPING BRO



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FOREWORD

Recent statistics show the disproportionate impact of HIV on gay and bisexual Latino and Black men. The Centers for Disease Control (CDC) is highly committed to reducing HIV and health disparities that exist among these populations.

This guide is designed to assist you in adapting behavior change interventions for gay and bisexual Latino and Black men. The CDC collaborates with community partners on a continuing basis and tools like this guide are designed to support you in your HIV prevention work.

The impact of HIV on Latino and Black gay and bisexual men has been significant and continues to pose a threat. Statistics show the disproportionate impact. There were about 54,230 cases of HIV among Whites, Blacks, and Hispanics in the United States in 2006. Of these HIV cases, almost half (46%) were in Blacks; and, among Blacks, almost half (41%) of the HIV infections were in men who have sex with men (MSM). The impact of HIV on Latino MSM is large as well. Of the total 2006 HIV cases, 18 percent were among Hispanics. More than half (59%) of these HIV cases were in Hispanic MSM.¹

These numbers are even more urgent because the Black and Hispanic populations in the U.S. are small. Only about 13 percent of the United States population is Black and about 15 percent is Hispanic.² And, the percentage of men who are sexually active with other men in any current year is not more than five percent of the total United States population.³ Black and Latino MSM are very much affected by HIV.

The CDC is committed to the fight, but cannot do it alone. Community partners play an essential role in providing behavior change prevention strategies and are critical in the fight to reduce HIV and health disparities that exist among Latino and Black MSM.

We believe that an urgent and collaborative response between CDC, community members, and influential leaders is needed to decrease HIV/AIDS in these populations. Together we can make a difference!

Rashad Burgess, Chief,
Capacity Building Branch
Division of HIV and AIDS Prevention
Centers for Disease Control and Prevention

August 2010

PURPOSE OF ADAPTATION GUIDE AND TARGET AUDIENCE

This Guide provides basic information, resources and tools for adapting HIV behavior change interventions for gay and bisexual Latino and Black men. This Guide is for those who deliver HIV prevention interventions to gay and bisexual Latino and Black men.

Throughout this Guide, we share two stories about adapting interventions. One story line is that of the **Hope AIDS Project** in Alabama, who just learned of a new funding opportunity to provide HIV prevention interventions in their state. They have a local university contact that will help them apply for the funding. The second story line is about **Border Health Services** in Texas. Tired of seeing young, gay Latino men getting infected, sick, and even dying from HIV and AIDS, they are applying for funding to make a real difference in these young men's health and lives. In this Guide, you will learn how the **Hope AIDS Project** and the **Border Health Services** select and adapt an HIV behavior change intervention, and the impact this has on the men in their communities.



HOW TO USE THIS GUIDE

The Chapters in this Guide walk you through how to select and adapt an intervention. In each Chapter we provide tools to help you with the selection and adaptation process. We also give you links to information and resources available on the Internet.

- **Chapter 1** gives you an overview of evidence-based HIV behavior change interventions. It also provides a summary of the Adaptation Process and a review of the literature on HIV and behavior change in gay and bisexual Latino and Black men.
- **Chapter 2** explains the Selection Stage of the Adaptation Process. This includes how to collect information on a population's HIV behavioral risk (HIV transmission behavior and behavioral determinants); HIV behavior change interventions; population "readiness" to address risk and receive interventions; and agency "readiness," or capacity to address risk and deliver interventions. This Chapter also talks about how to assess and select an intervention for adaptation, which will be used with gay and bisexual Latino and Black men.
- **Chapter 3** outlines the Adaptation Stage of the Adaptation Process. It talks about how to identify intervention activities to adapt; how to test and revise adaptations; and how to monitor and evaluate adaptations.
- **Appendices** have resources and tools to assist you with the Adaptation Process. They also contain, in full, the two adaptation stories told in Chapters 2 and 3.

THE BEHAVIOR CHANGE APPROACH TO HIV PREVENTION

“Behavior change” is one type of prevention practice used to reduce the spread of HIV/AIDS in the United States. Other prevention practices are disease control or bio-medical interventions and public health strategies. Structural or policy interventions may also be used to combat HIV/AIDS. We explain these types of prevention practices below to help you understand their roles in HIV prevention.

- **Disease control interventions** are also called **bio-medical interventions** and **public health strategies**. They are used to lower a person’s chances of spreading or getting HIV and other sexually transmitted diseases (STDs). For example, taking medicine like highly active antiretroviral therapy extends the life of a person living with HIV/AIDS. It also lowers the amount of HIV in a person’s body, which lowers the chances of that person spreading HIV to someone else. Other examples of disease control interventions are STD treatment and circumcision. **Disease Intervention Services** is a public health strategy that locates where cases of disease are, so treatment and prevention services can be offered. Public Health Strategies are HIV Counseling, Testing and Referral, Comprehensive Risk Reduction Counseling and Services, and Partner Services. These work with Disease Intervention Services to reduce HIV within a community or location. They also work with behavior change intervention approaches.
- **Structural and policy interventions** make changes on a larger social level. They also increase access to HIV prevention services. For example, if the Food and Drug Administration were to approve in-home, rapid HIV testing. These interventions also make changes to the physical environment to support HIV prevention efforts. This includes things like putting condom dispensers in bar restrooms or placing a health center in a community. Structural interventions can also lower stigma, make sure people are safe, and give groups the power and tools to speak up for themselves. For example, passing laws and setting up

programs that protect human rights, make violence against gay men illegal, and reduce unfair treatment because of income and gender.⁴

- **Behavior change interventions** help a person or a group of people to change their HIV transmission behavior, which lowers their chances of getting infected with HIV or giving HIV to someone else. For example, they help a person or group of people to always use condoms when having sex. These interventions can also help a person or a group of people to never share infected needles or other drug injection equipment. Behavior change interventions can increase positive, healthy behaviors like getting an HIV test or HIV treatment. They also target “risk groups” and settings. Risk groups can include runaway youth who do not use condoms, Black gay men who do not use condoms, and injection drug users who share dirty needles and/or do not use condoms. Settings can include jails, STD clinics, and bathhouses where people have unprotected sex or share dirty needles.

This Guide talks about how to adapt HIV behavior change interventions that can be used to lower or do away with HIV transmission behavior in gay and bisexual Latino and Black men. When we talk about HIV transmission behavior in this Guide, we mean unprotected anal intercourse and sharing infected needles.

Role of Behavior Change Interventions in Preventing HIV

HIV behavior change interventions are based on behavior science. Behavior science explains how people form behaviors and how these behaviors can be changed.⁵ In this Guide, we talk about changing HIV transmission behavior (unprotected anal intercourse, sharing infected needles) among gay and bisexual Latino and Black men. Also in this Guide, we only look at how to adapt evidence-based HIV behavior change interventions.

Evidence-based interventions have been shown by research to lower HIV transmission behavior. The CDC finds and reviews evidence-based interventions to help HIV prevention efforts in the United States. You can find these evidence-based interventions online in CDC’s Compendium of Evidence-based HIV Prevention Interventions. To access the Compendium, which currently has 69 interventions, go to www.cdc.gov/hiv/topics/research/prs/index.htm.



To make evidence-based interventions easier to understand and use, CDC has put in place its **Diffusing Effective Behavioral Interventions (DEBI)** project. The CDC takes an evidence-based intervention and “packages” it into a DEBI. Each DEBI has a “how to” manual and tools that walk you through how to do the intervention. CDC also provides training and technical assistance for the DEBIs. We suggest you use a DEBI when adapting interventions for gay and bisexual Latino and Black men. Go to www.effectiveinterventions.org for more information on DEBIs. DEBIs and evidence-based interventions that can be used and adapted for men who have sex with men are listed in the Guide’s appendices. Not every evidence-based intervention in CDC’s Compendium has been made into a DEBI.

Behavior science also talks about “**behavioral determinants.**” These are the things, or the factors, that are known to determine HIV transmission behavior. These factors are sometimes called the “reasons why” people do behaviors that can transmit HIV. For example, if a Black gay man does not know how to use a condom, it is unlikely he will use condoms. By not using condoms, he has a greater risk for giving or getting HIV. In this example, the behavioral determinant is the person’s lack of knowledge about condom use. You would want to change that person’s knowledge about condoms with an intervention. Once he knows how to use a condom, his chances of using one during sex go up. This lowers his risk for giving or getting HIV.

When we talk about the determinants of HIV transmission behavior in gay and bisexual Latino and Black men, we are talking about the **proximate (very near or close) social-cognitive determinants of HIV transmission behavior, i.e. condom use.** These are social and/or cognitive (thoughts, thinking) factors that have been shown in health psychology and social and behavioral science to determine a person’s use of a condom. Common social-cognitive determinants of individual HIV transmission behaviors in DEBIs are: knowledge; self-efficacy (belief in ability to do something); intentions; expectancies; attitudes; beliefs; perceived norms; perceptions; rationalizations; skill(s) to do behaviors; social norms; social support; and individual, social or community power and control (empowerment). In this Guide, we are talking about the proximate social-cognitive determinants or behavioral determinants. When we talk about HIV transmission behavior in this Guide, we are mostly talking about the nonuse of condoms.

Behavioral determinants include things “inside the individual,” like a person’s knowledge, skills, attitudes, and beliefs. Interventions given to one person or to people in small groups may address these “inside the individual” behavioral determinants. For example, one reason why gay and bisexual Latino men are having unprotected anal intercourse

is because they do not think they are at risk for getting HIV. To change that behavior, an intervention would first need to change beliefs about risk. So, an intervention would let a Latino man know there are a lot of people just like him in his community with HIV. It would also let him know most people are getting HIV from unprotected anal intercourse. This information may then help him to change the way he thinks about his risk of getting HIV.

Another example is one of new immigrant gay and bisexual Latino and Black men in a locale like Oakland, California. Determinants for these men might include knowledge and perceptions of condoms, as well as skills to use condoms. An agency decided to adapt the *VOICES/VOCES DEBI* for these men because this intervention targets these determinants. Adaptations the agency made to *VOICES/VOCES* included changes that addressed the languages these different immigrant populations use; branding of condoms in a way the men liked and could relate to; and delivering the intervention in a community setting where the men would be more at ease, rather than in a clinic. The agency also made *VOICES/VOCES* part of a dating program for newly arrived immigrant men, to help these men find people to date and to also learn about gay culture in their new homeland.

Behavioral determinants can also be things “outside” a person. This includes things like social norms, social support, racism, and homophobia. Community level interventions may address some of these types of behavioral determinants. For example, one reason why men have unprotected anal intercourse is because there is a “shared belief” or social norm of their social network that they do not need to use condoms. If the community does not value condom use, its members are not likely to value it as well. A community level intervention would change the community wide belief or social norm or “social pressure” to one that supports condom use. The new social norm might be that using condoms is a sign you are trying to keep yourself and your partner healthy.

How HIV Prevention Behavior Change Interventions “Work”

Behavior change interventions target behavioral determinants. Intervention activities address or change the determinants of the behavior. The change in these determinants effects or changes subsequent behavior by which the virus can be transmitted

Intervention activities are the actions you take in doing an intervention. They also are the things you do to monitor an intervention to make sure it is working with your population. In this Guide, we break down activities into “**Who**,” “**What**,” “**When**,” “**Where**,” “**How**,” and “**Why**.” The “*What*” is the topic of the activity, and also includes images that are liked by the intervention’s target population. The “*Who*,” “*When*,” “*Where*,” and “*How*” tells who is involved in the activity, and how to do it. The “*Why*” is the purpose or intent of the activity.

The way in which an intervention combines its activities – The “*Who*,” “*When*,” “*Where*,” and “*How*,” and “*Why*,” to get a certain result is called the intervention’s logic. For example, if an **intervention’s logic** is to build a person’s skills and beliefs they can use condoms, it does this by teaching people how to use condoms. One of its activities is to practice putting condoms on a penis model. The “*What*” is about using a condom. The “*Who*,” “*When*,” “*Where*,” and “*How*,” and “*Why*,” is having a health educator tell how to use a condom and then letting the men practice putting a condom on a penis model. After doing this activity, the men will have built skills to use a condom. Another result is the men will believe more in their ability to use a condom. If you only give a lecture about how to use a condom to these men, you will only give them information. But, if you give a lecture on how to use a condom and provide a skill and practice session, you will increase the men’s knowledge of how to use condoms and their belief in their ability to use a condom.

There are two types of results, or outcomes, for HIV behavior change interventions:

- **Immediate outcomes – changes in determinants** happen during or right after a person takes part in an intervention. Examples include changes in a person’s knowledge, attitudes, perception of risk, skills, intentions, and self-efficacy (belief in ability to do something). Changes can also happen in social norms and social supports.
- **Short-term outcomes – changes in transmission behavior** happen after the intervention when opportunities for such behavior occur in the lives of the men who received the intervention. Changes occur in the HIV transmission behavior itself, such as increased condom use and decreased sharing of infected needles.

HIV Behavior Change In Gay and Bisexual Latino and Black Men

When thinking about adapting interventions for gay and bisexual Latino and Black men, it helps to know what the research says about these populations. This section provides a review of the literature on HIV transmission behavior and risk among gay and bisexual Latino and Black men who have sex with men. Most of the literature reviewed comes from studies that focus on men who have sex with men. Fewer studies focus just on Black and Latino gay and bisexual men. In the Guide's appendices, references are listed for all of the studies used in this review.

The research shows that sexual transmission is responsible for most HIV infections in men who have sex with men.⁶ Men who have sex with men are at risk for HIV for many of the same reasons, no matter what their race and ethnicity. These reasons include thinking that HIV will never affect them, having a hard time sticking to safe behaviors when having sex over the course of a lifetime, and not practicing safe behaviors because of the effects of homophobia and stigma.⁷ While the level of unprotected sex among Black gay and bisexual men may not be as high as that among whites,⁸ the amount of virus and makeup of their sexual networks make them at highest risk for transmission.^{9,10,11,7} Latino men who have sex with men are also at high risk.

While disease control, structural and community level HIV interventions are needed for Black and Latino gay and bisexual men, behavior change interventions will continue to have a role in HIV prevention.^{12,13,14,15,16} Behavior change interventions impact aspects of sexual and injecting behavior. This involves things like using condoms when having sex or using clean needles when injecting, rather than stopping sex or injecting behavior. If all men who have sex with men use condoms for sex and only use clean needles, then uninfected people will not get infected and infected people will not infect others. Modifying the behavior prevents the transmission of HIV.

There are only a few HIV transmission behaviors. These are unprotected sex, sharing infected needles and drinking mother's infected milk. But, there are many reasons people act the way

they do. And, each act has its own environmental, cultural, social and psychological features. There are also differences in the determinants that affect HIV transmission behavior. Differences in HIV transmission behavior exist between and within subgroups and individuals not just in amounts, but also in how the behavior comes about (culturally), is arranged, and takes place.¹⁷ For example, group norms driving unprotected sex in a subculture of Black gay men in Philadelphia can be quite different from those in a subculture of gay Latino men in El Paso. Sources of social support can also vary.¹⁸ How and why a gay Black man forms his intention to have safer sex may not be the same as that among other gay Black men. Likewise, attitudes and beliefs are relative and specific to different cultures. Beliefs about types of partners who can infect you range a great deal among Black gay men in St. Louis. Attitudes and beliefs among bisexual Latino men living in New York City also vary because of cultural differences.¹⁹ And, there are different levels of HIV transmission behavior among Black men who have sex with men in Brooklyn.²⁰ Because culture varies and can affect a person's or a community's HIV transmission behavior in different ways, we need different types of HIV behavior change interventions.

It is unlikely that any one HIV behavior change intervention will work for every instance of an HIV transmission behavior. You will need to adapt the intervention. This is because the cultural factors that affect behavior will vary across time and place. Adaptation is needed no matter how closely an intervention matches the behavioral determinants and the context of the HIV transmission behavior.^{21,22,13}

The exact makeup of an HIV transmission behavior, from subculture to subculture, from person to person, and sometimes even within a person, is hard to see. Even when the behavior is "right in front of us," it is not easy to see all of its cultural and individual differences. Teasing apart these differences and choosing an intervention that best addresses the behavior is the role of the local community prevention provider. This key task is something only community prevention providers can do because of their knowledge, experience, and access to their service populations.

Behavioral Assessment

Part of the adaptation process is to do a behavioral assessment, which we talk about in detail in Chapter 2. When gathering information on HIV behavioral risk (HIV transmission behavior, risk factors, and behavioral determinants), you will likely look at studies that apply to your service population and their HIV transmission behaviors. Current literature is useful but has some limits. There is no complete description of all the behavioral risks of gay and bisexual Latino and Black men in the United States. Gathering this information would take huge resources. Reviewing the current literature requires pulling together insights from limited, small studies of subgroups of gay and bisexual Latino and Black men. Many of the studies are not focused on HIV transmission behavior. Their main purpose may be to describe sexuality or how much HIV disease exists in a population. These studies, though, can be very helpful to program developers and service providers because they increase knowledge about a population or a practice. In 2007, Millett, Malebranche and Peterson²³ published this type of review of the literature on HIV/AIDS research among Black men who have sex with men. In 2000, Peterson and Carballo-Diequez²⁴ published a review of research on risk reduction for Black and Latino men who have sex with men.

What to Adapt?

After learning about HIV behavioral risk in your targeted groups and areas, you will want to think about what types of HIV behavior change interventions to adapt. Know that the behavioral determinants of HIV transmission behavior of gay and bisexual Latino and Black men are like those of other people. But, as we have just noted, the context and makeup of these behaviors can vary by culture. This makes it hard to find an HIV behavior change intervention model that will be an easy “fit” to the exact behavior. Most interventions modify HIV transmission behavior through condom use. A small number of behavioral determinants have been shown in health psychology and social and behavioral science to be able to affect a person’s use of a condom.



Behavioral Determinants of HIV Transmission Behavior

Within the last 10 years, the literature on United States Latino and Black men who have sex with men points to some well-known behavioral determinants of HIV transmission behavior. Reviewing this information can help agencies better understand the needs of their populations. These behavioral determinants include:

- Self-efficacy^{25,26,27}
- Intentions²⁵
- Knowledge^{28,29,30,31,32}
- Attitudes³³
- Ideologies, perceptions of and beliefs about risk, treatment and testing^{34,35,36,37,38,39,40,41,28}
- Communication, negotiation, or disclosure skills including intentions^{42,43,44,45,46,47,48,49,50,51,27,43,37}
- Coping⁵²
- Social support^{53,54,18,25}
- Community involvement^{55,46}
- Perceived and social norms^{56,18,27,33,39,48,53,54}

Risk Factors and Conditions

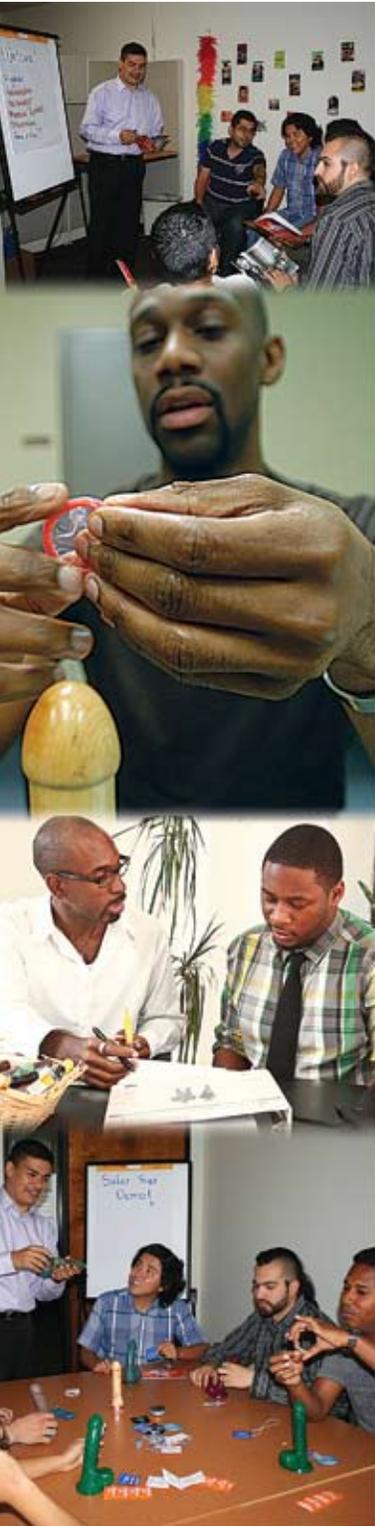
The literature also talks about **risk factors** and broader conditions under which HIV transmission behavior exists. These are important to explore so you can better understand your population and select the best intervention to adapt. For example, substance use is noted as a context for unsafe sex.^{57,58,59,60,61,62,10,22,25,30,36,48} Behavior change interventions may need to address and use behavioral determinants of condom use when someone is drunk or high.⁶³ While condom interventions may not “treat” substance use and abuse, they may address intention to use condoms for sex when using substances.

Interventions may also need to be adapted to work with certain populations within certain risk environments. Other contexts for adapting interventions talked about in the literature we reviewed include:

- Environments and environmental conditions, situations and/or venues like the Internet^{64,65,34,48,51}
- Incarceration⁵⁴
- Racial discrimination^{36,52,54}
- Stigma³⁶
- Sexism³³
- Family and other social support^{66,53,54}
- Age or developmental stage⁶⁷
- Educational attainment and acculturation^{30,52}
- Fatalism as a potential cultural factor³⁴
- Interpersonal factors like partner type or choices^{68,69,12,61,67}
- Relationship status^{70,69}
- Intimate partner violence⁷¹
- Other background factors or conditions that are psychological or very individual in nature like: social anxiety;⁷² internalized homophobia;^{26,46} fatalism in the individual;³⁴ identity;^{73,74,75,76} stress and/or distress;^{77,78} coping;⁵² pleasure;⁵¹ and cognitive disengagement from behavior.³³

Looking at men who have sex with men studies will help you broaden your understanding of your population. This will help you to select and adapt an intervention that best addresses the needs of your population.





THE HOPE AIDS PROJECT AND BORDER HEALTH SERVICES STORIES

To give you “real-life” examples of how the Adaptation Process works, we begin two story lines here. In this Guide, we tell the story of the Hope AIDS Project, an AIDS Service Organization in Fairhope, Alabama. The Hope AIDS Project wants to offer an HIV behavior change intervention to the Black gay men in its service population. They have been doing outreach to educate Black gay men about HIV and STDs. They have also been trying to get these men to come to their agency for HIV and STD testing and treatment services. But, like many agencies, their funding is tight and they do not have a lot of resources. Their Executive Director is seeing a new trend in funders wanting to support projects that use evidence-based interventions. He just learned the State health department is looking to fund agencies to provide DEBIs to gay and bisexual Black men. He decides to look into this funding and learn more about DEBIs.

Our second story line is about Border Health Services in McAllen, Texas. This small, community health organization on the Texas border is worried about the increase they are seeing in HIV and STD cases in young, migrant Latino men who have sex with men. They see a need for an intervention that builds support among these young men to use condoms. To figure out how to get funding for this project, Border Health Services meets with a contact they have at the local university. At this meeting, they learn about State health department funding for DEBIs. The funding is for a three-year project, which would give Border Health Services the time it needs to work with this population. Border Health Services and the university decide to partner and apply for State funding to do this project together.

Both the Hope AIDS Project and Border Health Services get the funding to provide a DEBI. In this Guide, we will share the process both agencies go through to select and adapt a DEBI for their populations. The Hope AIDS Project story is woven throughout Chapters 2 and 3. The Border Health Services story is told in two parts, at the end of Chapters 2 and 3. Both of these adaptation stories also appear in full in the Guide’s appendices.

OVERVIEW OF THE PROCESS FOR ADAPTING EVIDENCE-BASED HIV BEHAVIOR CHANGE INTERVENTIONS

Why Adapt?

While the number and types of DEBIs and evidence-based interventions continue to increase, they do not address every risk group and every risk behavior. Few of these interventions were developed solely with gay and bisexual Latino and Black men in mind. Some DEBIs and evidence-based interventions do apply to these populations, but you still will likely need to adapt them. For example, an intervention for Black gay men was proven to work. But, the original intervention study was done in New York City. The attitudes, beliefs, norms, and behaviors of Black gay men in New York City may not be the same as those of men from other regions. Some changes may be needed for Black gay men in the South or Midwest. To use this intervention, you would need to adapt some of its activities to make it better suited to your population.

What is Adaptation?

Adaptation is the process of changing or modifying an intervention's activities to address:

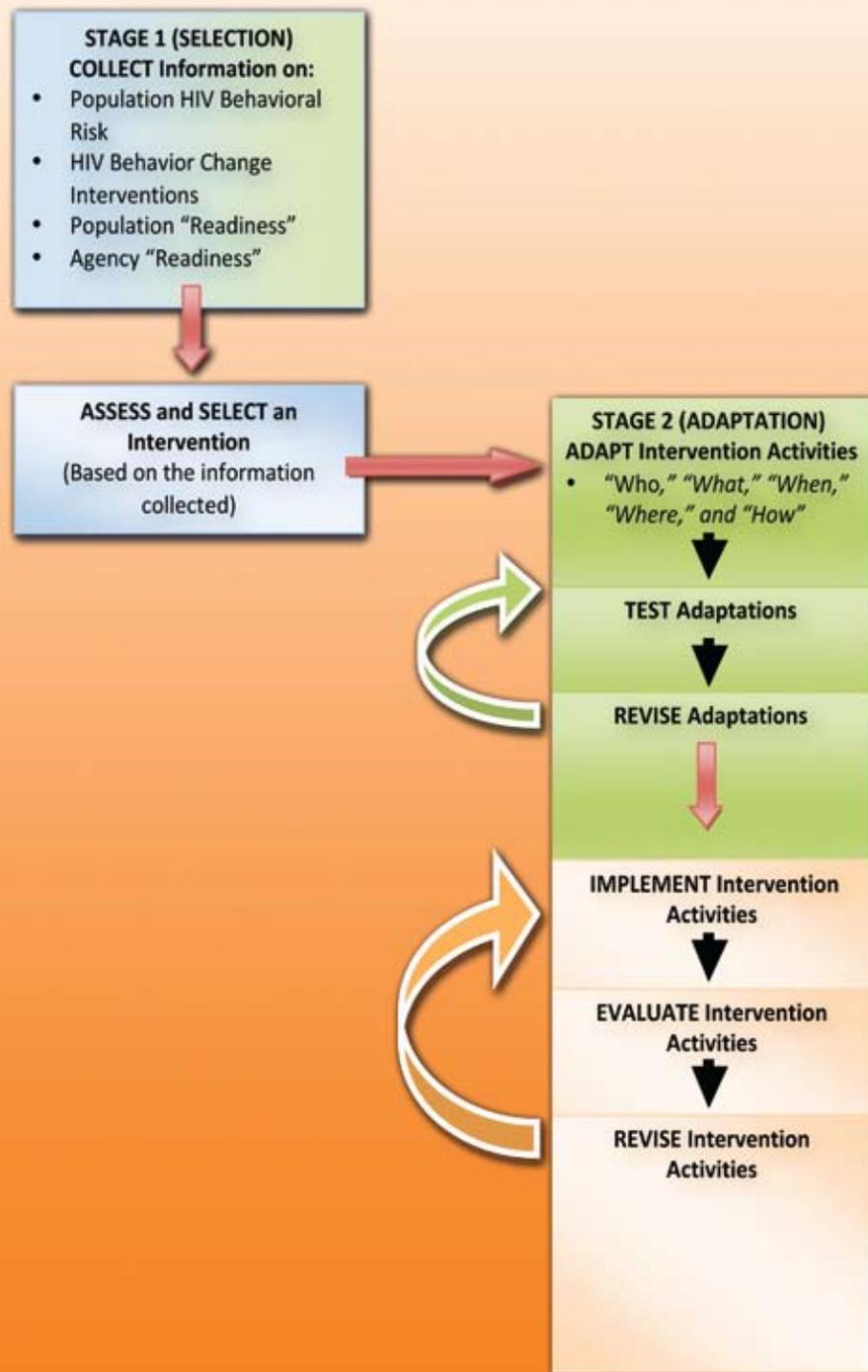
- Your **population's HIV behavioral risk** – HIV transmission behavior and behavioral determinants.
- Your **population's "readiness"** – willingness, need and ability to participate in interventions.
- Your **agency's "readiness"** – current or future capacity to deliver interventions and available resources.

You must be careful not to change any part of an activity that could change an intervention's core elements, logic or intent. If you do so, you may not get the protective results.

Overview of the Adaptation Process

The **Adaptation Process**, shown in Figure 1, has two stages: 1) the **Selection Stage**; and 2) the **Adaptation Stage**. For each stage, there are certain steps to complete. Due to the nature of the Adaptation Process, you may find some overlap in the steps. Also, some of these steps may happen at the same time, rather than in order. Chapter 2 tells you about the Selection Stage. Chapter 3 walks you through the Adaptation Stage.

The Adaptation Process: Stage1 (Selection) and Stage 2 (Adaptation)



Stage 1: Selection

The Selection Stage has two steps: 1) collect information; and 2) assess information and select an intervention.

- **The collect step** is where you gather information on your population’s HIV behavioral risk (HIV transmission behaviors, risk factors and behavioral determinants). You then collect information on DEBIs and other evidence-based interventions that address your population’s HIV behavioral risk. You also collect information on your population’s “readiness,” or willingness, need and ability to participate in interventions. And, you gather information on your agency’s “readiness” to provide interventions. This includes current capacity and resources, or capacity you can build easily. The information you collect helps you narrow your choices of interventions. It also helps you select an intervention that best meets your population’s and your agency’s needs. You use this information again in the Adaptation Process Stage 2, when you decide what intervention activities to adapt and how to adapt them.
- **The assess and select step** is where you review and assess the information you collected. You do this to find the best intervention to use with your population. You look at whether or not the intervention:
 - Targets your population’s HIV behavioral risk (HIV transmission behaviors and behavioral determinants).
 - Will be accepted by your population and/or the local community.
 - Can be adapted and carried out by your agency, using current or future resources, time, staff and funding.

Stage 2: Adaptation

The Adaptation Stage has three steps: 1) adapt intervention activities; 2) test and revise adaptations; and 3) implement, evaluate, and revise the intervention activities.

- **The adapt step** is where you identify and adapt an intervention’s activities, using the information you collected in Stage 1.

- **The test and revise step** is where you test your adaptations. This is also called **pilot testing**. You do this to see if the changes you made are working to give you the results you need. You also look at whether or not your **intervention population** likes the activities. Testing gives you feedback you can use to change the activities further.
- **The implement, evaluate, and revise step** is where you conduct and **monitor and evaluate** your adapted intervention activities. You collect information during this step, so you can see if the activities you changed are working to give you the results you want. You then change the activities, as needed.

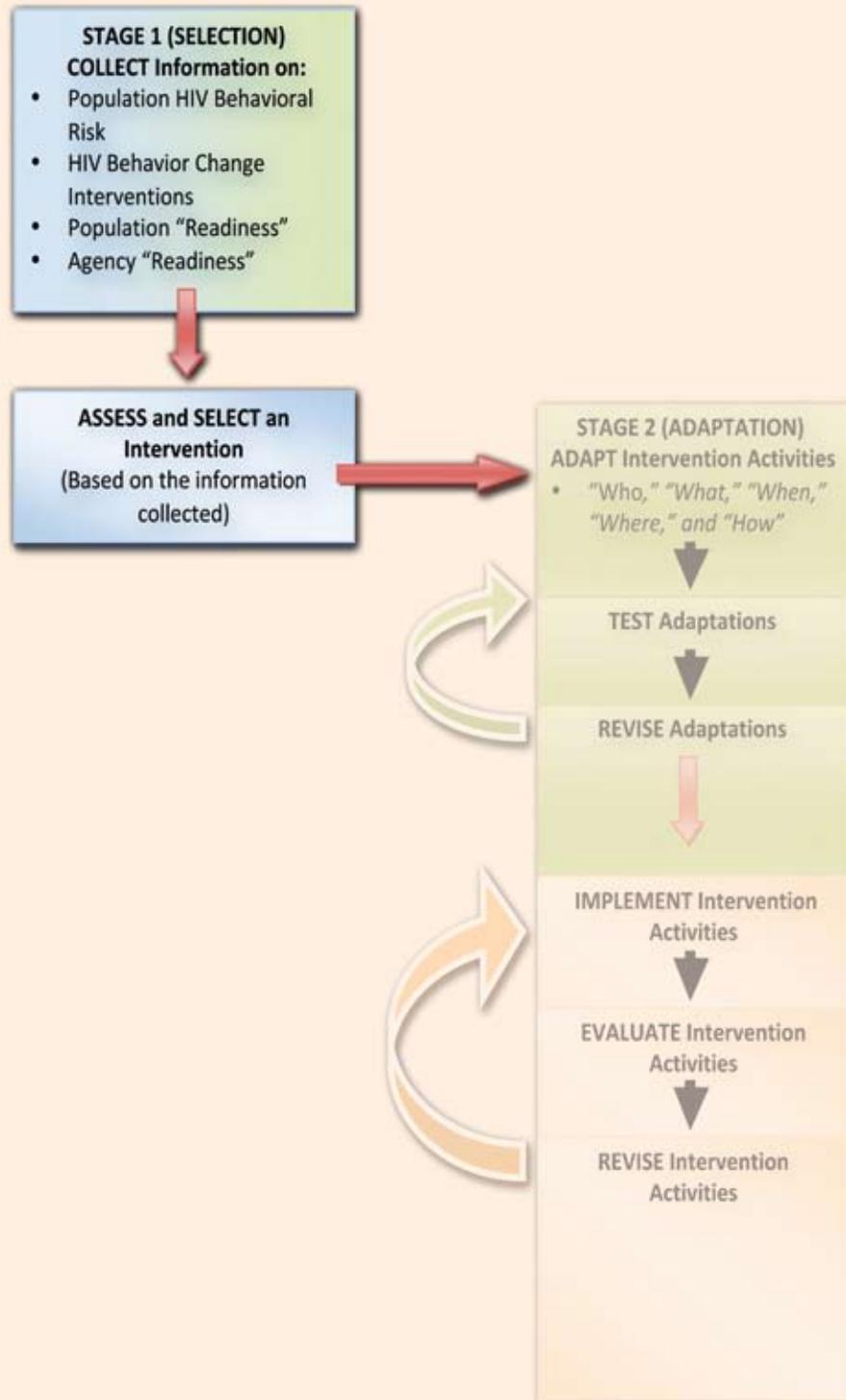
Sometimes an intervention just may not be a good “fit” for your population, even with adaptation. You may find after many rounds of adapting and testing your changes, the intervention is not working. If this happens, you need to go back to the Adaptation Process Stage 1 and select a new intervention.

Getting Help with Adapting Interventions

The Adaptation Process can be hard, even if you have done it before. We suggest getting technical assistance when you adapt an intervention. There are resources you can turn to for technical assistance and support. You can talk with your CDC Project Officer or funder about how to get technical assistance. You can also get help from your State or local health department and other experts, including CDC capacity building agencies, consultants, or staff from your agency that have experience with interventions. Your State or local HIV community-planning group is another good resource for information and help.

CDC’s National Network of STD/HIV Prevention Training Centers offer training courses on selecting interventions and data collection methods for adapting interventions. Go to <http://depts.washington.edu/nnptc> for more information.





THE HOPE AIDS PROJECT STORY

The Hope AIDS Project is an AIDS Service Organization that has been providing HIV and sexually transmitted disease (STD) testing and treatment services to Black communities in Fairhope, Alabama and surrounding areas since 2000. The agency's office is in the heart of the Black community and is known as "the clinic." People know you can get an HIV test, STD exam, see an "AIDS" doctor, and get "meds" at the clinic. Most clients of the Hope AIDS Project are poor, with little or no access to health care. A large number of clients are HIV-positive Black gay men who have a history of STDs. The Hope AIDS Project Executive Director, Wayne Simmons, wants to do something to prevent new cases of HIV among the Black gay men in the community. Alabama's State Health Department had a new round of funding for Black men who have sex with men. The funding says that agencies must provide a DEBI. The Hope AIDS Project feels they are in the right place at the right time and apply for the funding. They get the funding for a three-year period and are very excited! The agency's staff does not know a lot about behavior change interventions, so they think this will be a learning process. Wayne Simmons forms a committee to help the agency select and adapt a DEBI. He thinks this process will be a challenge and wants all the help he can get. On the committee are two high-level clinic administrators, two medical staff, and a client advocate.

The Hope AIDS Project's first order of business is to learn more about the HIV transmission behaviors of Black gay men in Fairhope. The agency has a contact with Auburn University, who refers them to Dr. Sharron Hawkins in the School of Nursing. This turns out to be a great contact because Dr. Hawkins has a lot of experience working with HIV prevention programs for Black communities in the South. She knows the Hope AIDS Project needs to learn more about the knowledge, attitudes, beliefs and behaviors of the Black gay men they serve. Learning this will help them figure out how these men are putting themselves at risk for HIV. Dr. Hawkins explains to the committee that a knowledge, attitude, beliefs, and behavior survey is the best way to collect this information. She helps the committee develop the survey.



The survey asks about knowledge, attitudes, and beliefs about HIV, STDs, condom use and negotiation, intentions, and partner communication. It also asks the men to rate how secure they are with talking about safer-sex with their partners, and how worried they are about getting HIV or an STD. The survey asks the men if there are any places in the community where they can be themselves without fear of discrimination or judgment. It also asks the men about the attitudes of their friends and other men in the community.

The Hope AIDS Project has done community assessments in the past, so its staff and volunteers know how to do surveys. But, Dr. Hawkins still does an in-service training to make sure all staff and volunteers understand the survey and its purpose. She also teaches them how to help community members with reading problems complete the survey. To get more in-depth information, Dr. Hawkins suggests they also do interviews with key informants. She helps the Hope AIDS Project put together the interview questions. The questions ask about unprotected anal intercourse, attitudes about condom use, what it is like to tell someone you are gay, how people respond when you tell them you are gay, and substance use. The Hope AIDS Project staff then did the surveys and interviews. We tell you what they found out later in this Chapter.

The Committee next sets out to learn more about DEBIs. They go to www.effectiveinterventions.org to do research. They download all the interventions designed for and/or tested with men who have sex with men. The Committee also gathers information on how “ready” gay Black men in Fairhope are to take part in an HIV behavior change intervention. They want to know if the men have any interest in getting HIV information. They also want to know if the men are willing to come to an intervention. And, they know they need to find out about the things that might stop the men from taking part in an intervention. Drawing on their good standing in the community and the relationships the staff has with key leaders, the Hope AIDS Project holds a meeting with community leaders. At the meeting, they explain the project and

why they need feedback from Black gay men. The Hope AIDS Project gets buy-in from the leaders right away, who said they would help find men to come to focus groups and interviews.

The Hope AIDS Project holds two focus groups – one for Black gay men aged 18 to 30 and one for Black gay men aged 31 to 50. One of the agency’s volunteers knows of a church network of Black gay men and some of its members agree to come to the focus groups. Dr. Hawkins and the client advocate work on questions to ask during the groups. The questions range from what type of HIV-prevention activities would the men like to the locations they would be able to get to and feel at ease in. The focus groups last about an hour and are done over a three-week time frame. The Hope AIDS Project staff and volunteers also do in-depth interviews with key informants. The interviews are held all over the city at times good for those being interviewed. Each interview is no more than one hour long. We tell you what the Hope AIDS Project finds out about the men later in this Chapter.

As they were collecting information, the Hope AIDS Project thought it would be helpful to find out the best ways to recruit men for an intervention. The committee asked staff and volunteers where the most popular “spots” or “hangouts” were for Black gay men. The agency then sent staff to observe these locations. Observers drew maps of each of the spots and nearby neighborhoods. They also wrote on the maps the best times to access and observe Black gay men. After weeks of observations and talking with men at the spots, the staff figured out the best times and places to recruit men. They even found some new volunteers!

Lastly, the Hope AIDS Project looks at its “readiness” to provide interventions. They dust off their agency’s capacity assessment done one year ago so they can update the information. You can find more information and resources on agency capacity assessments in the Guide’s appendices. We tell you about what the Hope AIDS Project learns from their information collection process later in this Chapter.

CHAPTER OVERVIEW

The Selection Stage has two steps:

- **Step 1 – Collect Information.** You gather information in four areas:
 - **Your population’s HIV behavioral risk** – this includes information on HIV transmission behaviors (unprotected anal intercourse, using infected needles), risk factors or contexts, and behavioral determinants (knowledge, self-efficacy, perceived risk, etc.). Because not all gay or bisexual men in your population are the same, you will define different subgroups or “profiles” of HIV behavioral risk that exist within your population.
 - **HIV behavior change interventions** – this involves identifying evidence-based interventions that address your population’s HIV behavioral risk, can be adapted and used by your agency, and will be liked by your population. We suggest you adapt a DEBI because of the materials and technical assistance you can get from CDC and other sources to adapt the intervention.
 - **Your population’s “readiness”** – this includes your population’s interest, willingness and need to address HIV transmission behavior. It also includes how able they are to participate in intervention activities.
 - **Your agency’s “readiness”** – this is your agency’s capacity (skills, staffing, access to population) and resources (funds, staff, volunteers) to provide interventions.



- **Step 2 – Assess and Select Interventions.** In this step, you assess the population, intervention, and agency information you collected in Step 1. You then select an intervention that best addresses the HIV behavioral risk in your population. You:
 - **Organize and match your population’s HIV behavioral risk.** You look at and match the HIV behavioral risk in your population with the interventions you collect.
 - **Create a narrowed list of interventions.** You select a small number of interventions to learn more about. These interventions should address the HIV behavioral risks you think are the most important to change in your population.
 - **Select an intervention that best meets the HIV behavioral risk “profile” you need to address.** Remember, you have different population subgroups with different HIV behavioral risk “profiles.” You need to choose the population subgroup you think is the most important to focus on, and the intervention that best addresses its risk. You also need to think about your population’s and your agency’s “readiness.” At this point, you can also begin to think about what activity(s) in the intervention you might need to adapt. Keep in mind you adapt activities to make the intervention work better, to produce the results you want, and to make the intervention one your population will accept.

You may be thinking this sounds like a lot of work that you do not need to do. You most likely know your population, what they need, and what works best with them. You may even have experience with some of the DEBIs and other evidence-based interventions. That said, we strongly advise you not to skip Stage 1. You do not want to select an intervention that your agency cannot do and your population will not take part in. You do want to select an intervention that will have the most prevention impact. To do so, you need the most current information at hand. You need to look at any new or emerging issues in your population. And, you need to know and understand as much as you can about the interventions you are thinking about adapting. We suggest you get technical assistance for this key step. See page 18 of the Guide for information on how to get technical assistance.

SELECTION STAGE STEP 1: COLLECT INFORMATION

Population's HIV Behavioral Risk

To figure out which interventions target your population's HIV transmission behavior, you need to first identify your population's **HIV behavioral risk**. A population's HIV behavioral risk is made up of **HIV transmission behaviors**, **risk factors**, and **behavioral determinants**.



HIV transmission behaviors are behaviors that people do that can result in the passing of HIV from one person to another. This is done through HIV infected blood, semen or breast milk. For gay and bisexual men, the biggest HIV transmission behavior of concern is unprotected anal intercourse. When we talk about HIV transmission behavior in this Guide, we are mostly talking about the nonuse of condoms.

Risk factors are activities, conditions or things which have been related statistically to a transmission behavior. Risk factors relate to likelihood of a transmission behavior occurring. Examples include lifetime number of sex partners and substance use.

In this Guide, we define **behavioral determinants** as the proximate (very near or close) social-cognitive determinants of HIV transmission behavior, i.e. condom use are social and/or cognitive (thoughts, thinking) factors that have been shown in health psychology and social and behavior science to be able to impact an individual's use of a condom. Common social-cognitive determinants of individual HIV transmission behaviors in DEBIs are: knowledge; self-efficacy (belief in ability to do something); intentions; expectancies; attitudes; beliefs; perceived norms; perceptions; rationalizations; skill(s) to do behaviors; social norms; social support; and individual, social or community power and control (empowerment). In this Guide, we are talking about the proximate social-cognitive determinants or behavioral determinants. For example, the *d-up!* DEBI addresses the social norm of condom use by and for Black men who have sex with men. The *Healthy Relationships* DEBI focuses on self-efficacy for condom use.



Before you collect information about your population's HIV behavioral risk, you should put together a list of key questions to answer. Questions can include:

- What are the subgroups in your population? These can be sex workers, immigrants, and injection drug users. Keep in mind that not all gay and bisexual Latino and Black men will have the same HIV behavioral risk. You will most likely identify different subgroups in your population with different behavioral risk. For example, gay and bisexual Latino men who are homeless will have different behavioral risk than gay and bisexual Latino men who are not homeless.
- What are the HIV transmission behaviors in your population subgroups? This includes behaviors such as unprotected anal intercourse and using infected needles and other drug injection equipment.
- What are the behavioral determinants affecting your population's HIV transmission behavior? Determinants include things like lack of knowledge about HIV and lack of peer or social support for using condoms.

You may have a team of staff persons from your agency collect information. You may also ask Board members or volunteers to help with gathering information. To guide this process, it is useful to put together a written plan that outlines the information you will collect, who will collect it, and a timeline. This helps you make sure all tasks get done. Types of information to collect include:

- HIV transmission behavior
- Behavioral determinants of HIV transmission behavior, like low self-efficacy for condom use, lack of knowledge around HIV prevention, social norms and values, etc.
- Key issues affecting HIV transmission behavior, such as substance use prior to unprotected anal intercourse, intimate partner violence and homelessness
- Places/venues where people gather (hang out) in the community and can be reached

HIV Behavior Change Interventions

There are quite a few DEBIs and other evidence-based interventions to learn about. You want to find and collect information on as many interventions as you can that address your population’s HIV behavioral risk. Keep in mind not every intervention you look at will be a match for the HIV behavioral risk you need to address.

Two CDC sources for finding HIV behavior change interventions are:

- The DEBI website at www.effectiveinterventions.org
- The Compendium of Evidence-based HIV Prevention Interventions at:
www.cdc.gov/hiv/topics/research/prs/best-evidence-intervention.htm

We suggest you look at the DEBIs first because they have intervention “kits” and materials you can use. You can also get technical assistance and training on the DEBIs. See page 18 of the Guide for how to get help.

For each intervention you find, collect the following information:

- Target population
- Purpose or intent
- HIV risk behavior and behavioral determinants the intervention targets
- Behavior change logic models
- Core elements and key characteristics
- Mode of delivery – individual, community, or group
- How long the intervention is and when it occurs (number and length of sessions)
- Places where the intervention happens
- Results or outcomes
- Staffing and volunteer requirements
- Resource requirements

Talk with your funder and other technical assistance providers to learn more about DEBIs and other evidence-based interventions. See the Guide’s appendices for a list of DEBIs and other evidence-based interventions for men who have sex with men, and for technical assistance resources.

Population “Readiness”

Collecting information on population “readiness” helps you learn more about the kinds of interventions and activities your population is most likely to support. It also helps you learn about any problems or concerns your population has with different types of interventions and activities. For example, an intervention may call for many sessions over a long period of time. Your population may not be able to attend a lot of sessions, due to work or other reasons. If you combine all the sessions into a weekend workshop, this intervention may work for your population. Also, an intervention may match your population’s HIV behavioral risk, but they may not like it. For example, an intervention may call for one-on-one counseling with a psychologist. You learn your population does not trust or respect professional counselors. An intervention that addresses the same HIV behavioral risk but uses peer educators may be a better fit.

Information to collect on population “readiness” includes:

- Interest in taking part in different types of intervention activities like counseling, educational sessions and HIV testing
- Barriers to taking part in interventions like lack of transportation, privacy concerns, and time commitment
- Things that would increase participation in interventions like incentives (money, coupons for services) and transportation assistance



Agency “Readiness”

Knowing your agency’s “readiness” helps you choose interventions your agency is able to provide. For example, if an intervention calls for a psychologist and you do not have one on staff or the funds to hire one, you may want to cross that intervention off your list.

Agency “readiness” includes your agency’s current capacity and resources. It can also include capacity you can build easily and resources you can get readily. Capacity is everything from staff skills to agency experience and access to the population. Resources are money and other things like space, equipment, volunteers and Board help. Information to collect on your agency’s readiness includes:

- Knowledge and experience with individuals and population subgroups
- Skill with implementing interventions (group facilitation, counseling, rapid HIV testing, accessing social networks, doing peer outreach)
- Languages spoken by staff
- Experience with DEBIs and other evidence-based interventions
- Funding, including any funding restrictions
- Space for interventions
- Staffing and volunteers
- Access to your population
- Agency mission and values
- Current partnerships with other service providers, community agencies, gatekeepers, stakeholders, and consultants. It is helpful to understand their needs and interests to determine what effect, if any, this will have on your agency’s efforts.

Returning to our story line, we look at the information the Hope AIDS Project collected on: HIV behavioral risk (HIV transmission behavior, risk factors and behavioral determinants); HIV behavior change interventions; population “readiness;” and agency “readiness.”

The Hope AIDS Project gathered information on HIV behavioral risk in their population of Black gay men. At the same time, they collected information on population “readiness.” Staff and volunteers went to the places Fairhope Black gay men hang out to recruit participants for its survey, focus groups, and in-depth interviews. They also visited bars, choir rehearsals, book clubs, and other events to find men to fill out surveys. It took them about four weeks to collect all of the information. The Hope AIDS Project staff worked with some of Dr. Hawkins’ students to design a database for the survey and interview information. Dr. Hawkins then helped the agency to sort through the information and figure out any trends in behaviors among the men. The Hope AIDS Project learns a lot about Black gay men in Fairhope from the survey. They find:

- *Black gay men in Fairhope are at risk for HIV infection because they are having unprotected anal intercourse:*
 - *79 percent reported they had unprotected anal intercourse (receptive) in the last 3 to 6 months*
 - *72 percent reported they had unprotected anal intercourse (insertive) in the last 3 to 6 months*
 - *5 percent reported using drugs like methamphetamines and ecstasy before having unprotected anal intercourse in the last 3 to 6 months*
 - *50 percent reported using alcohol before having unprotected anal intercourse*
- *Black gay men in Fairhope have many reasons for having unprotected anal intercourse:*
 - *HIV is not a problem in my community*
 - *I do not have sex with “those kind of dudes”*
 - *I do not think I can get “it” if I am the Top*
 - *I do not think I can talk about condoms with my partners*
 - *I do not think I am at risk for HIV because I am not a White gay man*
 - *I do not know how to negotiate condom use with my partners*
 - *I trust my sexual partners are “clean” because I do not see them at “the clinic”*
 - *My friends and I do not use condoms*

- *I only have sex when I am drunk and/or high*
- *Condoms are for gay men and I am not gay, so I do not need to use condoms*
- *My family does not accept me being gay*
- *My pastor/priest does not approve of being gay and says I am going to hell*
- *Unprotected sex “feels good and is sexy”*

From the focus groups and in-depth interviews the Hope AIDS Project learns:

- *The men did not want to participate in activities held at the Hope AIDS Project because it was known as the “the clinic”*
- *The men prefer to participate in activities that happen online or on the weekend*
- *The men want to participate in activities where they can interact with men “who get down” or are “in the life”*

After learning about their population, the Hope AIDS Project begins to look at the DEBIs. They go to www.effectiveinterventions.org to review and download all the interventions designed for and/or tested with men who have sex with men. They review: d-up!, Mpowerment, Popular Opinion Leader, RESPECT, Many Men, Many Voices, Healthy Relationships, VOICES/VOCES, and Community PROMISE. On the website they find and review “Starter Kits” for the interventions that contain:

- *Intervention fact sheets, including core elements*
- *Implementation summary sheets*
- *Sample budgets/cost worksheets*
- *Behavior change logic models*
- *Procedural guidance*
- *Agency readiness self-assessments*



The last thing the Hope AIDS Project collected information on was their “readiness.” They did informal, brief interviews with staff and looked at their current resources. They also filled out the readiness assessments for the DEBIs they were looking at on the www.effectiveinterventions.org web site. The Hope AIDS Project finds they have:

- *A strong and positive history of working with Black gay men*
- *Limited experience doing HIV prevention activities*
- *Strong community partnerships with many agencies and groups*
- *Staff with knowledge and skills*
- *Basic office and computer equipment*
- *Space to conduct meetings (two conference rooms)*

We explain how the Hope AIDS Project uses the information it gathered to select an intervention in the next section of this Chapter.

Methods for Collecting Information

We know collecting information can seem like a huge task. We also know every agency will have different levels of support for this task. So, where do you start? The simple answer is to start with what you already have. Using existing resources is always the best way to go. Many agencies have written population information from past needs assessments, program records, and donor reports. Agencies may also have capacity assessments and surveys of staff skills. Your State or local health department has HIV and STD statistics for different population groups. The HIV community planning group in your area should have needs assessment reports that have information about different population groups. State or local health department staff and planning group members should also have information or experience with HIV behavior change interventions.

Another great resource for population information is experts. You may have experts at local colleges or universities. You may also have experts in your agency, on your Board of Directors, or in other agencies. Experts may even have direct experience with the interventions you are thinking about adapting. You can also look at published journal articles and literature reviews to learn more about your population.

Sometimes existing resources do not have all the information you need. Information may be old and may need to be updated. Or, there may be a new or emerging issue in your community you want to learn more about. For example, there may be a growing community of recent immigrant Latino men who have sex with men who do not self-identify as gay. This group's HIV rates are rising and you want to find out why. There are a number of methods to use to collect information about your population. More information about these methods can be found in the Guide's appendices.

- **Surveys** allow you to collect and assess information on attitudes, knowledge, beliefs and practices around HIV with many people. Surveys use brief and focused closed-ended (yes/no, select one, etc.) questions. They can also contain open-ended questions. Some people feel more at ease sharing personal information on a survey because they do not have to give their name. You can also use surveys to get information about people's experiences with HIV services and barriers to getting these services.
- **In-depth interviews** are done with one person at a time and use open-ended questions that allow you to explore a topic more in-depth. By talking one on one with a person, you can get more details about risk-taking behavior. For example, you can learn more about a person's thoughts, feelings, and experiences that led them to take risks.
- **Focus groups** are led by a facilitator and have a small group of people focus in-depth on one topic or issue. For example, you can find out what people think about a program's service. You can also have people talk about the HIV-related needs they have that are not being met.
- **Direct observation** allows you to watch what is happening in a setting. It can help you learn more about how people behave and interact in the "real world." For example, observations can help you figure out where your population likes to hang out. This could be useful when finding places to recruit people for an intervention or to conduct outreach activities.

Selection Stage Step 1 Key Points

In this step you collect information to identify your population's HIV behavioral risk. You gather information on HIV behavior change interventions that address your population's HIV behavioral risk. You also collect information on your population's "readiness" to receive an intervention, and on your agency's "readiness" to provide an intervention. You will use all of this information in Step 2 of the Selection Stage, where you select an intervention to adapt. The information collection step is key because it helps you select an intervention that best addresses your population's HIV behavioral risk, is one your population will accept, and is one your agency will be able to implement.

Key Points:

- Collect information on your population's HIV behavioral risk. This includes information on HIV transmission behavior, risk factors, and behavioral determinants. Always use information that already exists to save time and money. When collecting "new" information, always be sure to thank the people you talk with or survey.
- Gather information on all the DEBIs and other evidence-based interventions that address your population's HIV behavioral risk. Identify as many interventions as you can, so you have enough to choose from. Not every intervention you look at will be a good match. Begin with the DEBIs because you can access materials, training, and technical assistance for them.
- Collect information on your population's "readiness." This includes looking at your population's need, willingness, and barriers to taking part in interventions and activities. This helps you select an intervention that your population will accept, like and be able to take part in.
- Collect information on your agency's "readiness." This involves looking at your agency's current and/or future capacity and resources. Use and update past agency capacity assessments when possible. This helps you select an intervention that your agency has (or could easily get) the staff, money and other resources to implement.

SELECTION STAGE STEP 2: ASSESS AND SELECT AN INTERVENTION

The Hope AIDS Project is now ready to begin Selection Stage Step 2. The agency reviews the information it collected in Selection Stage Step 1 and selects an intervention. As they make their choices, they keep in mind their population’s “readiness” and their agency’s “readiness.”

In Step 1, the Hope AIDS Project chose eight DEBIs to think about adapting. They are: d-up!, Mpowerment, Popular Opinion Leader, RESPECT, Many Men, Many Voices, Healthy Relationships, VOICES/VOCES, and Community PROMISE. They downloaded materials for each of these DEBIs from the www.effectiveinterventions.org web site. The Hope AIDS Project Committee now reviews these materials to see which interventions best address, or “match,” the HIV behavioral risk in its population of Black gay men. They also use the results of the survey, in-depth interviews, focus groups, and observations to guide their decision-making.

The Hope AIDS Project’s Organize and Match Information Tool					
	Population	HIV Transmission Behavior	Behavioral Determinants of HIV Transmission Behavior	Population “Readiness”	Agency “Readiness”
Information Collected	Black gay men with a history of STDs	Unprotected anal sex	Low self-efficacy for condom use; low-self-efficacy for condom negotiation; low perception of risk; poor communication skills; lack of knowledge about how HIV/STDs interact; low or no social support; rejection from family, friends, and religious community	Will take part in activities that happen online or on the weekend; will not come to the agency because it is known as “the clinic;” will take part in activities where they can interact with men who “get down” or “are in the life.”	Experience working with the Black community and with Black gay men; limited experience implementing HIV behavior change interventions; strong community partnerships; has space to conduct meetings and provide interventions; has office and computer equipment.
Interventions That Address These Things	<i>d-up!</i> <i>Mpowerment.</i> <i>Popular Opinion Leader</i> <i>RESPECT</i> <i>Many Men, Many Voices</i> <i>Healthy Relationships</i> <i>VOICES/VOCES</i> <i>Community PROMISE</i>	<i>d-up!</i> <i>Many Men, Many Voices</i> <i>Healthy Relationships</i> <i>VOICES/VOCES</i>	<i>d-up!</i> <i>Many Men, Many Voices</i> <i>Healthy Relationships</i> <i>VOICES/VOCES</i>	<i>d-up!</i> <i>Many Men, Many Voices</i> <i>Healthy Relationships</i> <i>VOICES/VOCES</i>	<i>d-up! (not sure if we have the resources or capacity)</i> <i>Many Men, Many Voices</i> <i>Healthy Relationships</i> <i>VOICES/VOCES</i>
Rationale for Interventions Listed	All interventions were designed for and/or tested with men who have sex with men.	We learned our population’s HIV transmission behavior is unprotected anal intercourse. These interventions all address this HIV transmission behavior in some way. Some of them also cover the relationship between HIV and STDs, which is important for our population. This is why this list is shorter.	We list only the interventions that best address our population’s most common reasons for engaging in risk behavior. This is why this list is shorter.	These interventions match our population’s readiness. The interventions listed look like they have activities we can modify to meet our population’s needs.	These interventions seem to best match our agency’s capacity. We have experience working with the Black community and with Black gay men. We also have experience with STDs. The one that would be a “stretch” for us is <i>d-up!</i> This is a community level intervention. We do not have a lot of experience with this type of intervention.

The Hope AIDS Project next looks at the “pros and cons” for each DEBI. They use the Organize and Match Information tool that follows to write down how well each intervention “fits” into the services their agency offers. They also note how well each intervention “matches” the HIV behavioral risk of their population. The Hope AIDS Project uses an **Organize and Match Information Tool** to examine their options (see chart, bottom left).

The Hope AIDS Project’s Organize and Match Information Tool allows them to have everything in one place when they sit down to decide which intervention to select. In the tool, the Hope AIDS Project summarizes the information they collected on their population of Black gay men in the top row of the table. This includes their population’s HIV transmission behavior, behavioral determinants, and “readiness.” The Hope AIDS Project also notes its agency’s “readiness” in the top row. In the second row, the agency then lists interventions they identified that address each of these areas. They do not limit the interventions they list, so they will have a good number of options to look at. In the third row, the Hope AIDS Project states its reasons for matching the interventions with the areas in the top row of the table.

The Hope AIDS Project is now ready to narrow its intervention choices. In the Organize and Match Information Tool, they look across the “Interventions That Address These Things” row to see which interventions appear in all or most of the columns. They see that the eight DEBIs they chose do not address all of its population’s behavioral determinants in the same way. They also see their population has different levels of “readiness” for each of the DEBIs. And, they know their agency is not “ready” to do all of the DEBIs, based on staff skill level and experience. Based on this assessment, the Hope AIDS Project narrows their choices to four interventions – d-up!, Many Men, Many Voices, Healthy Relationships and Voices/VOCES. These DEBIs make the agency’s “short” list because:

- They match their population
- They address the HIV-transmission behavior of Black gay men in Fairhope
- They address some of the behavioral determinants of their population’s HIV transmission behavior
- They have or can easily get the resources or build the capacity needed to conduct the intervention
- Their population is “ready” to take part in these interventions

The agency now has a much smaller list of interventions to choose from.

*The Hope AIDS Project next uses another tool – the **Assessing Interventions Tool**, to look more closely at the four DEBIs on its short list. We share the **Assessing Interventions Tool** they complete for the **Many Men, Many Voices DEBI**.*

The Hope AIDS Project's Assessing Interventions Tool for <i>Many Men, Many Voices</i>			
Intervention Name and Brief Description: <i>Many Men, Many Voices</i> is an intervention to prevent HIV and STDs among Black men who have sex with men. It addresses factors that influence behaviors of Black men who have sex with men including cultural, social and religious norms; interactions between HIV and STDs; sexual relationship dynamics; and social influences that racism and homophobia have on HIV risk behavior. This individual level intervention is delivered to small groups of men who have sex with men.			
	Original Intervention	Your Population	Match or Adapt
Population	Gay men of color; men who have sex with men, bisexual men (including men who do not self identify as gay)	Black gay men who have sex with men with a history of STDs	Was the intervention designed for your population? Yes No Describe what changes you may need to make so that it is a better fit.
HIV Transmission Behavior	Unprotected sex, specifically unprotected anal intercourse	Unprotected anal intercourse	Was the intervention designed to change the HIV risk behavior in your population? Yes No Describe what changes you may need to make so that it is a better fit.
Behavioral Determinants	Intentions and skills to use condoms; interactions between HIV and other STDs; sexual relationship dynamics; attitudes and coping with cultural, social and religious norms; and the social influences that racism and homophobia have on HIV risk behaviors	Low self-efficacy for condom use and condom negotiation; low or no social support; rejection from family, friends and religious community	Was the intervention designed to change the behavioral determinants of HIV transmission behavior in your population? Yes No Describe what changes you may need to make so that it is a better fit.
Population Readiness		Will participate in activities that happen online or on the weekend; will not come to the agency because it is known as "the clinic;" will take part in activities where they can interact with men who "get down" or "are in the life"	Was the intervention designed for and tested with your population? Yes No Describe what changes you may need to make so that it is a better fit. We will need to adapt activities to have the sessions take place at a site to be determined during a weekend retreat, and not at the agency's clinic during the week.
Agency Readiness and Resource Requirements	Knowledge of and skills related to the intervention: group facilitation; STDs; 2 facilitators, one of whom is a Black gay man; space to run group sessions; community partners like the population at risk/in need of intervention services; agency administrator to supervise facilitators; TV/ VCR; outreach materials	Experience working with the Black community and with Black gay men; limited experience implementing HIV behavior change interventions; strong community partnerships; has space to conduct meetings and provide interventions; has office and computer equipment	Do you have the time, resources, staff and funds? Yes No Describe what you need to implement the intervention. We have the time and skills, but some of our staff will need training on group facilitation. We will also need to find space for holding a weekend retreat.

After looking at the four DEBIs, the Hope AIDS Project decides:

- Not to select d-up! because it is a community-level intervention and their staff does not have the capacity to do a community-level intervention.*
- Not to select VOICES/VOCES because it does not affect some of the determinants of the HIV transmission behavior of their population. For example, VOICES/VOCES does not address the lack of social support due to negative messages about gay behavior and rejection from friends, family, churches, and communities.*
- Not to select Healthy Relationships because it is for HIV-positive people and the Hope AIDS Project decided to work with HIV-negative men.*

The Hope AIDS Project selects the Many Men, Many Voices DEBI because:

- It addresses the HIV-transmission behavior in their population.*
- It addresses many of the behavioral determinants in their population.*
- Its activities can be offered in different formats. For example, weekend retreats or twice-a-week sessions.*
- They have the capacity or can build easily the capacity to provide the intervention.*

In Step 2 of the Selection Stage you review and assess the information you collected in Step 1. You then select one intervention that best addresses the HIV behavioral risk in your population, keeping in mind your population and agency “readiness.” This step in the Selection Stage needs to be done carefully and with a lot of thought. You do not want to select an intervention that does not address the behavioral determinants in your population. You also do not want to choose an intervention your agency cannot do, or your population is not able or willing to take part in. We suggest getting technical assistance to help you with this process (see page 18 of the Guide for how to get help).

Assess Interventions

To assess interventions you:

- Organize information on your population’s HIV behavioral risk (HIV transmission behavior and behavioral determinants), population “readiness,” and agency “readiness,” and match each intervention to each of these areas
- Create a narrowed list of interventions
- Review the narrowed list of interventions

Organize and Match Information

You need to organize the information you collected in Step 1 of the Selection Stage so you can review it all at once. We suggest you use the **Organize and Match Information Tool** that we shared for our Hope AIDS Project story line.

Create a Narrowed List of Interventions

Keep in mind that not every intervention you look at will address all of your population’s and agency’s needs. So, how do you decide what interventions to look at more closely? At the very least, you should look at the interventions that do address your population’s HIV transmission behavior and behavioral determinants. We suggest picking no more than four interventions to consider more in-depth. You may also want to look at the interventions that will need the least amount of adaptation. This will save you both time and money. But do not forget that the intervention you choose must address your population’s HIV behavioral risk.

To decide which interventions to look at more closely, ask the following questions for each intervention you list:

- Does this intervention address my population’s HIV behavior transmission?
- Does this intervention address my population’s behavioral determinants?
- Is this intervention something my population is willing and able to take part in?
- Is my agency ready right now or can we build the capacity easily to provide this intervention?

Review the Narrowed List of Interventions

Once you create your narrowed list of interventions, you then review each intervention in more depth. Learning more about the interventions helps you choose the best one to adapt. We suggest using the **Assessing Interventions Tool** that follows to guide your review. We also suggest you fill out one tool for each intervention on your narrowed list.

The **Assessing Interventions Tool** we shared in the Hope AIDS Project story gives you a snapshot of how well each intervention on your narrowed list addresses your population's and your agency's needs. The tool also helps you begin to identify the changes you may want to make to an intervention. We suggest you fill out a tool for each intervention on your list. In the tool you will list:

- Information from the original intervention
- Information about your population
- Whether or not the information from the original intervention matches the information from your population and your agency
- If the information from the original intervention does not match the information from your population and/or your agency, state what do you need to do to make it work

Select An Intervention

Once you review your narrowed list of interventions, you are ready to select an intervention. To guide your decision-making, ask:

- How well does this intervention address the HIV behavioral risk in my population?
- Will this intervention work with and be liked by my population?
- Can my agency implement the intervention with fidelity? Fidelity means being true to an intervention by following its stated core elements, logic and intent when you implement it.
- Is my agency able to reach the population?
- Is my population "ready" and able to participate in this intervention?
- Is my agency "ready" and do we have the capacity (or can we build the capacity easily) to do this intervention?
- Does the intervention match my agency's mission and values?

After you select an intervention, it is always a good idea to write down your reasons for your choice. You may be asked to explain your choice to a funder, your Board of Directors or a community group. You may also want to include this information in reports or future funding proposals.

Selection Stage Step 2 Key Points

In this step, you assess and select an intervention to adapt that addresses your population’s HIV behavioral risk. To do so, you organize the information you collected in Step 1 on population HIV behavioral risk (HIV transmission behavior, risk factors and behavioral determinants), population “readiness” for receiving interventions, and agency “readiness” for providing interventions. For each HIV behavior change intervention you find, you match how well it addresses each of these areas. You then narrow your list of intervention choices and look more closely at each one. From this narrowed list, you select one intervention that you think best addresses your population’s HIV behavioral risk. You also take into account your population’s and agency’s “readiness” when you choose an intervention. Step 2 will increase your knowledge about the intervention you select to adapt. This knowledge helps you decide what activities of an intervention to adapt and how to adapt them. We talk about this in detail in Chapter 3.

Key Points:

- Organize information collected in Step 1 into areas on: your population’s HIV behavioral risk, population “readiness” and agency “readiness.” Match this information with the interventions you collect to see how well each intervention addresses each of these areas. Use the Organize and Match Information Tool to do this.
- Develop a narrowed list of intervention choices.
- Assess interventions using the Assessing Interventions Tool.
- Answer key questions for each intervention.
- Select the intervention that best addresses, or matches, your population’s HIV behavioral risk and “readiness” to receive the intervention, as well as your agency “readiness” to implement the intervention.

As we noted in Chapter 1, we share another agency’s story at the end of both Chapters 2 and 3. This is a story line about an organization in a Texas border town that is adapting the community level *Popular Opinion Leader* DEBI for a Latino population. We walk you through how they do the Selection Stage of the Adaptation Process.

THE BORDER HEALTH SERVICES STORY – PART 1

Border Health Services is a small community health organization in the border town of McAllen, Texas. The agency serves mostly migrant Latinos who work in agriculture. They provide basic health care services at their five partner clinics. They also have an HIV program that offers prevention and treatment services. Their prevention activities include education and outreach, and HIV counseling and testing. They have a brief HIV 101 session that is given to clients while they wait to get services at the clinics. Border Health Services has three full time staff members: a program manager; an HIV educator who provides HIV counseling and testing; and an administrative assistant.

Over the past few years, there has been an increase in the number of HIV and STD cases in young Latino (18 to 24 year olds) men who have sex with men. Border Health Services thinks there are two behaviors that are driving this increase in HIV and STD rates. One is that these men are having unprotected anal intercourse. The second is that these men do not get tested for HIV or seek medical services. They only go to the clinic when their symptoms prevent them from working. The agency has tried to conduct outreach and mobile HIV testing, but knows these men will not come to their clinic because they fear they will be seen as having “SIDA” (AIDS). Border Health Services really wants to help these men but does not have the money to work with them. They turn to a local university for help. Border Health Services and the university learn about, apply for and get State health department funding to conduct an intervention with Latino men who have sex with men over a three-year period. The funding calls for them to provide a DEBI.



Border Health Services Collects Information To Select a DEBI (Selection Stage Step 1)

The Border Health Services staff has some knowledge about their population's HIV transmission behavior. But, they decide to learn more about why younger Latino men who have sex with men are not using condoms and not getting tested for HIV. They review research articles on Latino men who have sex with men to learn about the reasons why men do not use condoms during anal intercourse. Border Health Services also reviews findings from a knowledge, attitudes, beliefs, and behaviors survey the local university conducted with about 60 young Latino men who have sex with men. To add to the survey information, Border Health Services interviews about 10 to 15 young men who have sex with men. They want to find out why the young men think their peers are having unprotected anal intercourse. They also want to learn more about where these young men hang out and what types of interventions they would like.



Border Health Services learns the following about the young Latino men who have sex with men in the community:

- *Men are having unprotected anal intercourse with other men. The survey found only 25 percent of the men reported condom use the last time they had anal sex. This number was lower when they were the receptive (bottom) partner. Reasons they gave for not using a condom included:

 - *Condoms don't feel good*
 - *They did not have a condom*
 - *Using a condom meant you had a disease*
 - *"Real men" don't worry about disease or use a condom**
- *Most men have to hide the fact they are gay because the community does not approve of men having sex with men. Some men are known to be gay, and are more "out" than others. But, they would still never show affection with another man in public.*

- *Because many of the men live with their extended families, they have to be secret about where, with whom and when they have sex. There are some “hook up” spots that are out of the way. The men know they can go there to have sex with other men and not get found out. They often do not have access to condoms in these places, though, unless they have one with them.*
- *There is one bar, El Matador, which is 10 miles out of town and is “gay friendly.” Many of these men hang out there at night. There are also some parks where they meet to hang out and drink.*
- *They do not know a lot about HIV and STDs. Many believe myths about how HIV is transmitted, such as you can get it from a mosquito, you can’t get infected if you are the insertive partner, and you can’t get infected if you don’t come inside your partner.*
- *Some have poor self-image and low self-esteem because having sex with a man is not accepted in their culture. It conflicts with traditional family and religious values. This could be a cause of depression and hopelessness seen in some of the men.*
- *“Machismo” beliefs drive their sex behavior and create conflicts with how the men see themselves. Men feel they have to have lots of sex and get drunk often, to prove their manhood. They also feel shame and guilt for being gay. This leads to depression, feeling alone, and low self esteem. The men do not feel they are valued and do not value themselves. This makes them reckless with their behaviors. They say, “I don’t care what happens to me.”*
- *The men only get tested for HIV or STDs if they are sick and have to go to the clinic. They do not see the point of knowing if they have HIV or an STD because they believe there is nothing they can do about it. Machismo also plays a role in this behavior. Men see using a condom or going to the clinic when they are not sick as being “weak.”*

Border Health Services next sets out to collect HIV behavior change interventions that may address their population's HIV behavioral risk. They do a brief review of the DEBIs to see if any of them target Latino men who have sex with men. They do not find any DEBIs that are designed specifically for Latino men who have sex with men. But, they do find some DEBIs they think they can adapt for their population. The agency chooses four DEBIs – VOICES/VOCES, Mpowerment, Community PROMISE, and Popular Opinion Leader to learn more about. They also talk to other HIV prevention agencies in their area to see if they can suggest any evidence-based interventions. The agencies are not able to do so, because they never have done evidence-based interventions or DEBIs. Border Health Services goes to www.effectiveinterventions.org and downloads information on the four DEBIs.

Border Health Services also wants to learn about its population's "readiness" to take part in interventions. They look at the information collected during the interviews with young Latino men who have sex with men and learn that:

- There are about 100 to 150 young men who have sex with men in the community. Most hang out at El Matador. Men who have sex with men from other nearby, smaller towns also meet at El Matador.*
- Most of the men do not have transportation. They have to use buses, get rides from friends, or hitchhike.*
- While most of the men are seasonal farm workers, the population is somewhat stable; only 20 percent of men travel for other jobs.*
- Because their work schedules vary, it is hard for the men to attend an intervention with many sessions.*
- Their primary language is Spanish; only about 10 percent of the men know some English.*
- Some of the men do not trust health care providers. The providers they trust the least are white males.*



- *Most of the men have low levels of education and cannot read in Spanish or in English.*
- *Many of the men will not go to a program or building that offers HIV/AIDS services for fear of being seen as infected and/or gay.*

Last but not least, Border Health Services looks at its “readiness” to provide interventions. They hold a meeting with their university partner to look at strengths and resources. They note that:

- *All staff persons speak both Spanish and English and are Latino.*
- *They have funding to support hiring one or two new staff persons.*
- *They have support from the university to help with adaptation; they can also translate materials into Spanish.*
- *Their Program Manager has a Masters in Public Health with a focus on Health Education, and has strong knowledge of behavior change interventions.*
- *Their Health Educator has a lot of knowledge about HIV and STDs, but low knowledge of behavior change interventions. She also has strong contacts with young Latino men who have sex with men in the community.*



Border Health Services Looks at the Information it Collected and Selects a DEBI to Adapt (Selection Stage Step 2)

Border Health Services pulls together all the information they collected about their population, interventions, and agency. They meet with their university partner to discuss which interventions best address their population's HIV behavioral risk. Their main goal is to get more men to wear condoms during anal sex. They know they need to address the behavioral determinants of their population's HIV transmission behavior. These include attitudes and beliefs about condom use, such as using a condom means you have HIV and you do not need to use a condom if you are "on top." They also know they need to give their population basic information about how you can get HIV. Border Health Services wants the DEBI they choose to counter some of the negative beliefs the men have about themselves. They also want a DEBI that will let them reach men where they hang out, since most of the men will not go to an HIV program. Outreach will have to be done in a way that does not attract attention (no outreach vans, community health workers or nurses doing outreach). They are open to looking at English language interventions, since they are able to translate them into Spanish.

Border Health Services and the university look more closely at four of the DEBIs they found. They are very interested in VOICES/VOCES because it targets condom use and is in Spanish. They also review three community-level interventions – Mpowerment, Popular Opinion Leader, and Community PROMISE. They decide VOICES/VOCES will not work since it is done in a clinic setting. They also decide that Mpowerment will not work because it calls for men to create a community center for men who have sex with men. This was something the men were scared to do. With Community PROMISE, they decide they do not have the resources to develop the role model stories and do ongoing evaluation.

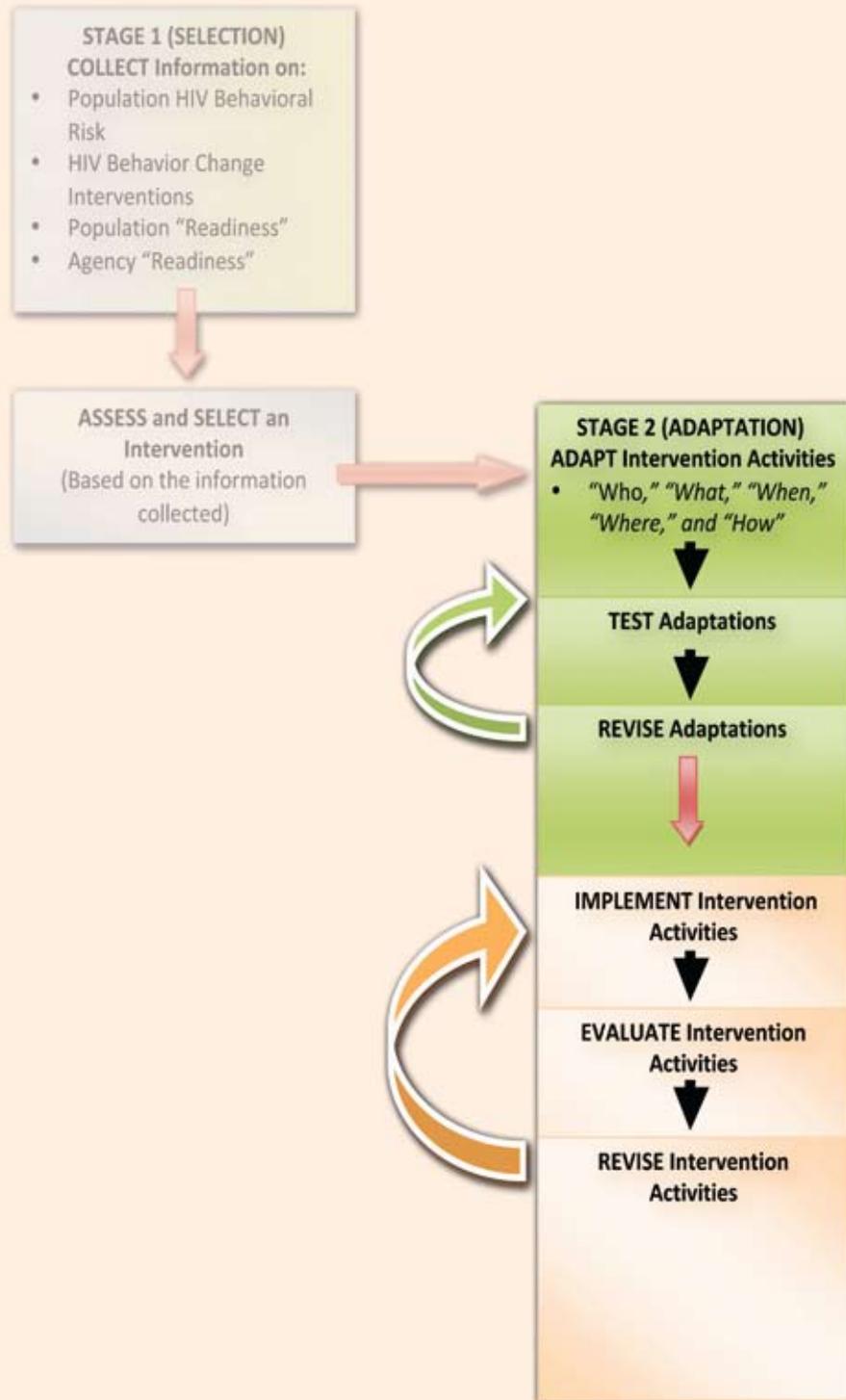
Border Health Services and the university select the Popular Opinion Leader DEBI to adapt. They choose Popular Opinion Leader because it will let Border Health Services reach the men where they already hang out. The intervention also does not make everyone attend formal sessions. It only trains existing opinion leaders in formal sessions to carry out risk reduction conversations



with their friends in the community. Border Health Services thinks this approach will help them to reach men who are not open to talking about HIV and safer behaviors. The opinion leaders can work to establish a norm that promotes condom use. Opinion leaders can let men know that using condoms is a sign of strength, and not a sign that you have disease or are weak. The opinion leaders will also be able to address other “myths” men have about HIV and their self-image. Border Health Services thinks they can recruit enough men to serve as opinion leaders. And, they think one or two of the men can be taught to be opinion leader trainers. Lastly, Border Health Services likes that they can address almost any social norm with Popular Opinion Leader. If they can get the men to use condoms more, they can then focus on getting the men to seek out HIV and STD testing and treatment.

We tell you how Border Health Services adapts the Popular Opinion Leader DEBI at the end of Chapter 3.





THE HOPE AIDS PROJECT STORY CONTINUES

In Chapter 2, the Hope AIDS Project decided to select and adapt the Many Men, Many Voices DEBI. They hire a Program Director to guide their adaptation process. After looking at the information they gathered in Stage 1 of the Adaptation Process, they define their intervention population as Black gay men:

- Between the ages of 31 and 45*
- Whose HIV transmission behavior is unprotected anal sex*
- Who are HIV-negative and have a history of STDs*
- Who have low self-efficacy for condom use and condom negotiation*
- Who have little or no social support*
- Who feel rejected by family, friends, and the religious community*

The Hope AIDS Project is now ready to find activities to adapt in the Many Men, Many Voices intervention. The Program Director and the Committee review the information they found on www.effectiveinterventions.org for the intervention. They want to know what it requires in terms of staff, training, materials, computers and other things. They look at the Starter Kit and learn the intervention has seven sessions with different kinds of activities.

To understand the activities in each of the seven sessions, the Program Director breaks down the “Who,” “What,” “When,” “Where,” “How,” and “Why” of each activity. To help with this process, he looks at the Facilitator’s Guide and the behavior change logic model. The Facilitator’s Guide tells him how each activity is done and what behavioral determinants are addressed. The logic model shows him how the behavioral determinants and the activities work together to produce the intervention outcomes. The logic model also helps him understand how the intervention changes the HIV transmission behavior of Black gay men.

Next, the Hope AIDS Project reviews the determinants that drive the HIV transmission behavior of their population. They know their population is having unprotected anal intercourse because of:

- Not knowing about how HIV and STDs interact*
- Thinking they are not at risk or low risk for HIV and STDs*
- Poor communication skills*
- Not being able to negotiate condom use*
- Lack of self-efficacy to use condoms*
- Lack of social support for condom use*
- Not feeling good about same-sex/gay behaviors*
- Lack of family support for same-sex behaviors*
- Lack of support and judgment from pastors/priests/religious leaders*
- Feeling that having sex without using a condom is hot*

The Hope AIDS Project knows they need to make some changes to Many Men, Many Voices, even though the intervention does address many of the determinants of its population's behaviors. The agency wants to help the men deal with the negative messages coming from local church leaders. They know these messages and lack of support from church leaders lead the men to have poor self-images. This can cause them to have unprotected anal intercourse. The Hope AIDS Project thinks if they address the negative messages coming from church leaders, they can change the self-image of the men. They choose to adapt Exercise 7.3: How Can I Build On This Experience to address this issue. This activity focuses on a person's well-being and emotional growth, which could help build their population's self-image. They also think this will be a good way for the men to talk about what they experience when they hear negative messages from church leaders.

The Hope AIDS Project also knows their population does not have a lot of free time during the week. They want to do activities online or on the weekend. They start to think about how to do Many Men, Many Voices in a different format. They talk about doing a weekend retreat or giving the men an incentive to come to the seven weekly sessions. The Hope AIDS Project thinks it will work better to change the weekly sessions to a weekend retreat. They also think a retreat will create a "safe space" so the men will be more at ease taking about their HIV transmission behavior and other issues. We talk more about how the Hope AIDS Project makes these two adaptations later in this Chapter.

CHAPTER OVERVIEW

The Adaptation Stage has three steps:

- **Step 1 – Adapt Intervention Activities.** In Step 1, you identify the activities in the intervention that you need to adapt. For each activity you select, you may adapt its “Who,” “What,” “When,” “Where,” and “How.” You may not change the “Why” of an activity because this would change its intent. When you modify an activity, you need to make sure it still affects the behavioral determinants the activity targets. You also need to keep in mind your population’s and agency’s “readiness.”
- **Step 2 – Test and Revise Adaptations.** During Step 2, you test the adapted activities. Testing gives you feedback you can use to make any needed changes. In some cases, you may decide the changes do not work, and will need to select another intervention to adapt.
- **Step 3 – Implement, Evaluate, and Revise the Intervention.** Step 3 involves implementing, monitoring, and evaluating the adapted intervention. You do this to make sure the intervention is addressing your population’s HIV behavioral risk. Based on monitoring and evaluation results, you may need to revise the adapted intervention activities. Monitoring and evaluation will likely be ongoing.

Like with the Selection Stage, the Adaptation Stage can be hard to do. We suggest you get technical assistance to help you with this stage. See page 18 of the Guide for how to get technical assistance.



ADAPTATION STAGE STEP 1: ADAPT INTERVENTION ACTIVITIES

Understanding How Intervention Activities “Work”

Intervention activities are actions you take to implement an intervention. They are stand-alone activities or ones that affect how intervention activities are done. Examples include the following.

“Stand-alone” activities, such as:

- Conducting role-plays during a session
- Giving a PowerPoint on STDs
- Showing how to carry out risk reduction conversations
- Facilitating a group discussion about experiences with homophobia and racism
- Recruiting intervention participants at gay clubs

Activities that affect how intervention activities are done, such as:

- Conducting exercises with peer facilitators
- Delivering the intervention at a particular setting
- Providing a certain number of sessions
- Delivering group sessions to a certain number of participants

In this Guide, we break down intervention activities into “Who,” “What,” “When,” “Where,” “How,” and “Why” categories. Before you decide which activities to adapt, you need to learn how each activity “works.” Each activity affects the behavioral determinants of your intervention population’s HIV transmission behavior. Knowing how activities affect behavioral determinants will help you to make adaptations that are more likely to work with your intervention population.



Intervention activities are broken down into “Who,” “What,” “When,” “Where,” “How,” and “Why.”

“Who” is the intervention population (Latino bisexual men, Black gay men). “Who” also describes the people who deliver the intervention. Some interventions call for staff with certain types of training and/or educational backgrounds, experience with a population, sexual orientation, and race/ethnicity.

“What” are the content, images, and/or messages of the activity. It is also the information the activity provides like local HIV rates among gay and bisexual Latino men or steps for getting a partner to wear a condom. Content can also be things like the images of Black men on recruitment posters and slogans like “Black. Sexy. Safe. Alive.”

“When” describes the timing, length, and order of the activities.

“Where” are the locations where you conduct the intervention’s activities. This includes in a clinic, at a community setting, on the Internet, or in everyday relations between friends.

“How” is the way in which the activity is done, such as group discussion, lecture, role-play, demonstration, and outreach. It includes other approaches or methods like observations, focus groups, and giving a pre/post test survey. It also includes the number or amount of activities conducted.

“Why” is the intent or purpose of the activity. It explains the reason an activity is done in a certain way (the “Who,” “What,” “When,” “Where,” “How,” and “Why”) in order to get a certain result. You can never change the “Why” of an activity or intervention.

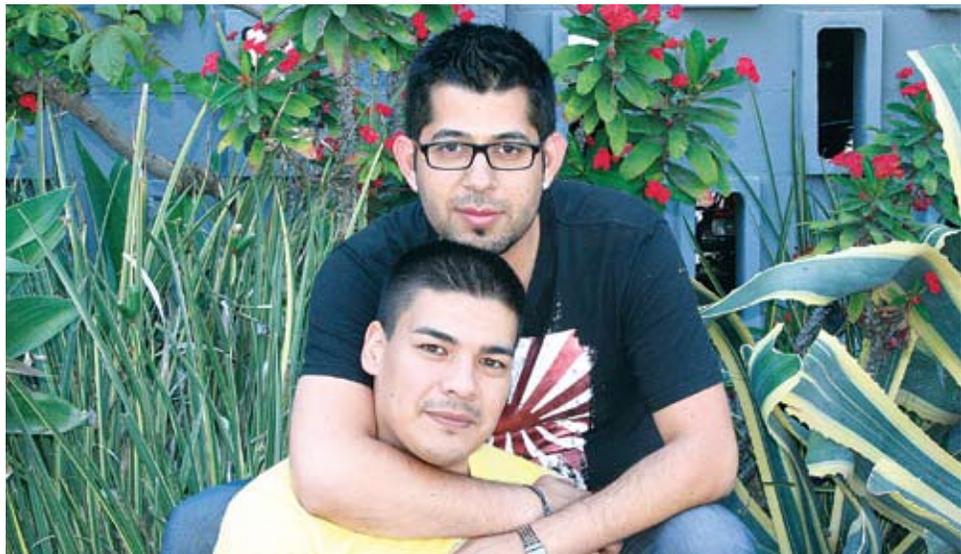
Breaking down intervention activities helps you understand the intent or the “Why” of an activity. An activity is meant to do something and get a certain result. Most activities focus on changing one or more of the behavioral determinants of HIV transmission behavior. For example, the intent (“Why”) of a role-play activity may be to increase a person’s skill and self-efficacy to ask their partner to wear a condom. Skills and self-efficacy are the behavioral determinants that can lead a person

to ask their partner to use a condom. This can result in the person having protected sex.

You also need to understand the “Who,” “What,” “When,” “Where,” and “How” of an activity. For our role-play activity example the:

- “Who” are the men doing the role-play and the staff guiding the role-play
- “What” is the content of the role-play (talking about using a condom)
- “When” is the session where the activity occurs and how long each role-play lasts
- “Where” is the location of the session
- “How” is the role-play itself (two men acting it out) and the number of role-plays done

The “Who,” “What,” “When,” “Where,” and “How” helps an activity achieve its intent (“Why”) and produce a certain result. When you change any of these, make sure you do not change the intent (the “Why”). For example, if you change the role-play into a lecture, you will no longer be building condom negotiation skills. The lecture will only affect knowledge about how to talk to partners about using condoms. It will not affect skills, which are built through practice (role-play). Practicing something in a role-play builds skills, while just telling someone how to do something may not have an effect on skills.



Resources for Understanding Interventions

There are resources you can look at to better understand DEBIs and their activities. These include implementation manuals, behavior change logic models, implementation summary sheets, and technical assistance guides. Information on DEBIs can be found at www.effectiveinterventions.org. If you are adapting an evidence-based intervention, you may need to contact the intervention’s developer for this type of information.

- **Implementation manuals** give an overview of the intervention, describe how it works, list **core elements** and **key characteristics**, and explain agency capacity and resources needed to do the intervention. Guidance is also given on how to implement, monitor and evaluate the intervention.
- **Behavior change logic models** give a snapshot of how an intervention works. They show the determinants of HIV transmission behavior, the activities that address them, and the desired outcomes of the activities.
- A sample, shortened version of the behavior change logic model for the *d-up!* DEBI follows.

<i>d-up!</i> Behavior Change Logic Model			
Behavioral Determinants (address HIV transmission behavior)	Activities (address behavioral determinants of HIV transmission behavior)	Outcomes (expected changes as a result of activities targeting behavioral determinants)	
Social norms about safer sex and sexual risk in the social network.	Trained opinion leaders engage members of their friendship groups in risk reduction conversations about safer sex that men can relate to.	Friendship groups adopt safer sex attitudes and behaviors and create safer sex norms within the social network.	Safer sex norms are adopted and maintained by the social network; this results in increased condom use and decreased transmission of HIV.

In the *d-up!* intervention example, HIV transmission behavior is affected by norms around safer sex. The behavioral determinants are addressed by the activity that has opinion leaders promote condom use to their friends. This activity will lead the friends of the opinion leaders to change their attitudes and social network norms about safer sex. In turn, condom use increases among the men in the social network.

- **Implementation summary sheets** list the resources needed for activities and **program outputs** (deliverables or products that result from implementation activities).
- **Core elements** are the parts of an intervention that are based on the behavioral theory and logic of an intervention. They are the parts most likely to produce the intervention's main effects. Core elements cannot be changed or dropped. Doing so can affect the intent of the activity and may no longer result in the desired outcome. Looking at the core elements will help you understand which activities are key and which ones must not be changed.
- **Key characteristics** are the key activities and ways an intervention is done. These may be changed to address the needs and likes of your population.
- **Technical assistance guides** have information, frequently asked questions, and suggestions for doing the intervention. The technical assistance guide also has information on lessons learned from other agencies that have done the intervention.



Deciding What Activities to Adapt

Once you fully understand your intervention’s activities, you can pick which ones to adapt. Use the information you collected in Step 1 of the Selection Stage to decide which activities to adapt and how you will change them. Keep in mind that activities are adapted to fill in gaps and match your intervention to:

- Your intervention population’s HIV transmission behavior and determinants of this behavior
- Your intervention population’s “readiness,” or willingness, ability and need to take part in an intervention
- Your intervention population’s likes and needs
- Your agency’s “readiness,” or current and/or future capacity and resources

To explain more about how you decide what activities to adapt, we look at the DEBI *Healthy Relationships*. This is a small-group intervention for men and women living with HIV/AIDS. *Healthy Relationships* focuses on developing skills and building self-efficacy and positive expectations for new, safer sex behaviors. It does this by showing video clips that model these behaviors. An agency in Atlanta, Georgia is planning to use *Healthy Relationships* with young, Black gay men who are living with HIV. One thing affecting their population’s risk behavior is their feelings of rejection from their families because they have not disclosed their sexuality and HIV status.

The agency reviews the intervention to get a better understanding of its activities. They find *Healthy Relationships* videos clips that show a man coming out to his family. They decide this activity does address their population’s behavioral determinants. The agency has a DVD player and TV, so they can easily show video clips. The one problem is that the *Healthy Relationships* video clips only feature white men. Also, the family dynamics shown in the videos are not those found in a Black family. Since the agency knows its population will not relate to these video clips, they will need to find or develop clips that feature a Black man coming out to his family.

Adapting Activities

Returning to our story line, the Hope AIDS Project uses the Decision Tool for Adapting Interventions to record, describe and explain the changes they make to two activities of the Many Men, Many Voices intervention.

The Hope AIDS Project's Decision Tool for Adapting interventions: <i>Many Men, Many Voices</i>					
Activity	"What"	"Who," "When," "Where," "How"	"Why" (Intent)	How the Activity Will Be Adapted	Justification for Adaptation
Exercise 7.3 – How Can I Build On This Experience. The purpose of the exercise is for men to discuss their growth (emotional and personal) during <i>Many Men, Many Voices</i> .	Men's personal growth, self-development, and emotional development as a result of taking part in <i>Many Men, Many Voices</i> .	Men talk about their personal growth, self-development, and emotional development. The men are introduced to a Mental Health professional who tells them about his services.	The exercise increases men's awareness of how much they have grown and developed as a result of <i>Many Men, Many Voices</i> . Also, the exercise makes it okay to talk to a Mental Health professional and continue to grow and develop after the intervention is over.	Instead of a Mental Health professional talking to the men, a pastor from a local church (who is openly gay and whose church supports the Black gay community) will talk about the importance of spirituality and faith for self-development. He will also talk about the counseling services and other mental health services offered by his church.	When we looked at the information we collected, we learned our population felt rejected from church leaders because they are gay and/or bisexual. This rejection results in a poor self-image and leads to risky behaviors such as unprotected anal intercourse. We want to teach the men that there are churches that support them. This should help the men find churches that meet their spiritual needs.
Deliver <i>Many Men, Many Voices</i> over 7 weeks (one session per week).	Men meet once a week to talk, practice skills, get feedback on skills practice, and do role-plays.	Two staff persons that the population can relate to give 7 weekly sessions to HIV-negative Black gay and/or bisexual men.	Meeting in session with other HIV-negative Black gay and/or bisexual men increases the men's STD/HIV knowledge, perception of HIV/STD risk, skills and self-efficacy for condom use, negotiation skills, and ability to communicate with partners.	<i>Many Men, Many Voices</i> will be done as a weekend retreat format. Session 1 will be done Friday night, Sessions 2 and 3 will be done Saturday, Sessions 4, 5, and 6 will be done Sunday. Session 7 will happen 2 weeks later as a follow-up. Men will meet at a local gay church to talk about how the intervention changed their lives.	We know our men like weekend activities better than coming to 7 weekly sessions. Having a weekend retreat will also reduce drop out rates of the men.

As you can see in the Hope AIDS Project's Decision Tool for Adapting Interventions for Many Men, Many Voices, they make two changes to the intervention. They change Exercise 7.3 to address the lack of social support for gay Black men that was coming from church leaders. They also switch the Mental Health professional the exercise calls for to a gay pastor of a gay church. They want to see if this change will better address the lack of support the men feel and give them positive messages about being Black and gay. The Hope AIDS Project hopes a gay pastor will uplift the men and help them to have a better self-image. They also hope this change will affect the men's HIV transmission behavior. The negative messages from church leaders are one of the determinants of the men's HIV transmission behavior. The agency also wants to know if the men like and feel at

ease hearing from a gay pastor. The second thing the Hope AIDS Project changes is the seven session weekly format to a weekend retreat, so more men can complete the intervention. They want to test if the men like the weekend retreat format. They also want to find out if the men think other gay Black men from the community would be willing to come to a weekend retreat. In the tool, you can also see the Hope AIDS Project makes sure to describe clearly how they will adapt each activity. They also give a reason for why they change each activity. This information will help them when they test their changes to see if they work. We will talk more about testing in the next section of this Chapter. This tool also helps them explain to funders why and how they made changes to the intervention.

Remember, when you adapt an activity, you make changes to the “Who,” “What,” “When,” “Where,” and “How” of the activity. You should not make changes to the “Why,” or the intent, of an activity. Your changes should affect the determinants that drive the HIV transmission behavior of your intervention population. You also adapt activities to address your population’s “readiness.” Lastly, you adapt activities to address your agency’s “readiness.” When adapting activities, we suggest you use the sample **Decision Tool for Adapting Interventions** that follows. We also provide instructions for completing this tool.

Sample Decision Table for Adapting Interventions and Instructions					
Activity	“What”	“Who,” “When,” “Where,” “How”	“Why” (Intent)	How the Activity Will Be Adapted	Justification for Adaptation
Specific or overall activities such as: Conducting observations of potential target venues. Implementing recruitment activities. Facilitating an interactive exercise. Recruiting and/or hiring appropriate facilitators (race, gender, sexual orientation, professional background). Delivering intervention sessions; duration of sessions.	Topic of the activity (observing recruitment venues; recruiting peer educators; providing HIV rapid tests); topic areas covered; images used.	“Who” is the intervention population (Latino bisexual men, Black bisexual men with HIV transmission risk behavior), or the facilitators who deliver the intervention. “When” is the session frequency and duration. “Where” are the locations the intervention is delivered or done (e.g., clinic, community setting, Internet, or in everyday relations between friends). “How” the activity is implemented; how the content is delivered. Includes mode of delivery (group discussion, lecture, role-play, demonstration, and outreach) as well as other action approaches or methods (observations; focus groups; administering a pre/post test questionnaire).	Purpose of the activity; the specific behavioral determinants of the HIV transmission behavior it affects.	Description of how you would like to change the activity to better address the needs of your intervention population and/or agency. You can make changes to the activity’s “Who,” “What,” “When,” “Where,” and “How,” as long as the intent (the “Why”) does not change.	State why you think it is necessary to make changes to an intervention activity based on your understanding of the determinants impacting the intervention population’s HIV transmission behavior, “readiness,” and preferences as well as your agency’s “readiness.”
EXAMPLE					
Add an activity to build the self-efficacy of Black gay men to negotiate condom use with causal partners.	The new role-play will build self-efficacy and skills to negotiate condom use with causal partners.	The men will act out role-play scenarios where they are negotiating condom use with casual partners.	Self-efficacy will increase ability (skills and confidence) to negotiate condom use with causal partners.	After discussing the importance of using condoms with causal partners, the men will do a role-play to build skills to negotiate condom use with causal partners.	We are adding this role-play since our intervention population does not have the self-efficacy to negotiate condom use with causal partners. The original intervention role-plays did not address this area. In order for our population to use condoms with causal partners, they need to build skills to negotiate condom use. The role-play will build skills to negotiate condom use.



ADAPTATION STEP TWO: TEST AND REVISE ADAPTATIONS

The Hope AIDS Project Program Director is now ready to develop a plan to test their two adaptations to the Many Men, Many Voices intervention. This type of test is called a “pilot test.” They decide to test the entire intervention because they changed the seven-session format to a weekend retreat. They need to make sure the weekend retreat format works for both the men and their staff. The Hope AIDS Project’s pilot test plan includes information on the type of information to collect, who will collect the information, ways to collect the information, and who will analyze the results. The plan also outlines the logistics, including participant recruitment, venue selection, and transportation. The Program Director hires two Black gay male staff persons to conduct the pilot test. These staff persons go to a Many Men, Many Voices training where they learn how to do the intervention. When they return to their agency, the staff persons practice the sessions and get ready for the retreat.

After the weekend retreat, the Hope AIDS Project holds a focus group to get the men’s reactions to the intervention as a whole and to the two adaptations they made. Dr. Hawkins helps them develop the focus group questions. The questions ask how the men like the retreat, the pastor’s talk, and meeting at the local church. After the men finish the retreat, they also fill out a Many Men, Many Voices survey. This survey asks how well the intervention addresses the lack of social support and negative messages from church leaders. During the retreat, the Program Director watches and takes notes on each of the sessions. One thing he is looking for is whether or not the activities in each of the sessions are being done the correct way.

After the pilot test, the Hope AIDS Project looks at their results and learns the changes they made to Many Men, Many Voices are working well. Nine men came to the retreat and all gave very positive feedback on the changes. The men really liked the retreat format. And, they liked visiting the church for one of the sessions. The men also said they would have liked more time to talk more

about spirituality and sexuality. Survey results show that the changes did address the men's lack of support. The men were happy to learn there was a church that supported them in their community. They said they planned to visit this church in the future. They also said they planned to use condoms more often. During the retreat, the Program Director saw the need for improving how the intervention was done. He held a meeting with the retreat staff to talk about the intervention and ways to improve how the activities were being done.

Testing and Revising Adaptations

After you make your adaptations, the next step is to pilot test them. This means trying out the changes with your intervention population. You do this to make sure the adaptations work. By “work,” we mean the changes achieve the desired results of the intervention. Depending on the number of adaptations you make, you will either:

- Test stand-alone intervention activities or new materials
- Test the entire adapted intervention

Testing adapted activities is called pilot testing. Piloting testing tells you if the adaptation is giving you the desired results without changing the “Why” (intent) of the activity or intervention. Pilot testing can also show you things that you may need to change before you do the intervention again.

It is always best to pilot test the adaptations with your intervention population. Doing so will tell you how your intervention population will react to the changes. Pilot testing answers questions like:

- Does my intervention population like the adapted activities?
- Do the changes impact the determinants of HIV transmission behavior in my intervention population?
- Can we do the activities correctly and consistently

You must carefully record this process so you do not lose track of what worked and what needs to be changed. This is key to showing your agency and funders that your adaptations are

getting results without changing the intent of the activity or the intervention. We suggest getting technical assistance to help you with pilot testing. See page 18 of the Guide for how to get help.

Test Intervention Activities or the Entire Intervention

When you pilot test your changes, you need to decide whether to test only the activities you changed or to test the whole intervention. There are times when it makes sense to pilot test the whole intervention. There are also times when it makes more sense to pilot test just the activities you changed. If you have made major changes to an intervention, like adding a number of new activities, you will want to test the whole intervention. This will help you see how all the activities work together and affect the intervention. You may also want to test the entire intervention if you change its format.

Most of the time, you will only need to test the activities you changed. For example, if your adaptation involves adding a new material, like a video clip or a role-play, there is no need to test the whole intervention. You would just test the new material. We do not suggest pilot testing the whole intervention when doing a community level intervention. Community level interventions take too long, in some cases an entire year. But, you may be able to pilot test certain activities of a community-level intervention.

In the pilot test, you will conduct the same four steps whether you test an activity or the whole intervention, as follows.

Pilot Test Step 1: Develop a Plan to Pilot Test

Plans should include:

- The activities and materials you will test.
- Who will do the pilot test – agency staff, consultants, volunteers, etc.
- The methods you will use to document and analyze reactions and feedback of the people who take part in the test.

Pilot Test Step 2: Decide What Information to Collect

The information you collect during the pilot test will tell you if the adapted activities worked or if you will need to make changes to them. Questions you want to ask during the pilot test include:

- Does the adaptation maintain the “Why” (intent) of the activity?
- Does the adaptation address the intervention population’s determinants of HIV transmission behavior?
- Did the intervention population like the way the content was given?
- Was the language appropriate?
- Were the images likeable?
- Did the intervention population like the adapted activity?
- What was liked about the adapted activity? What needs to be changed?
- Does the adaptation make the intervention easier for your population to relate to?

Pilot Test Step 3: Decide How You Will Collect Information

There are different ways to collect information, and each has its pros and cons. Some methods work best for getting lots of details, while other methods are good for getting general information. It helps to decide what information you want to collect and how you will use it before you choose your methods. You also want to make sure your agency has the resources it needs to analyze and evaluate pilot test results. You may need to get technical assistance for this step. See page 18 for how to get technical assistance. Also see the Guide’s appendices for more information on these information collection methods:

- **Focus groups** are helpful for group responses to material and new activities. Focus groups can provide lots of details on a very narrow topic. Focus groups can answer questions like:
Does my intervention population like the images?
Is the language appropriate?
- **In-depth interviews** allow you to get more detailed information about the adaptation. This includes asking questions like:
How well did the adaptation address the behavioral determinants? What do people think would make the adaptations work better?

- **Surveys** are another way to collect feedback about your adaptations. You can also use a survey to find out the knowledge, attitudes, beliefs, and behaviors of your population. Surveys are good for collecting general information on a variety of topics. This helps you figure out how your adaptation is affecting the determinants of your population's HIV transmission behavior. It also helps you see if the adaptation is producing your desired results.

Pilot Test Step 4: Organize and Conduct the Pilot Test

Before doing the pilot test, we suggest you:

- Review the purpose and goals of the pilot test with the staff that will be doing the pilot test.
- Let people in the pilot test know you will be noting their feedback and how they react to the adaptations. Be sure to explain why you need this information.

You then pilot test your adapted activities or the intervention as a whole. You record all feedback and reactions to the adaptations. Do not forget to thank the people who take part in your pilot test! Pilot testing is key because it tells you what worked well and how to improve the activities and/or the intervention. After the pilot test, you review the information you gathered and look for what worked and what did not work.

Adaptations are most often successful. But, you need to know there may be times when adaptations do not work. This does not mean you did something wrong. When your adaptations do not work, you should talk about them and:

- Ask people in the pilot test to give you more in-depth information about what they thought about the adaptations.
- Go back to the Decision Tool for Adapting Interventions. You may need to change how an activity is done or design a new material. You may even want to think about changing different activities. After making your changes, you will need to pilot test what you changed or maybe even the whole intervention.

Adapting, pilot testing, and revising an intervention is a process that you may do over and over again. You will never test and revise an activity or an intervention only once. As you give your intervention over time, you will have new people take part in it. Sometimes the new people may have different reactions than the people who already went through the intervention. This could mean there is a new issue in the community or a new subgroup of men. We talk about this more in the next section of this Chapter. Keep in mind that as you keep testing and revising your intervention, you may find that an activity is just not working. If this happens, you may need to go back to the Selection Stage and choose a new intervention to adapt.

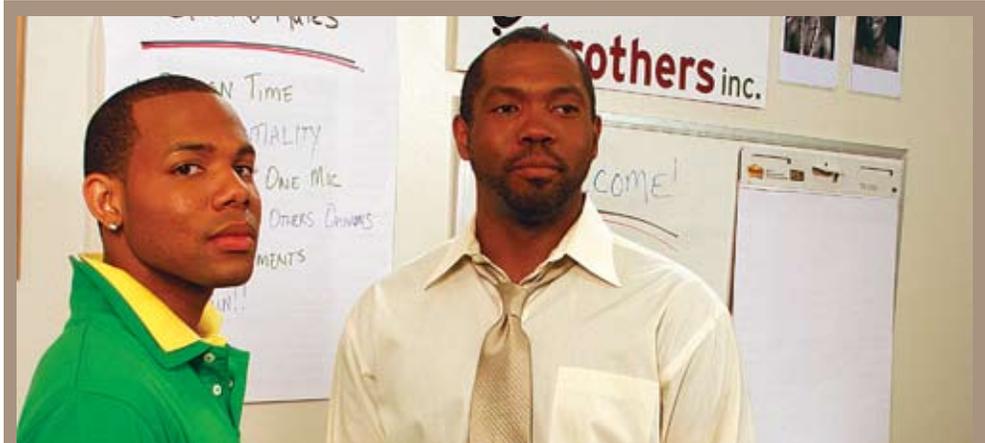
Adaptation Stage Step 2 Key Points

In this step, you develop a plan to pilot test the adaptations you made to your intervention. You test the adaptation with the intervention population and gather feedback on the changes. You then use this information to revise your adaptations. It is important to pilot test every change you make and get feedback on the changes. This will help you make sure your adaptations are working to address the HIV transmission behavior in your population. You may test and revise your adaptation every time you give your intervention. This will help you to be sure you are addressing your population's needs over time.

Key Points:

- Pilot testing is the process of testing adapted intervention activities and materials.
- Pilot test the adaptation with the intervention population. Do not forget to thank the people who take part in the pilot test!
- Based on your changes, pilot test either the whole intervention or just the adapted activities.
- Use methods (e.g., focus groups, in-depth interviews, surveys) to gather feedback from your population on the adaptations.
- Revise adaptations as needed.

ADAPTATION STEP THREE: IMPLEMENT, EVALUATE, AND REVISE THE INTERVENTION



The Hope AIDS Project is now ready to offer Many Men, Many Voices to its population! Even though the agency pilot tested and revised its adapted activities and materials, they are still not sure their intervention will “work.” They will only know this once they begin providing their adapted version of Many Men, Many Voices on a routine basis. As they offer the intervention, they will need to monitor and evaluate it to make sure they are getting the results they need. They also want to make sure the intervention is still meeting the needs and is liked by their population.

The Hope AIDS Project uses the Implementation Plan for Many Men, Many Voices it got on the www.effectiveinterventions.org web site. They make some changes to the plan, including doing two weekend retreats and changing some of the role-plays. They also change the plan to show they will do the seven-session, weekly format one time. They do this to reach men who cannot come to the weekend retreats. The Hope AIDS Project Program Director decides to meet with the staff after each weekend retreat. He will also meet with the staff after each session when the intervention is done during the week. During each meeting, changes and tweaks are made to the intervention, based on feedback from the men. The Hope AIDS Project makes changes to the role-plays and writes down their reasons for making the changes. They record everything so their agency and funders will know what changes were made, why they were made, and the results of the changes.

To evaluate the intervention, the Hope AIDS Project gives a knowledge, attitudes, beliefs, and behaviors survey to the men before and after the weekend retreat and the series of weekly sessions. They do this to see if the men's self-efficacy increased with talking to their partners about using condoms. Over time, the survey results show no increase in self-efficacy among the men. The Hope AIDS Project knows something is wrong. Maybe the staff did not do the role-plays in the correct way? The agency's Program Director watched the role-plays when they were being done. He saw the men liked the role-plays very much. But, he also saw the staff did not set up and explain the role-plays very well, which confused the men. When talking with the staff, he learns they are confused about how to do the role-plays. The staff also say it would have been helpful to practice doing the role-plays with each other before doing the intervention. The Hope AIDS Project Director has the staff develop better guides for how to do the role-plays. He also has the staff practice the role-plays before they deliver the intervention. By gathering information about how the staff conducts the role-plays, the Hope AIDS Project was able to improve the way in which they are delivered. This will help increase the agency's chances of achieving the desired intervention outcomes.

The Hope AIDS Project also finds with its implementation of the weekly sessions that many of the men have a hard time coming to all of the sessions. The men tell them they like the weekend retreat the best. Most of the men who come to the retreats stay for the whole weekend and do not drop out. Over time, the Hope AIDS Project staff also say it gets easier for them to do the retreats. As a result of this feedback, the agency decides to offer only weekend retreats.

After a year of implementing Many Men, Many Voices, the Hope AIDS Project does another survey with their intervention population. The Black gay men show a decrease in unprotected anal intercourse, an increase in condom use and negotiation, and have better self-images. After all their hard work in adapting and implementing the intervention, the Hope AIDS Project is pleased to see it is making a positive impact in the community!

By the time you get to Step 3 in the Adaptation Stage, you already have selected, developed, and tested adaptations to your intervention. But, the adaptation process is not over! You still do not know if your adapted intervention will “work” until you start doing the intervention. By “working” we mean does the intervention affect the determinants of your population’s HIV transmission behavior? And, does your population like the intervention? As more people go through the intervention, not all groups will react the same way to the intervention. You need to keep testing to be sure you are meeting the needs of your population. During this last step of the Adaptation Stage you:

- Develop an implementation plan and do your intervention.
- Monitor and evaluate your intervention and the activities you adapted.
- Make changes to your intervention activities based on monitoring and evaluation information.

Develop an Implementation Plan and Implement the Intervention

You develop a plan to keep track of the key activities when implementing your intervention. This plan should say how you will conduct, monitor and evaluate your intervention. All DEBIs have implementation planning tools you can use to create your plan. You can find these tools on the www.effectiveinterventions.org web site. The Guide’s appendices also have information on how to develop an implementation plan.

Monitor and Evaluate the Intervention

Monitoring and evaluation helps you see if your adapted activities are “working.” In other words, did your adapted activities achieve the desired outcomes? Monitoring and evaluation will also show you if your intervention is having an effect on your population’s determinants of HIV transmission behavior. If no effect is found, you will need to review your monitoring and evaluation information to figure out what is not working.

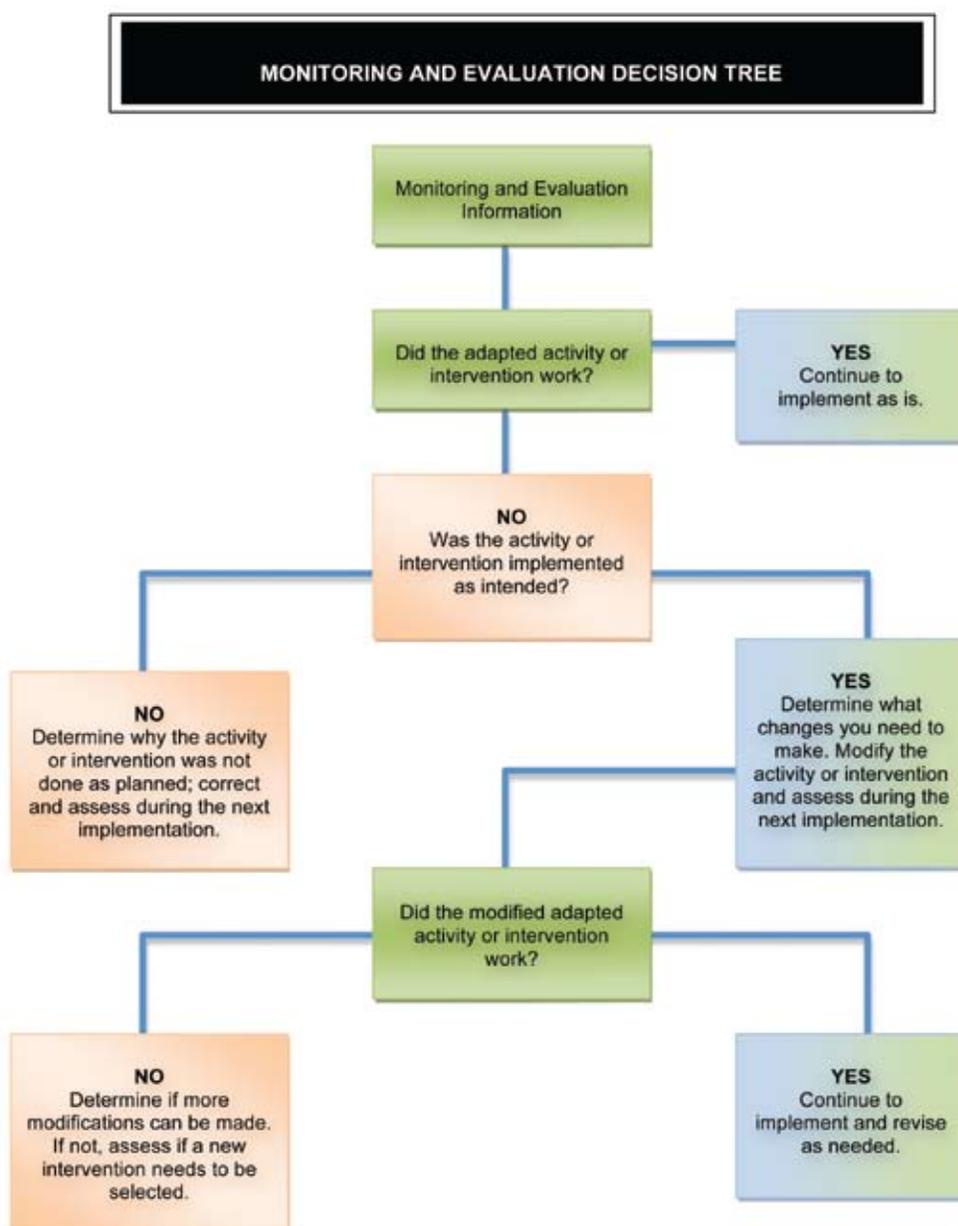
Key questions to ask when monitoring and evaluating adapted activities and interventions include:

- Did your adaptations work? If not, what are the reasons they did not work?
- Did your staff conduct the adapted activities as planned?
- Did your intervention population like your adaptations?
- Are there other activities you need to adapt or add?

Reviewing and Using Monitoring and Evaluation Information

There is no point in monitoring and evaluating your intervention if you do not use the information. Take time to look at the information you collect so you can make your interventions work better. What worked well? What can be improved? What objectives were met?

What outcomes were achieved? The following **Monitoring and Evaluation Decision Tree** will help you answer these questions.



Whenever you do your adapted intervention, be sure to always conduct monitoring and evaluation. This helps you to make sure your intervention is meeting the needs of your population and agency. But, know that sometimes your intervention may not give you the results you want, even with making many changes over time. If this happens, the intervention you adapted might not be a good fit for your population. You may need to consider adapting another intervention.

For more information on monitoring and evaluation, including how to plan monitoring and evaluation activities, see the Guide's appendices.

Adaptation Stage Step 3 Conclusion and Key Points

Once you pilot test and revise the activities you adapted, you are ready to implement your intervention. Developing an intervention plan helps you to make sure all activities are done correctly. You also need to monitor and evaluate your activities to see if your adaptations are working. Based on what you learn, you revise your adaptations. We strongly suggest you assess and revise your activities **every time** you conduct your intervention.

Key Points:

When you finish pilot testing your adaptations, you will:

- Develop an implementation plan that spells out monitoring and evaluation activities.
- Implement your intervention with the population you intend to reach.
- Monitor and evaluate the implementation of your intervention.
- Review monitoring and evaluation information to see if you need to make further changes to the adapted activities.
- Make changes based on your monitoring and evaluation results.
- Continue to monitor and evaluate your intervention every time you deliver it.

THE BORDER HEALTH SERVICES STORY – PART 2

We continue with our story line of the adaptation of the Popular Opinion Leader DEBI for a Latino population in a Texas border town.

Border Health Services Adapts their Intervention Activities (Adaptation Stage Step 1)

After selecting their intervention, Border Health Services reviews the Popular Opinion Leader materials more closely and decides the activities they need to adapt. They use the Decision Tool for Adapting Interventions to list the activities, describe how they will adapt them, and give their reasons for making the adaptations.

The Popular Opinion Leader intervention changes behavior by addressing and promoting social norms. Border Health Services decides they will increase condom use by having opinion leaders promote the idea that using condoms is a good thing to do. Using condoms means you are healthy and want to stay healthy. This will help to change the current idea that using condoms means you are sick. They also want to help men value themselves and stay healthy so they can support their families. Being sick and infected does not allow them to fulfill their roles as “providers” or as “men.” They will talk about machismo in a way that makes having safer sex mean you are manly and strong. Lastly, they want the opinion leaders to stress there is nothing wrong with being gay, their lives have value, and their families and friends care about them.

Opinion Leader Training (Changing the “Who” “What,” “When,” “Where,” and “How”)

Border Health Services knows they need to make changes to the Popular Opinion Leader’s opinion leader training. Since their population knows very little about HIV, they decide to add a session to provide information about how you can get and prevent HIV. They also add another session for opinion leaders to talk about their sexuality and the struggles they face being gay/bisexual Latinos. In this session, they will also talk about how machismo



affects the attitudes, beliefs and behaviors of Latino gay men. They think this session is key because most of the opinion leaders, as well as the men they will be talking to, have to hide their “true” identity. And, they think this session will help the opinion leaders talk to men about the value of being gay and Latino. This should help build support among the men and allow them to talk about the things that can put them at risk for HIV.

In Popular Opinion Leader, the opinion leaders are taught about the theories and research behind the intervention. Border Health Services does not think this will work with their opinion leaders because they do not have much education. So, they decide to give a basic talk on the theory and research, using pictures to show how the process of diffusion (spreading messages and information) works. Popular Opinion Leader also teaches the opinion leaders how to carry out risk reduction conversations using demonstrations and role-play practice. Border Health Services decides to modify the way their opinion leaders will have their risk reduction conversations. This is because Latino communication is not as direct as mainstream American culture. They show opinion leaders how to start and carry out conversations in a way that is closer to how Latinos talk to each other.

Border Health Services hires and trains two young gay Latinos who are highly respected in the community. These young men become trainers and provide support to the opinion leaders. Having these young men on board helps Border Health Services to gain buy-in from the community and the men they want to reach.

Border Health Services translates all training and other materials for the Popular Opinion Leader intervention into Spanish, because most of the men speak Spanish only. Also, since most of the men do not read, they plan to do all of the training verbally and with simple pictures and diagrams.

The opinion leader training has four weekly sessions. The research Border Health Services did found that it was hard for men to go to a lot of sessions due to changing work schedules. So, they decide to do the opinion leader training during a one-day “retreat.” They give rides to the retreat, which are held at a local community center. This location was picked to increase attendance because it was not an AIDS service organization or an agency that dealt with HIV prevention. Border Health Services knows the men will not come to these types of locations.

Border Health Services designs green-colored T-shirts, buttons, and bags that have the phrase “Se Un Hombre” (Be A Man) on them as incentives. The color is the same as the jerseys of a popular local soccer team. Border Health Services thinks the men will like these materials, but will not make them stand out as being with an HIV prevention program.

Border Health Services uses the Decision Tool for Adapting Interventions that follows to record their adaptations.

The Hope AIDS Project’s Decision Tool for Adapting interventions: <i>Many Men, Many Voices</i>					
Activity	“What”	“Who,” “When,” “Where,” “How”	“Why” (Intent)	How the Activity Will Be Adapted	Justification for Adaptation
Exercise 7.3 – How Can I Build On This Experience. The purpose of the exercise is for men to discuss their growth (emotional and personal) during <i>Many Men, Many Voices</i> .	Men’s personal growth, self-development, and emotional development as a result of taking part in <i>Many Men, Many Voices</i> .	Men talk about their personal growth, self-development, and emotional development. The men are introduced to a Mental Health professional who tells them about his services.	The exercise increases men’s awareness of how much they have grown and developed as a result of <i>Many Men, Many Voices</i> . Also, the exercise makes it okay to talk to a Mental Health professional and continue to grow and develop after the intervention is over.	Instead of a Mental Health professional talking to the men, a pastor from a local church (who is openly gay and whose church supports the Black gay community) will talk about the importance of spirituality and faith for self-development. He will also talk about the counseling services and other mental health services offered by his church.	When we looked at the information we collected, we learned our population felt rejected from church leaders because they are gay and/or bisexual. This rejection results in a poor self-image and leads to risky behaviors such as unprotected anal intercourse. We want to teach the men that there are churches that support them. This should help the men find churches that meet their spiritual needs.
Deliver <i>Many Men, Many Voices</i> over 7 weeks (one session per week).	Men meet once a week to talk, practice skills, get feedback on skills practice, and do role-plays.	Two staff persons that the population can relate to give 7 weekly sessions to HIV-negative Black gay and/or bisexual men.	Meeting in session with other HIV-negative Black gay and/or bisexual men increases the men’s STD/HIV knowledge, perception of HIV/STD risk, skills and self-efficacy for condom use, negotiation skills, and ability to communicate with partners.	<i>Many Men, Many Voices</i> will be done as a weekend retreat format. Session 1 will be done Friday night, Sessions 2 and 3 will be done Saturday, Sessions 4, 5, and 6 will be done Sunday. Session 7 will happen 2 weeks later as a follow-up. Men will meet at a local gay church to talk about how the intervention changed their lives.	We know our men like weekend activities better than coming to 7 weekly sessions. Having a weekend retreat will also reduce drop out rates of the men.

Border Health Services Finds Out if its Adaptations Will Work (Adaptation Stage Step 2)

Border Health Services does a practice run of their opinion leader training, which they give to their agency and university staff and some young gay Latinos. One thing they see right away is the training is too long to be done in one day. People in the pilot test feel most opinion leaders will not want to spend a whole day going to a training. Plus, there is a lot to cover, and people may not take in as much towards the end of a long day. So, Border Health Services changes the opinion leader training to a two-day retreat.

People in the pilot test also feel there needs to be more role-play scenarios to help the opinion leaders start risk reduction conversations. Most of the conversations are staged to take place at a bar or a party. Border Health Services creates other role-plays, so the opinion leaders can have conversations at work, at a soccer game, and at community events. Border Health Services also designs a role-play about talking about getting tested and treated for HIV and STDs. They do this because the people who went through the pilot test think it is important to help men get tested and treated.

Border Health Services Puts their Intervention to the Test (Adaptation Stage Step 3)

Border Health Services wants to find out if their intervention will give them their desired results. They develop an implementation plan with a timeline for opinion leader training and follow-up (booster) sessions. The plan outlines times for opinion leaders to get together and report on their progress and talk about problems. The plan also includes evaluation activities. They decide to collect information on three main areas: opinion leader training; opinion leader's experiences with carrying out risk reduction conversations; and changes in the intervention population's condom use.

Border Health Services staff speaks with the opinion leader trainers at the end of each training event, to see how the

sessions went. They learn the men like the training. And, the men really like the session where they talk about their sexuality and the struggles they face as gay Latinos. But, the session is too short to give all the men a chance to talk. Border Health Services decides to add more time to this session. They also add more time to the booster sessions to talk about these things.

During the booster sessions, the opinion leaders share they had some trouble having conversations at first, but got better with time and practice. They also share they do not know enough about STDs to answer basic questions. Most of the men they talked to wanted to know about STDs. So, Border Health Services decides to add a STD 101 talk to their booster session, as well as to the opinion leader training. They will also teach opinion leaders how to refer men to STD and HIV testing and treatment services.

After six months of doing the Popular Opinion Leader intervention, the university helps Border Health Services to do a knowledge, attitudes, beliefs and behavior survey with about 50 young, gay Latinos. The survey shows the men did raise their knowledge about HIV transmission and prevention. It also shows the men now feel they are at risk for HIV. The survey finds the men have a better self-image, and also have better attitudes toward using condoms. But, even with these changes, condom use is still low. Few of the men say they carry condoms with them or can get condoms. To improve access to condoms (and hopefully condom use), Border Health Services gives their opinion leaders condoms to hand out during their conversations. Border Health Services is also gets El Matador to keep a box filled with free condoms in its restrooms.

Border Health Services hopes that with these changes to the Popular Opinion Leader DEBI, they will be able to lower the rates of unprotected anal intercourse among young, migrant Latino men. If condom use among these men increases over time, they will try setting in place a new norm around getting tested and treated for HIV and STDs. The staff at Border Health Services feels good about their efforts! They think they are making a real difference in lives of young gay Latinos in the community.



GLOSSARY OF TERMS

TERM	DEFINITION
Adaptation	The process of selecting, adapting and applying an intervention to a particular context, while adhering to the original model.
Adaptation Process Stage 1: Selection	The Selection Stage of adapting an intervention has two steps: 1) collect information on population’s HIV behavioral risk, population “readiness,” HIV behavior change interventions, and agency “readiness;” 2) assess information collected and select an intervention.
Adaptation Process Stage 2: Adaptation	The Adaptation Stage of adapting an intervention has three steps: 1) adapt intervention activities; 2) test and revise adaptations; 3) implement, evaluate, and revise intervention activities.
Agency “readiness”	An agency’s current or future capacity to deliver interventions, based on access to the population, staffing, experience, funding and other available resources.
Behavioral assessment	Identifies a population’s or population subgroup’s HIV behavioral risk.

TERM	DEFINITION
Behavioral determinants	<p>The things, or the factors, that affect or lead to HIV transmission behavior. These factors are sometimes called the “reasons why” people do behaviors that can transmit HIV.</p>
Behavior change logic model	<p>A picture or graphic representation of the unique way a specific intervention brings about changes in risk behavior.</p>
Behavior change interventions	<p>Interventions that help a person or a group of people to change their HIV transmission behavior, which lowers their chances of getting infected with HIV or giving HIV to someone else.</p>
Community-level interventions	<p>An intervention that seeks to improve the HIV transmission behaviors in a community through a focus on the community as a whole, rather the individual as the unit for change.</p>
Core elements	<p>The parts of an intervention that represent the behavioral theory and logic of an intervention, and most likely produce the intervention’s main effects. Core elements cannot be changed or dropped when implementing an intervention.</p>

TERM	DEFINITION
Direct observation	An information collection method where you watch what is happening in a setting. It can help you learn more about how people behave and interact in the “real world.”
Diffusion of Effective Behavioral Interventions (DEBIs)	This CDC project takes an evidence-based intervention and “packages” it into a DEBI. Each DEBI has information and tools that tell you how to implement the intervention. CDC also provides training and technical assistance for its DEBIs and has a web site: www.effectiveinterventions.org .
Disease control interventions (also called bio-medical interventions and public health strategies)	Interventions that are used to lower a person’s chances of spreading or getting HIV and other sexually transmitted diseases (STDs). For example, taking medicine like highly active antiretroviral therapy. Public Health Strategies are HIV Counseling, Testing and Referral, Comprehensive Risk Reduction Counseling and Services, and Partner Services.
Disease intervention services	A public health strategy that locates where cases of disease are, so treatment and prevention services can be offered.

TERM	DEFINITION
Evidence-based behavioral interventions	Interventions that have been shown by research to lower HIV transmission behavior.
Fidelity	Being true to an intervention by following its stated procedures, activities and content when you implement it.
Focus group	A structured discussion led by a facilitator, where a small group of people talks in-depth on one topic or issue.
HIV behavioral risk	A “profile” of a population, group or subgroup of people that shows the HIV transmission behavior and the behavioral determinants that drives the HIV transmission behavior, as well as associated risk behaviors.
HIV behavior change interventions	These interventions help a person or a group of people to change their HIV transmission behavior, which lowers their chances of getting infected with HIV or giving HIV to someone else.
HIV transmission behavior	Behaviors that put a person at risk for getting infected with HIV or giving HIV to another person. These include having unprotected sex, sharing infected needles and

TERM	DEFINITION
	<p>other injection drug equipment and drinking mother’s milk. In this Guide, we focus on unprotected anal intercourse as the main HIV transmission behavior for gay and bisexual Latino and Black men.</p>
<p>Immediate intervention outcomes</p>	<p>Changes in behavioral determinants that occur during or immediately after a person’s participation in an intervention.</p>
<p>Implementation plan</p>	<p>Plans used to guide and monitor project objectives and tasks, and track progress when implementing an intervention.</p>
<p>Individual-level interventions</p>	<p>Interventions designed to change individual risk behavior through the use of “one-on-one” interactions carried out in one or more individual sessions. They can also be done with small groups of people.</p>
<p>In-depth interviews</p>	<p>In-depth interviews are done with one person at a time and use open-ended questions that allow you to explore a topic more in-depth. By talking one-on-one with a person, you can get detailed information about risk-taking behavior.</p>
<p>Intent</p>	<p>The purpose and design of an intervention as determined by its original developer.</p>

TERM	DEFINITION
Intervention activities and the “Who,” “What,” “When,” “Where,” “How,” and “Why”	The actions you take in doing an intervention. In this Guide, we break down activities into “Who,” “What,” “When,” “Where,” “How,” and “Why.” The “What” is the topic of the activity, and also includes images that are liked by the intervention’s target population. The “Who,” “When,” “Where,” and “How” tells who is involved in the activity, and how to do it. The “Why” is the purpose or intent of the activity.
Intervention or internal logic	The way in which an intervention combines its activities – the “Who,” “What,” “When,” “Where,” “How,” and “Why,” to get a certain result.
Intervention population	The population that an intervention will be done with.
Knowledge, Attitudes, Beliefs and Behaviors Survey (KABB)	A survey that uses specific questions and scales to determine a person’s knowledge, attitudes, beliefs and behaviors.
Key characteristics	Activities and delivery methods for conducting an intervention, which may be changed for different contexts and populations.

TERM	DEFINITION
Observation	Allows you to watch what is happening in a setting. It helps you learn more about how people behave and interact in the community.
Pilot test	A process that tells you if the adaptation you made to an activity(s) or an intervention is giving you the desired results, without changing the “Why” (intent) of the activity or intervention.
Pilot test plan	A “road map” for how you will do a pilot test. Pilot test plans should include: the activities and materials you will test; who will do the pilot test; and the methods you will use to document and analyze reactions; and feedback of the people who take part in the test.
Population “readiness”	A population’s willingness, need and ability to participate in interventions.
Program outputs	The deliverables or products that result from implementation activities. Outputs provide evidence of service delivery.

TERM	DEFINITION
Proximate social-cognitive determinants of HIV transmission behavior, i.e., condom use	<p>These are proximate (very near, close) social and/or cognitive (thoughts, thinking) factors that have been shown in health psychology and social and behavioral science to affect a person's use of a condom or "dirty" needles. Common social-cognitive determinants of individual HIV transmission behaviors in DEBIs are: knowledge; self-efficacy (belief in ability to do something); intentions; expectancies; attitudes; beliefs; perceived norms; perceptions; rationalizations; skill(s) to do behaviors; social norms; social support; and individual, social or community power and control (empowerment). In this Guide, we are talking about the proximate social-cognitive determinants or behavioral determinants. When we talk about HIV transmission behavior in this Guide, we are mostly talking about the nonuse of condoms.</p>
Review of the literature	<p>A review of published studies in peer-reviewed journals on a particular topic area or concern.</p>
Risk behavior	<p>Behaviors that people have that put them at risk for getting or giving HIV.</p>

TERM	DEFINITION
Risk factors	An activity, condition, or thing that has been related statistically to risk and susceptibility for becoming infected with HIV. For example, lifetime number of sex partners and substance use.
Risk group	A group of people that, because of their behavior and situation, are at increased risk for HIV, such as injection drug users, runaway youth, etc.
Service population	The population an agency provides services to; services include HIV/AIDS prevention and treatment services.
Short-term intervention outcomes	Changes in HIV transmission behavior that happens due to and after an intervention.
Structural and policy interventions	These interventions make changes on a larger social level. They also increase access to HIV prevention services by doing things like passing laws that support government funding of needle exchange programs. These interventions also make changes to the physical

TERM	DEFINITION
Surveys	<p>environment to support HIV prevention efforts. This includes things like putting condom dispensers in bar restrooms or placing a health center in a community.</p> <p>Structural interventions can also lower stigma, make sure people are safe, and give groups the power and tools to speak up for themselves. For example, passing laws and setting up programs that protect human rights and make violence against gay men illegal.</p> <p>Allow you to collect and assess information on attitudes, knowledge, beliefs and practices around HIV with many people. Surveys most often use brief and focused closed-ended (yes/no, select one, etc.) questions.</p> <p>Some people feel more at ease sharing personal information on a survey because they do not have to give their name. You can also use surveys to get information about people's experiences with HIV services and barriers to getting these services.</p>

Evidence-based HIV Behavior Change Interventions for Men Who Have Sex with Men

This table lists evidenced-based HIV behavior change interventions for men who have sex with men that are approved by CDC. The table describes each intervention, its outcomes, modes of delivery, target population, and the original study population. The table also notes if the intervention is a DEBI. DEBIs are evidence-based interventions that are packaged and distributed by CDC. You can find them online at www.effectiveinterventions.org.

Intervention		Intervention Description		Immediate Outcomes	
<i>Behavioral Self-Management and Assertion Skills (also called Partners In Prevention)</i>		A 12-week, small group-based intervention. Each session lasts about 75 to 90 minutes. 2 clinical psychologists and 2 project assistants lead the sessions. The sessions cover: HIV/AIDS risk reduction education; identification of high-risk sexual activity; assertiveness skills training; relationship skills building; risk reduction strategies; and social support and relapse prevention.		Increased knowledge of HIV and AIDS	
				Increased self-efficacy for condom use	
				Increased social support	
				Increased knowledge of risk reduction strategies	
Short-term Outcomes	Mode of Delivery	Intervention Population	Original Study Population ¹	DEBI?	
Decrease in unprotected anal intercourse	Small group-based intervention	Asian/Pacific Islander men who have sex with men	Men who have sex with men 13% African American or Hispanic 87% White Average age 31	NO	

¹ The information in this column comes from <http://www.cdc.gov/hiv/topics/research/prs/evidence-based-interventions.htm> and gives the race and ethnic background of the men in each intervention study.

Intervention	Intervention Description		Immediate Outcomes	
Brief Group Counseling	<p>A group-based counseling and skills training intervention for gay Asian-Pacific Islander men. Conducted with a group of about 8 men, it consists of one 3-hour culturally adapted session with four key components: 1) development of positive self-identity and social support; 2) safer sex education; 3) promoting positive attitudes towards safer sex; 4) negotiating safer sex. HIV transmission facts, correct condom use, and partner risk are also covered. Men discuss how to increase their comfort with being API and gay. This promotes a positive sense of self and social support. Men learn how to negotiate safer sex through role-play and demonstrations.</p>		<p>Increased positive self-identity</p> <p>Increased social support</p> <p>Increased knowledge of HIV and AIDS</p> <p>Increased safer-sex negotiation skills</p> <p>Enhanced attitudes and beliefs towards safer-sex practices</p>	
Short-term Outcomes	Mode of Delivery	Intervention Population	Original Study Population ¹	DEBI?
Decrease in unprotected sex	Small group-based intervention	Asian/Pacific Islander men who have sex with men	<p>Men who have sex with men</p> <p>37% Chinese 34% Filipino 11% Other 10% Japanese 8% Vietnamese Average age 29</p>	NO

Intervention	Intervention Description		Immediate Outcomes	
<p><i>d-up: Defend Yourself!</i></p>	<p>A community-level intervention that uses an existing social network of Black men who have sex with men to promote condom use. d-up! teaches men how to deal with bias (discrimination about being a man who has sex with men and about being Black) and helps them build their self worth. This helps the men cope with bias. d-up! uses social network members, called opinion leaders, who are trusted and well respected in their network. They promote the benefits of condom use. They also try to build the self-worth of their friends and others in the network.</p>		<p>The social network of Black men who have sex with men accepts the social norm related to the risk behavior</p> <p>Increased skills for coping with bias</p> <p>Decreased bias-based attitudes among the men in the social network</p> <p>Increased self-efficacy, attitudes, intention, and knowledge to communicate safer sex practices to Black men who have sex with men, friends and others</p> <p>Increased behavioral skills for coping with bias that affects HIV transmission risk</p>	
Short-term Outcomes	Mode of Delivery	Intervention Population	Original Study Population ¹	DEBI?
<p>Condom use behavior for sexual intercourse</p> <p>Increased communication about safety</p>	<p>Community-level intervention</p>	<p>Black men who have sex with men</p>	<p>Black men who have sex with men</p> <p>Average age 25</p>	<p>YES</p>

Intervention	Intervention Description		Immediate Outcomes	
EXPLORE	10 counseling sessions delivered one-on-one to participants. The first 3 sessions establish a comfort level between the counselor and the participant, and a personal risk assessment is done. The other 7 sessions cover topics such as communication, knowing your HIV status, and the role of alcohol and drug use in risk behavior. Coping with the triggers of unsafe sex and how to change risky behavior are also covered. Motivational Interviewing is used to help participants make and maintain behavior change.		<p>Increased knowledge of HIV transmission and HIV risk-related</p> <p>Increase self-efficacy to use condoms</p> <p>Increased intentions to practice risk-reduction strategies</p> <p>Increased knowledge of risk behavior triggers</p>	
Short-term Outcomes	Mode of Delivery	Intervention Population	Original Study Population ¹	DEBI?
Decrease in unprotected anal intercourse	Individual-based intervention	Men who have sex with men	<p>HIV-negative men who have sex with men</p> <p>72% White</p> <p>15% Hispanic</p> <p>7% African American</p> <p>6% Other</p> <p>Average age 34</p>	NO

Intervention	Intervention Description		Immediate Outcomes	
<p>Many Men, Many Voices</p>	<p>A small group-based intervention that addresses behavioral determinants and other factors that affect HIV/STD risk and protective behaviors of Black men who have sex with men. The other factors include cultural, social and religious norms, identity of Black men who have sex with men and their connection to the Black and gay communities, HIV/STD interactions, sexual relationship dynamics, and the social influences of racism and homophobia. The intervention consists of seven 2 to 3 hour sessions, which are held over 7 weeks or as a weekend retreat.</p>		<p>Increase in positive identity, values, self-standards as a Black man who has sex with men</p> <p>Increased perception of personal susceptibility for HIV and STDs</p> <p>Increased knowledge of STDs and the interaction between STDs and HIV</p> <p>Increased knowledge of risk-reduction and health promotion behaviors</p> <p>Increased knowledge of HIV risk-reduction behavior skills</p> <p>Increased skills and self-efficacy related to consistent condom use, condom negotiation, and partner communication</p> <p>Increased intentions to adopt a risk reduction or health promotion behavior</p>	
Short-term Outcomes	Mode of Delivery	Intervention Population	Original Study Population ¹	DEBI?
<p>Reduced frequency of unprotected anal intercourse</p> <p>Reduced number of male sex partners</p> <p>Increased HIV testing</p> <p>Increased condom use for anal intercourse</p> <p>Increased STD testing</p>	<p>Small-group based intervention</p>	<p>Black men who have sex with men</p>	<p>Men who have sex with men</p> <p>68% African American</p> <p>17% Caribbean West Indian</p> <p>11% Afro-Latino</p> <p>3% Mixed Ancestry</p> <p>1% African</p> <p>Average age 30</p>	<p>YES</p>

Intervention	Intervention Description		Immediate Outcomes	
Mpowerment	A community-level intervention for young gay men ages 18-29. It is based on an empowerment model where a core group of 10-15 young gay men design and carry out all project activities. Mpowerment is guided by principles of personal and community empowerment; diffusion of new behaviors through social networks; peer-influence; putting HIV prevention within the context of other compelling issues for young gay/bisexual men (e.g. social issues); community building; and using gay-positive approaches, which are instilled in its structures (coordinators, core groups, and project space) and activities (formal and informal outreach, Mgroups, and publicity campaigns).		<p>Increase in young gay/ bi men spreading safer sex supportive values, attitudes, and behaviors among them</p> <p>Young gay/bisexual men create a social and support network or community of young, gay/bisexual men</p> <p>Increase perceptions of support for sexuality and safety among young gay/ bisexual men</p> <p>Increased sense of self-and community-power and control over project and destiny among gay/bisexual men in the community</p>	
Short-term Outcomes	Mode of Delivery	Intervention Population	Original Study Population ¹	DEBI?
Increase in safer behavior among young gay/ bisexual men	Community-level intervention	Young men who have sex with men	Men who have sex with men 81% White 7% Asian / Pacific Islander 4% African American 2% Other Average age 23	YES

Intervention	Intervention Description		Immediate Outcomes	
<i>Personalized Cognitive Counseling Intervention</i>	A single counseling session designed to reduce high-risk sexual behavior (unprotected anal intercourse) among men who have sex with men who are repeat testers for HIV. The goal is to help men avoid future instances of unprotected anal sex. The men identify thoughts, feelings, and desires that lead to risky behaviors. The counselor helps men plan for ways they can protect themselves when they want to have sex.		<p>Increased awareness of personal self-justifications in risky situations</p> <p>Increased awareness of how thoughts, attitudes, and beliefs may promote risky behavior</p> <p>Commitment to new ways of thinking and behaving in future risky situations</p>	
Short-term Outcomes	Mode of Delivery	Intervention Population	Original Study Population ¹	DEBI?
Decrease in unprotected anal intercourse	Individual-based intervention	Men who have sex with men	<p>Men who have sex with men</p> <p>74% White</p> <p>11% Hispanic</p> <p>6% Asian / Pacific Islander</p> <p>3% African American</p> <p>6% Other</p> <p>Average age 33</p>	NO

Intervention	Intervention Description		Immediate Outcomes	
Popular Opinion Leader	A community-level intervention designed to identify, enlist and train key opinion leaders. These leaders promote safer sexual norms and behaviors with their social networks of friends and others through risk-reduction conversations.		The social network, subculture or “community” of friends embraces the social norm related to the risk behavior	
Short-term Outcomes	Mode of Delivery	Intervention Population	Original Study Population ¹	DEBI?
<p>Condom use behavior for sexual intercourse becomes a norm for the social network</p> <p>Decrease in unprotected anal intercourse</p>	Community-level intervention	Men who have sex with men who frequent gay bars	<p>Men who have sex with men</p> <p>86% White</p> <p>14% African American or Hispanic</p> <p>Average age 29</p>	YES

Intervention	Intervention Description		Immediate Outcomes	
<p><i>Small-group Lecture Plus Skills Training</i></p>	<p>A lecture and a skills training session conducted in a 2-session, small group format. Lecture topics include HIV transmission, risks of certain sexual practices like unprotected anal sex, the importance of risk reduction, and correct condom use.</p>		<p>Increased knowledge about HIV, AIDS, and other STDs</p> <p>Enhanced attitudes and beliefs towards safer sex</p> <p>Self-efficacy for condom use and negotiation</p> <p>Increased intentions to practice safer sex</p>	
Short-term Outcomes	Mode of Delivery	Intervention Population	Original Study Population ¹	DEBI?
<p>Decrease in unprotected anal intercourse</p>	<p>Small-group based intervention</p>	<p>Men who have sex with men</p>	<p>Men who have sex with men</p> <p>2% African American</p> <p>Less than 1% Hispanic</p> <p>Less than 1% Asian</p> <p>95% White</p> <p>Average age 33</p>	<p>NO</p>

Intervention	Intervention Description		Immediate Outcomes	
<p>SUMIT Enhance Peer-led</p>	<p>A peer-led intervention that is delivered to groups of gay or bisexual men living with HIV. The goal is to reduce risky sexual behavior. Led by HIV-positive gay or bisexual men, group activities focus on sexual and romantic relationships, HIV and STD transmission, drug and alcohol use, assumptions about HIV status of sex partners, disclosure of HIV status, and mental health.</p>		<p>Increased self-efficacy for condom use</p> <p>Increased perception of risk and risk-related activities</p> <p>Enhanced attitudes and beliefs about safer-sex practice and disclosure</p> <p>Increased knowledge of triggers</p> <p>Increased knowledge of HIV, AIDS, and other STDs</p>	
Short-term Outcomes	Mode of Delivery	Intervention Population	Original Study Population ¹	DEBI?
<p>Decrease in unprotected receptive anal intercourse</p>	<p>Small-group based intervention</p>	<p>HIV-positive men who have sex with men</p>	<p>Men who have sex with men</p> <p>51% White</p> <p>23% African American</p> <p>17% Hispanic</p> <p>1% Asian</p> <p>1% Native American Indian</p> <p>7% Other</p> <p>Average age 42</p>	<p>NO</p>

Checklist of Information to Collect During Adaptation Process Stage 1

Information Area	Things to Collect/Identify
HIV Behavioral Risk	<ul style="list-style-type: none"> • HIV transmission behaviors (for population subgroups) • Behavioral determinants of HIV transmission behaviors • Risk factors
HIV Behavior Change Interventions	<ul style="list-style-type: none"> • Target population Intervention intent • Targeted HIV transmission behaviors and behavioral determinants • Behavior change logic models • Core elements and key characteristics • Mode of delivery (individual, community, group) and place where intervention happens • Intervention frequency and duration, if applicable (number and length of sessions, etc.) • Intervention outcomes • Staffing and volunteer requirements • Resource requirements
Population Readiness	<ul style="list-style-type: none"> • Language considerations (languages spoken/ written, literacy level) • Social norms • Gathering places/venues • Other issues, such as substance abuse, intimate partner violence, homelessness that may affect participation in interventions

Information Area	Things to Collect/Identify
Population Readiness (continued)	<ul style="list-style-type: none"> • Types of information people would like to receive about HIV and risk reduction • Interest in participating in different types of intervention activities (counseling, educational sessions, etc.) • Barriers to participating in different types of intervention activities
Agency Readiness	<ul style="list-style-type: none"> • Knowledge and experience with individuals and population subgroups • Skill with implementing interventions (facilitation, counseling, HIV rapid testing, outreach) • Cultural competence and languages spoken/written • Experience with evidence-based interventions and DEBIs • Funding, including any funding restrictions • Space for implementing interventions • Staffing and volunteers • Access to individuals and population subgroups • Agency mission and values • Existing and potential partnerships with other service providers, gatekeepers, stakeholders, and experts/consultants • Interests and needs of community stakeholders

Methods for Collecting Information and Conducting Pilot Tests of Adapted Interventions

Method	Description
Surveys	Allow you to ask questions about attitudes, knowledge, beliefs and practices related to HIV to many people at once. You can also use surveys to get information about experiences with HIV services and barriers to getting services. Surveys can have open- and closed-ended questions.
Pluses	Minuses
<p>Great for collecting information from a broad range of individuals. Can be done quickly. Can be completed anonymously. Some people feel more at ease sharing personal information when they do not have to give their name.</p> <p>There are different ways to do a survey, depending on your needs and what will work best with your population. You can do a mail survey, telephone survey, or have people fill out the survey at the time they participate in an intervention. A trained interviewer can also verbally give a survey by asking the person the questions and writing down their answers.</p> <p>Can be low cost.</p> <p>Information is easy to pull together, compare and analyze.</p> <p>Can be done at different points in time, to identify any changes among a population. For example, a survey can be given both before (pre) and after (post) an intervention.</p>	<p>May be costly if you need to hire an expert to help you develop the survey and analyze results.</p> <p>Results may not be useful if the survey is not designed well. It is always best to pilot test a survey. You do this to make sure your questions are easy to understand. You also do this to make sure your questions are giving you the information you are looking for.</p> <p>Can take time to collect information. The information you collect may be limited. For example, you may ask about behaviors that put a person at risk for HIV, but may not be able to find out the reasons that people are engaging in risky behaviors.</p> <p>The people filling out the survey may answer the questions the way they think you want them to respond. This will not give you a true picture of what is happening in your population.</p> <p>Even with anonymous surveys, participants still might have confidentiality concerns.</p>

Method	Description
In-depth Interviews	<p>Provide more information than surveys. By talking one-on-one and in-depth with a person, you can learn more about what makes them take risks. For example, you can learn more about their thoughts, feelings, and experiences that affect their HIV transmission behavior.</p> <p>A trained interviewer does a one-on-one interview and asks questions about a topic. Questions tend to be open ended. Interviews can be short (10 or 15 minutes) or long (1 hour), depending on the type of information you are trying to collect and the amount of time the interviewee can spend.</p>
Pluses	Minuses
<p>Does not cost a lot. Printing costs are low.</p> <p>Lets you dig deeper to find out more information by using open-ended questions.</p> <p>Lets people answer questions in their own words.</p> <p>Lets the interviewer ask follow-up questions to make sure they understand what the person is saying.</p>	<p>Confidentiality may be an issue for some people.</p> <p>Requires skilled staff to do the interview.</p> <p>Sometimes people have a hard time saying what they mean. Because of this, the interviewer may wrongly describe what the person told them.</p> <p>Interviews are time consuming.</p> <p>Because people do not give standard responses to interview questions, the information can be hard to pull together and analyze.</p> <p>Only provides information from the people you talk to. Will not give you a picture of the whole population.</p>

Method	Description	
<p>Focus Groups</p>	<p>Let you explore a topic you want to learn more about in an in-depth way. By having a small group of people focus on one topic or issue, you can capture more in-depth information. For example, you can find out what people think about a program's service. You can also have people talk about the HIV-related needs they have that are not being met.</p> <p>During a focus group, participants are asked a number of key questions about the topic being discussed. A trained facilitator leads the group discussion.</p> <p>The questions are developed before the group and the facilitator can ask follow-up questions to "probe" participants to get more in-depth information.</p> <p>Focus groups contain a small number of participants; no more than 10 persons and 6 to 8 persons are best.</p>	
<p>Pluses</p>		<p>Minuses</p>
<p>More in-depth information can be collected.</p> <p>Talking with each other can help participants to think of things to share with you that they may not think of on their own.</p> <p>Lets you gather quick thoughts about an intervention or program model.</p> <p>Creates a safe space for participants to talk and share information and concerns about an intervention or program.</p> <p>Unplanned topics can come up during a focus group, providing valuable information about the participants and their experiences</p>		<p>Process is time intensive.</p> <p>Participants may feel shy about speaking in a group.</p> <p>Information is limited to the points of view of those people in the group.</p> <p>May require an incentive for participation like money or vouchers for transportation, food, etc.</p> <p>Time commitment is most often 1 to 2 hours.</p> <p>Participants may not represent the population well. This can limit the usefulness of the information shared. Requires a skilled facilitator, which can be costly or hard to find.</p> <p>May be hard to schedule, especially among hard-to-reach populations.</p>

Method	Description	
<p>Observation</p>	<p>Allows you to watch what is happening in a setting. It helps you learn more about how people behave and interact in the community. For example, observation can help you figure out which members of your population are close to each other, how they talk among themselves naturally about things, and where they hang out. This would be useful when looking for places to conduct recruitment or outreach activities.</p> <p>Observation will also help you find out what times are best to reach your population.</p> <p>When you pilot your intervention, you can observe how well the facilitators conduct a session. You can also observe how participants react to the intervention, and how much they participate in the intervention.</p>	
Pluses		Minuses
<p>Low cost. Requires a small number of staff persons.</p> <p>Can help you learn figures of speech and how to best talk to your population.</p> <p>Helpful way to begin to learn more about a population when you are not sure what you are looking for.</p> <p>Lets you gather information that you may not be able to get using other methods. This includes non-verbal reactions to an activity and the way in which a staff person is conducting the intervention.</p> <p>Can view the intervention activities as they are happening.</p> <p>Lets you collect information on the physical environment.</p> <p>Lets you collect information on how population members interact with each other in a community setting.</p> <p>Can be easily combined with other information collection methods.</p>		<p>Can be time consuming.</p> <p>The observer may see only what s/he wants to see, which can result in biased or wrong information.</p> <p>Information is limited. For example, you cannot “see” a person’s knowledge about a topic.</p> <p>Privacy and confidentiality issues when a person does not know they are being observed.</p> <p>Need trained staff to conduct observations.</p> <p>It can be hard to understand some behaviors. It can also be hard to describe some behaviors.</p> <p>Behaviors observed may not be “typical behaviors.”</p> <p>Observers can influence the behaviors of the people they are observing.</p> <p>Information is based only on the locations observed, which may not give you the true picture.</p>

Seven Steps for Developing an Implementation Plan

Follow these seven steps to develop an effective implementation plan for your intervention.

Step 1: Form a team to work on planning and implementing your intervention. Include program managers/coordinators, intervention facilitators, and any other staff you will need to successfully implement your intervention.

Step 2: Review support materials that describe how you should implement your intervention activities. These may include an implementation summary, logic model, protocols, and implementation guide.

Step 3: Hold meetings to create objectives and develop plans and timelines for completing activities. For each activity, figure out when it should be done, who will do it, what resources and knowledge are needed, and how you will conduct the activity. You can outline your plan using an implementation flowchart (see example on next page). Note: You must create objectives before developing your intervention plan. They are important because they will guide your activities and evaluation plans. Examples of objectives include: 1) Recruit and identify 100 potential intervention participants by April 2010; 2) By May 2010, train four staff members as intervention facilitators. You may need to adjust your objectives once you start implementing your activities. For example, you set an objective to conduct your intervention 10 times in the first year. After the second month, you had budget cuts and lost staff. You now do not have enough money to conduct your intervention 10 times and will need to reduce the number to four.

Step 4: Begin implementing your intervention.

Step 5: Document your progress and completion of activities, using your objectives and implementation plan as guides.

Step 6: Hold team meetings to review the implementation progress. Adjust objectives and plans as needed.

Step 7: Document all revisions.

Developing a Monitoring and Evaluation Plan

A monitoring and evaluation plan can help you plan and conduct the evaluation of your intervention and the activities you adapted. It also lets you collect information on any objectives you have set. For each activity or objective you want to evaluate, you will need to specify:

- Questions you need answered
- Information needed to answer your questions
- Information sources and instruments to collect information
- When the data will be collected
- Who will collect the data
- Data analysis and use plan

You will use the results of your evaluation to help improve your adaptations and future deliveries of the intervention.

Developing Evaluation Questions

The first step in developing your monitoring and evaluation plan is creating a list of questions you want to answer about your intervention. There are at least two areas of information you should collect information on: 1) intervention activities; and 2) intervention participants (the people who take part in the intervention).

Evaluating Activities

It will be important for you to collect and review information on your intervention's activities. Some questions to ask about your activities include:

- Did the recruitment activities reach the men you wanted to reach?
- What recruitment activities were most effective at reaching the men you wanted to reach?
- Were the activities conducted as they were supposed to be? If not, why not?

- How well did staff conduct an activity? What areas do staff need additional help with?
- Were there any barriers to conducting activities? How satisfied were the men with an activity?
- How satisfied were the men with the entire intervention?
- What did the men like about the intervention? What did the men not like about the intervention?
- What recommendations do the men have for improving the intervention and its activities?

Evaluating Participants

You will also want to collect information on the men who take part in your intervention, including basic demographics (age, race, and sex). This will tell you if you are reaching the men you planned on reaching with your intervention. You will also want to know their HIV transmission behavior and behavioral determinants.

Note: You may end up with a lot of questions you want to answer. But, you may not have the time or resources to answer all of them. You will need to decide which questions are most important to get answers to, given your time and resources.

Identifying Required Data and Data Sources

Once you have your evaluation questions, you will then identify what information you need to collect. For example, if one of your questions is, “Was there a change in men’s attitudes toward using condoms during anal sex after completing the intervention?” To answer this question, you will need to know: 1) the men’s attitudes towards using condoms BEFORE starting the intervention; and 2) the men’s attitudes towards using condoms AFTER the intervention.

You will next identify the best source(s) for the information you want to collect. For example, your intervention facilitators may have a

sense of men's attitudes toward condom use. However, the best way to get this information is to ask the men themselves.

Planning Data Collection – Methods, Schedule, and Collectors

After you have identified your information sources, you will need to decide what methods you will use to get the information. Methods to gather information include surveys, in-depth interviews, focus groups and observations. For example, you may use a survey that has a question where men rank their attitudes towards using condoms

during anal sex. You may conduct an in-depth interview to understand how the intervention changed the way in which men think about their risk behavior. A focus group can give you information about what men liked and did not like about an intervention. Observations let you see how well facilitators are conducting a session or an activity.

It will be important for you to decide and plan for when you will collect information. Some information can only be collected at certain times, like before or after the intervention. To make sure information is collected at the right time, you will need to assign people to be responsible for collecting that information. Be sure to communicate to your staff what information they are collecting and how and when they should collect it.

Developing a Data Analysis and Use Plan

To finalize your monitoring and evaluation plan, you will need to plan how you will manage and analyze the information. Your plan should also address how the information will be shared with staff, funders and other stakeholders. Finally, your plan should describe how you plan to use your evaluation results. Your data analysis and use plan should address the following questions:

- Where will you store the information? You will need to decide where you will keep hard copies (pre/post tests, attendance sheets) as well as electronic information (database, Excel spreadsheet).

- Where will you store the information? You will need to decide where you will keep hard copies (pre/post tests, attendance sheets) as well as electronic information (database, Excel spreadsheet).
- What analyses will you conduct? Your analysis plan can just be a simple statement, such as “Compare post-test with pre-test responses and determine average change score for men’s attitudes toward using condoms during anal sex.”
- Who will analyze the information?
- When will the information be analyzed?
- How will you use the evaluation results? One of the main reasons for evaluating your intervention is to improve future implementations.

Organizing Your Plan

The following Evaluation Planning Table can help you organize and develop your monitoring and evaluation plan. It will also help you get the right information you need to improve your intervention and adaptations. For each evaluation question, you will describe:

- Information you need to answer that question
- Information sources
- Information collection methods
- How you will analyze the information
- Staffing
- Timeframe for collecting and analyzing information and reporting
- How the information will be reported and used

Monitoring and Evaluation Planning Table

EXAMPLE	Monitoring and Evaluation Question	Information Needed	Data Source	Collection Method
	What percentage of men completed all the intervention sessions?	<p>Number of people enrolled in the intervention every time you implement the intervention</p> <p>Number of people who attended all the intervention sessions every time you implement the intervention</p>	Sign in sheets	Review of sign in sheets
	Analysis Plan	Responsible Team/Staff	Timeframe	Reporting Plan
<p>Review sign in sheets every time you conduct the intervention</p> <p>Determine which participants attended every session</p> <p>Divide the total number of participants who attended all the sessions by the total number of participants enrolled</p>	<p>Project coordinator – analysis</p> <p>Facilitators – information collection</p>	Review attendance information after the first 5 times you implement the intervention	Presentation at staff meeting	

Monitoring and Evaluation Question	Information Needed	Data Source	Collection Method	EXAMPLE
<p>What percentage of trained opinion leaders conducted 14 risk reduction conversations?</p>	<p>Number of opinion leaders trained</p> <p>Numbers of opinion leaders who conducted 14 risk reduction conversations</p>	<p>Opinion leaders</p>	<p>Opinion Leader Conversation Tracking Form</p> <p>Opinion Leader Conversation Tracking Summary</p>	
Analysis Plan	Responsible Team/Staff	Timeframe	Reporting Plan	EXAMPLE
<p>Review the tracking forms to determine the number of opinion leaders who conducted 14 risk reduction conversations</p> <p>Divide that number by the total number of trained opinion leaders</p>	<p>Facilitators</p>	<p>Ongoing collection and review</p> <p>Summary analysis at end of year</p>	<p>Updates at staff meetings</p> <p>Final project report</p>	

THE HOPE AIDS PROJECT STORY

The Hope AIDS Project is an AIDS Service Organization that has been providing HIV and sexually transmitted disease (STD) testing and treatment services to Black communities in Fairhope, Alabama and surrounding areas since 2000. The agency's office is in the heart of the Black community and is known as "the clinic."

People know you can get an HIV test, STD exam, see an "AIDS" doctor, and get "meds" at the clinic. Most clients of the Hope AIDS Project are poor, with little or no access to health care. A large number of clients are HIV-positive Black gay men who have a history of STDs. The Hope AIDS Project Executive Director, Wayne Simmons, wants to do something to prevent new cases of HIV among the Black gay men in the community. Alabama's State Health Department had a new round of funding for Black men who have sex with men. The funding says that agencies must provide a DEBI. The Hope AIDS Project feels they are in the right place at the right time and apply for the funding. They get the funding for a three-year period and are very excited! The agency's staff does not know a lot about behavior change interventions, so they think this will be a learning process. Wayne Simmons forms a committee to help the agency select and adapt a DEBI. He thinks this process will be a challenge and wants all the help he can get. On the committee are two high-level clinic administrators, two medical staff, and a client advocate.

Hope AIDS Project Collects Information To Select a DEBI (Selection Stage Step 1)

The Hope AIDS Project's first order of business is to learn more about the HIV transmission behaviors of Black gay men in Fairhope. The agency has a contact with Auburn University, who refers them to Dr. Sharron Hawkins in the School of Nursing. This turns out to be a great contact because Dr. Hawkins has a lot of experience working with HIV prevention programs for Black communities in the South. She knows the Hope AIDS Project needs to learn more about the knowledge, attitudes, beliefs and behaviors of the Black gay men they serve. Learning this will help them figure out how these men are putting themselves at

risk for HIV. Dr. Hawkins explains to the committee that a knowledge, attitude, beliefs, and behavior survey is the best way to collect this information. She helps the committee develop the survey. The survey asks about knowledge, attitudes, and beliefs about HIV, STDs, condom use and negotiation, intentions, and partner communication. It also asks the men to rate how secure they are with talking about safer-sex with their partners, and how worried they are about getting HIV or an STD. The survey asks the men if there are any places in the community where they can be themselves without fear of discrimination or judgment. It also asks the men about the attitudes of their friends and other men in the community.

The Hope AIDS Project has done community assessments in the past, so its staff and volunteers know how to do surveys. But, Dr. Hawkins still does an in-service training to make sure all staff and volunteers understand the survey and its purpose. She also teaches them how to help community members with reading problems complete the survey. To get more in-depth information, Dr. Hawkins suggests they also do interviews with key informants. She helps the Hope AIDS Project put together the interview questions. The questions ask about unprotected anal intercourse, attitudes about condom use, what it is like to tell someone you are gay, how people respond when you tell them you are gay, and substance use. The Hope AIDS Project staff then did the surveys and interviews. We tell you what they found out later in this Chapter.

The Committee next sets out to learn more about DEBIs. They go to www.effectiveinterventions.org to do research. They download all the interventions designed for and/or tested with men who have sex with men. The Committee also gathers information on how “ready” gay Black men in Fairhope are to take part in an HIV behavior change intervention. They want to know if the men have any interest in getting HIV information. They also want to know if the men are willing to come to an intervention. And, they know they need to find out about the things that might stop the men from taking part in an intervention. Drawing on their good standing in the community and the relationships the staff has

with key leaders, the Hope AIDS Project holds a meeting with community leaders. At the meeting, they explain the project and why they need feedback from Black gay men. The Hope AIDS Project gets buy-in from the leaders right away, who said they would help find men to come to focus groups and interviews.

The Hope AIDS Project holds two focus groups – one for Black gay men aged 18 to 30 and one for Black gay men aged 31 to 50. One of the agency’s volunteers knows of a church network of Black gay men and some of its members agree to come to the focus groups. Dr. Hawkins and the client advocate work on questions to ask during the groups. The questions range from what type of HIV-prevention activities would the men like to the locations they would be able to get to and feel at ease in. The focus groups last about an hour and are done over a three-week time frame. The Hope AIDS Project staff and volunteers also do in-depth interviews with key informants. The interviews are held all over the city at times good for those being interviewed. Each interview is no more than one hour long.

As they were collecting information, the Hope AIDS Project thought it would also be helpful to find out the best ways to recruit men for an intervention. The committee asked staff and volunteers where the most popular “spots” or “hangouts” were for Black gay men. The agency then sent staff to observe these locations. Observers drew maps of each of the spots and nearby neighborhoods. They also wrote on the maps the best times to access and observe Black gay men. After weeks of observations and talking with men at the spots, the staff figured out the best times and places to recruit men. They even found some new volunteers!

Lastly, the Hope AIDS Project looks at its “readiness” to provide interventions. They dust off their agency’s capacity assessment done one year ago so they can update the information. You can find more information and resources on agency capacity assessments in the Guide’s appendices. We tell you about what the Hope AIDS Project learns from their information collection process later in this Chapter.

Hope AIDS Project Looks at the Information it Collected and Selects a DEBI to Adapt (Selection Stage Step 2)

The Hope AIDS Project gathered information on HIV behavioral risk in their population of Black gay men. At the same time, they collected information on population “readiness.” Staff and volunteers went to the places Fairhope Black gay men hang out to recruit participants for its survey, focus groups, and in-depth interviews. They also visited bars, choir rehearsals, book clubs, and other events to find men to fill out surveys. It took them about four weeks to collect all of the information. The Hope AIDS Project staff worked with some of Dr. Hawkins’ students to design a database for the survey and interview information. Dr. Hawkins then helped the agency to sort through the information and figure out any trends in behaviors among the men. The Hope AIDS Project learns a lot about Black gay men in Fairhope from the survey. They find:

- *Black gay men in Fairhope are at risk for HIV infection because they are having unprotected anal intercourse:*
 - *79 percent reported they had unprotected anal intercourse (receptive) in the last 3 to 6 months*
 - *72 percent reported they had unprotected anal intercourse (insertive) in the last 3 to 6 months*
 - *5 percent reported using drugs like methamphetamines and ecstasy before having unprotected anal intercourse in the last 3 to 6 months*
 - *50 percent reported using alcohol before having unprotected anal intercourse*

- *Black gay men in Fairhope have many reasons for having unprotected anal intercourse:*
 - *HIV is not a problem in my community*
 - *I do not have sex with “those kind of dudes”*
 - *I do not think I can get “it” if I am the Top*
 - *I do not think I can talk about condoms with my partners*
 - *I do not think I am at risk for HIV because I am not a White gay man*

- *I do not know how to negotiate condom use with my partners*
- *I trust my sexual partners are “clean” because I do not see them at “the clinic”*
- *My friends and I do not use condoms
I only have sex when I am drunk and/or high*
- *Condoms are for gay men and I am not gay, so I do not need to use condoms*
- *My family does not accept me being gay*
- *My pastor/priest does not approve of being gay and says I am going to hell*
- *Unprotected sex “feels good and is sexy”*

From the focus groups and in-depth interviews the Hope AIDS Project learns:

- *The men did not want to participate in activities held at the Hope AIDS Project because it was known as the “the clinic”*
- *The men prefer to participate in activities that happen online or on the weekend*
- *The men want to participate in activities where they can interact with men “who get down” or are “in the life”*

After learning about their population, the Hope AIDS Project begins to look at the DEBIs. They go to www.effectiveinterventions.org to review and download all the interventions designed for and/or tested with men who have sex with men. They review: d-up!, Mpowerment, Popular Opinion Leader, RESPECT, Many Men, Many Voices, Healthy Relationships, VOICES/VOCES, and Community PROMISE. On the website they find and review “Starter Kits” for the interventions that contain:

- *Intervention fact sheets, including core elements*
- *Implementation summary sheets*
- *Sample budgets/cost worksheets*
- *Behavior change logic models*
- *Procedural guidance*
- *Agency readiness self-assessments*

The last thing the Hope AIDS Project collected information on was their “readiness.” They did informal, brief interviews with staff and looked at their current resources. They also filled out the readiness assessments for the DEBIs they were looking at on the www.effectiveinterventions.org web site. The Hope AIDS Project finds they have:

- A strong and positive history of working with Black gay men*
- Limited experience doing HIV prevention activities*
- Strong community partnerships with many agencies and groups*
- Staff with knowledge and skills*
- Basic office and computer equipment*
- Space to conduct meetings (two conference rooms)*

The Hope AIDS Project is now ready to begin selecting an intervention. The agency reviews the information it collected in Selection Stage Step 1, as described above, and selects an intervention. As they make their choices, they keep in mind their population’s “readiness” and their agency’s “readiness.”

In Step 1, the Hope AIDS Project chose eight DEBIs to think about adapting. They are: d-up!, Mpowerment, Popular Opinion Leader, RESPECT, Many Men, Many Voices, Healthy Relationships, VOICES/VOCES, and Community PROMISE. They downloaded materials for each of these DEBIs from the www.effectiveinterventions.org web site. The Hope AIDS Project Committee now reviews these materials to see which interventions best address, or “match,” the HIV behavioral risk in its population of Black gay men. They also use the results of the survey, in-depth interviews, focus groups, and observations to guide their decision-making.

The Hope AIDS Project next looks at the “pros and cons” for each DEBI. They use the Organize and Match Information tool that follows to write down how well each intervention “fits” into the services their agency offers. They also note how well each intervention “matches” the HIV behavioral risk of their population. The Hope AIDS Project uses an Organize and Match Information Tool to examine their options (see next page).

The Hope AIDS Project's Organize and Match Information Tool					
	Population	HIV Transmission Behavior	Behavioral Determinants of HIV Transmission Behavior	Population "Readiness"	Agency "Readiness"
Information Collected	Black gay men with a history of STDs	Unprotected anal sex	Low self-efficacy for condom use; low-self-efficacy for condom negotiation; low perception of risk; poor communication skills; lack of knowledge about how HIV/STDs interact; low or no social support; rejection from family, friends, and religious community	Will take part in activities that happen online or on the weekend; will not come to the agency because it is known as "the clinic;" will take part in activities where they can interact with men who "get down" or "are in the life."	Experience working with the Black community and with Black gay men; limited experience implementing HIV behavior change interventions; strong community partnerships; has space to conduct meetings and provide interventions; has office and computer equipment.
Interventions That Address These Things	d-up! Mpowerment, Popular Opinion Leader RESPECT Many Men, Many Voices Healthy Relationships VOICES/VOCES Community PROMISE	d-up! Many Men, Many Voices Healthy Relationships VOICES/VOCES	d-up! Many Men, Many Voices Healthy Relationships VOICES/VOCES	d-up! Many Men, Many Voices Healthy Relationships VOICES/VOCES	d-up! (not sure if we have the resources or capacity) Many Men, Many Voices Healthy Relationships VOICES/VOCES
Rationale for Interventions Listed	All interventions were designed for and/or tested with men who have sex with men.	We learned our population's HIV transmission behavior is unprotected anal intercourse. These interventions all address this HIV transmission behavior in some way. Some of them also cover the relationship between HIV and STDs, which is important for our population. This is why this list is shorter.	We list only the interventions that best address our population's most common reasons for engaging in risk behavior. This is why this list is shorter.	These interventions match our population's readiness. The interventions listed look like they have activities we can modify to meet our population's needs.	These interventions seem to best match our agency's capacity. We have experience working with the Black community and with Black gay men. We also have experience with STDs. The one that would be a "stretch" for us is <i>d-up!</i> This is a community level intervention. We do not have a lot of experience with this type of intervention.

The Hope AIDS Project's Organize and Match Information Tool allows them to have everything in one place when they sit down to decide which intervention to select. In the tool, the Hope AIDS Project summarizes the information they collected on their population of Black gay men in the top row of the table. This includes their population's HIV transmission behavior, behavioral determinants, and "readiness." The Hope AIDS Project also notes its agency's "readiness" in the top row. In the second row, the agency then lists interventions they identified that address each of these areas. They do not limit the interventions they list, so they will have a good number of options to look at. In the third row, the Hope AIDS Project states its reasons for matching the interventions with the areas in the top row of the table.

The Hope AIDS Project is now ready to narrow its intervention choices. In the Organize and Match Information Tool, they look across the "Interventions That Address These Things" row to see which interventions appear in all or most of the columns. They see that the eight DEBIs they chose do not address all of its population's behavioral determinants in the same way. They also see their population has different levels of "readiness" for each of the DEBIs. And, they know their agency is not "ready" to do all of the DEBIs, based on staff skill level and experience. Based on this assessment, the Hope AIDS Project narrows their choices to four interventions – d-up!, Many Men, Many Voices, Healthy Relationships and Voices/ VOCES. These DEBIs make the agency's "short" list because:

- They match their population*
- They address the HIV-transmission behavior of Black gay men in Fairhope*
- They address some of the behavioral determinants of their population's HIV transmission behavior*
- They have or can easily get the resources or build the capacity needed to conduct the intervention*
- Their population is "ready" to take part in these interventions*

The agency now has a much smaller list of interventions to choose from.

The Hope AIDS Project next uses another tool – the Assessing Interventions Tool, to look more closely at the four DEBIs on its short list. We share the Assessing Interventions Tool they complete for the Many Men, Many Voices DEBI.

The Hope AIDS Project's Assessing Interventions Tool for *Many Men, Many Voices*

Intervention Name and Brief Description: *Many Men, Many Voices* is an intervention to prevent HIV and STDs among Black men who have sex with men. It addresses factors that influence behaviors of Black men who have sex with men including cultural, social and religious norms; interactions between HIV and STDs; sexual relationship dynamics; and social influences that racism and homophobia have on HIV risk behavior. This individual level intervention is delivered to small groups of men who have sex with men.

	Original Intervention	Your Population	Match or Adapt
Population	Gay men of color; men who have sex with men, bisexual men (including men who do not self identify as gay)	Black gay men who have sex with men with a history of STDs	Was the intervention designed for your population? Yes No Describe what changes you may need to make so that it is a better fit.
HIV Transmission Behavior	Unprotected sex, specifically unprotected anal intercourse	Unprotected anal intercourse	Was the intervention designed to change the HIV risk behavior in your population? Yes No Describe what changes you may need to make so that it is a better fit.
Behavioral Determinants	Intentions and skills to use condoms; interactions between HIV and other STDs; sexual relationship dynamics; attitudes and coping with cultural, social and religious norms; and the social influences that racism and homophobia have on HIV risk behaviors	Low self-efficacy for condom use and condom negotiation; low or no social support; rejection from family, friends and religious community	Was the intervention designed to change the behavioral determinants of HIV transmission behavior in your population? Yes No Describe what changes you may need to make so that it is a better fit.
Population Readiness		Will participate in activities that happen online or on the weekend; will not come to the agency because it is known as "the clinic;" will take part in activities where they can interact with men who "get down" or "are in the life"	Was the intervention designed for and tested with your population? Yes No Describe what changes you may need to make so that it is a better fit. We will need to adapt activities to have the sessions take place at a site to be determined during a weekend retreat, and not at the agency's clinic during the week.
Agency Readiness and Resource Requirements	Knowledge of and skills related to the intervention: group facilitation; STDs; 2 facilitators, one of whom is a Black gay man; space to run group sessions; community partners like the population at risk/in need of intervention services; agency administrator to supervise facilitators; TV/ VCR; outreach materials	Experience working with the Black community and with Black gay men; limited experience implementing HIV behavior change interventions; strong community partnerships; has space to conduct meetings and provide interventions; has office and computer equipment	Do you have the time, resources, staff and funds? Yes No Describe what you need to implement the intervention. We have the time and skills, but some of our staff will need training on group facilitation. We will also need to find space for holding a weekend retreat.

After looking at the four DEBIs, the Hope AIDS Project decides:

- *Not to select d-up! because it is a community-level intervention and their staff does not have the capacity to do a community-level intervention.*
- *Not to select VOICES/VOCES because it does not affect some of the determinants of the HIV transmission behavior of their population. For example, VOICES/VOCES does not address the lack of social support due to negative messages about gay behavior and rejection from friends, family, churches, and communities.*
- *Not to select Healthy Relationships because it is for HIV-positive people and the Hope AIDS Project decided to work with HIV-negative men.*

The Hope AIDS Project selects the Many Men, Many Voices DEBI because:

- *It addresses the HIV-transmission behavior in their population.*
- *It addresses many of the behavioral determinants in their population.*
- *Its activities can be offered in different formats. For example, weekend retreats or twice-a-week sessions.*
- *They have the capacity or can build easily the capacity to provide the intervention.*

Hope AIDS Project Adapts their Intervention Activities (Adaptation Stage Step 1)

The Hope AIDS Project has decided to select and adapt the Many Men, Many Voices DEBI. They hire a Program Director to guide their adaptation process. After looking at the information they gathered in Stage 1 of the Adaptation Process, they define their intervention population as Black gay men:

- *Between the ages of 31 and 45*
- *Whose HIV transmission behavior is unprotected anal sex*

- *Who are HIV-negative and have a history of STDs*
- *Who have low self-efficacy for condom use and condom negotiation*
- *Who have little or no social support*
- *Who feel rejected by family, friends, and the religious community*

The Hope AIDS Project is now ready to find activities to adapt in the Many Men, Many Voices intervention. The Program Director and the Committee review the information they found on www.effectiveinterventions.org for the intervention. They want to know what it requires in terms of staff, training, materials, computers and other things. They look at the Starter Kit and learn the intervention has seven sessions with different kinds of activities.

To understand the activities in each of the seven sessions, the Program Director breaks down the “Who,” “What,” “When,” “Where,” “How,” and “Why” of each activity. To help with this process, he looks at the Facilitator’s Guide and the behavior change logic model. The Facilitator’s Guide tells him how each activity is done and what behavioral determinants are addressed. The logic model shows him how the behavioral determinants and the activities work together to produce the intervention outcomes. The logic model also helps him understand how the intervention changes the HIV transmission behavior of Black gay men.

Next, the Hope AIDS Project reviews the determinants that drive the HIV transmission behavior of their population. They know their population is having unprotected anal intercourse because of:

- *Not knowing about how HIV and STDs interact*
- *Thinking they are not at risk or low risk for HIV and STDs*
- *Poor communication skills*
- *Not being able to negotiate condom use*
- *Lack of self-efficacy to use condoms*
- *Lack of social support for condom use*

- *Not feeling good about same-sex/gay behaviors*
- *Lack of family support for same-sex behaviors*
- *Lack of support and judgment from pastors/priests/religious leaders*
- *Feeling that having sex without using a condom is hot*

The Hope AIDS Project knows they need to make some changes to Many Men, Many Voices, even though the intervention does address many of the determinants of its population's behaviors. The agency wants to help the men deal with the negative messages coming from local church leaders. They know these messages and lack of support from church leaders lead the men to have poor self-images. This can cause them to have unprotected anal intercourse. The Hope AIDS Project thinks if they address the negative messages coming from church leaders, they can change the self-image of the men. They choose to adapt Exercise 7.3: How Can I Build On This Experience to address this issue. This activity focuses on a person's well-being and emotional growth, which could help build their population's self-image. They also think this will be a good way for the men to talk about what they experience when they hear negative messages from church leaders.

The Hope AIDS Project also knows their population does not have a lot of free time during the week. They want to do activities online or on the weekend. They start to think about how to do Many Men, Many Voices in a different format. They talk about doing a weekend retreat or giving the men an incentive to come to the seven weekly sessions. The Hope AIDS Project thinks it will work better to change the weekly sessions to a weekend retreat. They also think a retreat will create a "safe space" so the men will be more at ease taking about their HIV transmission behavior and other issues. The agency uses the Decision Tool for Adapting Interventions to record, describe and explain the changes they make to two activities of the Many Men, Many Voices intervention.

The Hope AIDS Project's Decision Tool for Adapting interventions: <i>Many Men, Many Voices</i>					
Activity	"What"	"Who," "When," "Where," "How"	"Why" (Intent)	How the Activity Will Be Adapted	Justification for Adaptation
Exercise 7.3 – How Can I Build On This Experience. The purpose of the exercise is for men to discuss their growth (emotional and personal) during <i>Many Men, Many Voices</i> .	Men's personal growth, self-development, and emotional development as a result of taking part in <i>Many Men, Many Voices</i> .	Men talk about their personal growth, self-development, and emotional development. The men are introduced to a Mental Health professional who tells them about his services.	The exercise increases men's awareness of how much they have grown and developed as a result of <i>Many Men, Many Voices</i> . Also, the exercise makes it okay to talk to a Mental Health professional and continue to grow and develop after the intervention is over.	Instead of a Mental Health professional talking to the men, a pastor from a local church (who is openly gay and whose church supports the Black gay community) will talk about the importance of spirituality and faith for self-development. He will also talk about the counseling services and other mental health services offered by his church.	When we looked at the information we collected, we learned our population felt rejected from church leaders because they are gay and/or bisexual. This rejection results in a poor self-image and leads to risky behaviors such as unprotected anal intercourse. We want to teach the men that there are churches that support them. This should help the men find churches that meet their spiritual needs.
Deliver <i>Many Men, Many Voices</i> over 7 weeks (one session per week).	Men meet once a week to talk, practice skills, get feedback on skills practice, and do role-plays.	Two staff persons that the population can relate to give 7 weekly sessions to HIV-negative Black gay and/or bisexual men.	Meeting in session with other HIV-negative Black gay and/or bisexual men increases the men's STD/HIV knowledge, perception of HIV/STD risk, skills and self-efficacy for condom use, negotiation skills, and ability to communicate with partners.	<i>Many Men, Many Voices</i> will be done as a weekend retreat format. Session 1 will be done Friday night, Sessions 2 and 3 will be done Saturday, Sessions 4, 5, and 6 will be done Sunday. Session 7 will happen 2 weeks later as a follow-up. Men will meet at a local gay church to talk about how the intervention changed their lives.	We know our men like weekend activities better than coming to 7 weekly sessions. Having a weekend retreat will also reduce drop out rates of the men.

As you can see in the Hope AIDS Project's Decision Tool for Adapting Interventions for Many Men, Many Voices, they make two changes to the intervention. They change an exercise from Session 7.3 to address the lack of social support for gay Black men that was coming from church leaders. They also switch the Mental Health professional the exercise calls for to a gay pastor of a gay church. They want to see if this change will better address the lack of support the men feel and give them positive messages about being Black and gay. The Hope AIDS Project hopes a gay pastor will uplift the men and help them to have a better self-image. They also hope this change will affect the men's HIV transmission behavior. The negative messages from church leaders are one of the determinants of the men's HIV transmission behavior. The agency also wants to know if the men like and feel at ease

hearing from a gay pastor. The second thing the Hope AIDS Project changes is the seven session weekly format to a weekend retreat, so more men can complete the intervention. They want to test if the men like the weekend retreat format. They also want to find out if the men think other gay Black men from the community would be willing to come to a weekend retreat. In the tool, you can also see the Hope AIDS Project makes sure to describe clearly how they will adapt each activity. They also give a reason for why they change each activity. This information will help them when they test their changes to see if they work. This tool also helps them explain to funders why and how they made changes to the intervention.

Hope AIDS Project Finds Out if its Adaptations Will Work (Adaptation Stage Step 2)

The Hope AIDS Project Program Director is now ready to develop a plan to test their two adaptations to the Many Men, Many Voices intervention. This type of test is called a “pilot test.” They decide to test the entire intervention because they changed the seven-session format to a weekend retreat. They need to make sure the weekend retreat format works for both the men and their staff. The Hope AIDS Project’s pilot test plan includes information on the type of information to collect, who will collect the information, ways to collect the information, and who will analyze the results. The plan also outlines the logistics, including participant recruitment, venue selection, and transportation. The Program Director hires two Black gay male staff persons to conduct the pilot test. These staff persons go to a Many Men, Many Voices training where they learn how to do the intervention. When they return to their agency, the staff persons practice the sessions and get ready for the retreat.

After the weekend retreat, the Hope AIDS Project holds a focus group to get the men’s reactions to the intervention as a whole and to the two adaptations they made. Dr. Hawkins helps them develop the focus group questions. The questions ask how the men like the retreat, the pastor’s talk, and meeting at the local church. After the men finish the retreat, they also fill out a Many Men, Many Voices survey. This survey asks how well the intervention addresses the lack of social support and negative messages from church leaders. During the retreat, the Program Director watches and takes notes on each of the sessions. One thing he is looking for is whether or not the activities in each of the sessions are being done the correct way.

After the pilot test, the Hope AIDS Project looks at their results and learns the changes they made to Many Men, Many Voices are working well. Nine men came to the retreat and all gave very positive feedback on the changes. The men really liked the retreat format. And, they liked visiting the church for one of the sessions. The men also said they would have liked more time to talk more about spirituality and sexuality. Survey results show that the changes did address the men's lack of support. The men were happy to learn there was a church that supported them in their community. They said they planned to visit this church in the future. They also said they planned to use condoms more often. During the retreat, the Program Director saw the need for improving how the intervention was done. He held a meeting with the retreat staff to talk about the intervention and ways to improve how the activities were being done.

Hope AIDS Project Puts their Intervention to the Test (Adaptation Stage Step 3)

The Hope AIDS Project is now ready to offer Many Men, Many Voices to its population! Even though the agency pilot tested and revised its adapted activities and materials, they are still not sure their intervention will “work.” They will only know this once they begin providing their adapted version of Many Men, Many Voices on a routine basis. As they offer the intervention, they will need to monitor and evaluate it to make sure they are getting the results they need. They also want to make sure the intervention is still meeting the needs and is liked by their population.

The Hope AIDS Project uses the Implementation Plan for Many Men, Many Voices it got on the www.effectiveinterventions.org web site. They make some changes to the plan, including doing two weekend retreats and changing some of the role-plays. They also change the plan to show they will do the seven-session, weekly format one time. They do this to reach men who cannot come to the weekend retreats. The Hope AIDS Project Program Director decides to meet with the staff after each weekend retreat. He will also meet with the staff after each session when the intervention is done during the week. During each meeting, changes and tweaks are made to the intervention, based on feedback from the men. The Hope AIDS Project makes changes to the role-plays and writes down their reasons for making the changes. They record everything

so their agency and funders will know what changes were made, why they were made, and the results of the changes.

To evaluate the intervention, the Hope AIDS Project gives a knowledge, attitudes, beliefs, and behaviors survey to the men before and after the weekend retreat and the series of weekly sessions. They do this to see if the men's self-efficacy increased with talking to their partners about using condoms. Over time, the survey results show no increase in self-efficacy among the men. The Hope AIDS Project knows something is wrong. Maybe the staff did not do the role-plays in the correct way? The agency's Program Director watched the role-plays when they were being done. He saw the men liked the role-plays very much. But, he also saw the staff did not set up and explain the role-plays very well, which confused the men. When talking with the staff, he learns they are confused about how to do the role-plays. The staff also say it would have been helpful to practice doing the role-plays with each other before doing the intervention. The Hope AIDS Project Director has the staff develop better guides for how to do the role-plays. He also has the staff practice the role-plays before they deliver the intervention. By gathering information about how the staff conducts the role-plays, the Hope AIDS Project was able to improve the way in which they are delivered. This will help increase the agency's chances of achieving the desired intervention outcomes.

The Hope AIDS Project also finds with its implementation of the weekly sessions that many of the men have a hard time coming to all of the sessions. The men tell them they like the weekend retreat the best. Most of the men who come to the retreats stay for the whole weekend and do not drop out. Over time, the Hope AIDS Project staff also say it gets easier for them to do the retreats. As a result of this feedback, the agency decides to offer only weekend retreats.

After a year of implementing Many Men, Many Voices, the Hope AIDS Project does another survey with their intervention population. The Black gay men show a decrease in unprotected anal intercourse, an increase in condom use and negotiation, and have better self-images. After all their hard work in adapting and implementing the intervention, the Hope AIDS Project is pleased to see it is making a positive impact in the community!

THE BORDER HEALTH SERVICES STORY

Border Health Services is a small community health organization in the border town of McAllen, Texas. The agency serves mostly migrant Latinos who work in agriculture. They provide basic health care services at their five partner clinics. They also have an HIV program that offers prevention and treatment services. Their prevention activities include education and outreach, and HIV counseling and testing. They have a brief HIV 101 session that is given to clients while they wait to get services at the clinics. Border Health Services has three full time staff members: a program manager; an HIV educator who provides HIV counseling and testing; and an administrative assistant.

Over the past few years, there has been an increase in the number of HIV and STD cases in young Latino (18 to 24 year olds) men who have sex with men. Border Health Services thinks there are two behaviors that are driving this increase in HIV and STD rates. One is that these men are having unprotected anal intercourse. The second is that these men do not get tested for HIV or seek medical services. They only go to the clinic when their symptoms prevent them from working. The agency has tried to conduct outreach and mobile HIV testing, but knows these men will not come to their clinic because they fear they will be seen as having “SIDA” (AIDS). Border Health Services really wants to help these men but does not have the money to work with them. They turn to a local university for help. Border Health Services and the university learn about, apply for and get State health department funding to conduct an intervention with Latino men who have sex with men over a three-year period. The funding calls for them to provide a DEBI.

Border Health Services Collects Information To Select a DEBI (Selection Stage Step 1)

The Border Health Services staff has some knowledge about their population’s HIV transmission behavior. But, they decide to learn more about why younger Latino men who have sex with men are not using condoms and not getting tested for HIV. They review research articles on Latino men who have sex with men to learn about the reasons why men do not use condoms during anal intercourse. Border Health Services also reviews findings from a knowledge, attitudes, beliefs, and behaviors survey the local university conducted with about 60 young Latino men who have sex with men. To add to the survey information, Border Health Services interviews about 10 to 15 young

men who have sex with men. They want to find out why the young men think their peers are having unprotected anal intercourse. They also want to learn more about where these young men hang out and what types of interventions they would like.

Border Health Services learns the following about the young Latino men who have sex with men in the community:

- *Men are having unprotected anal intercourse with other men. The survey found only 25 percent of the men reported condom use the last time they had anal sex. This number was lower when they were the receptive (bottom) partner. Reasons they gave for not using a condom included:
 - *Condoms don't feel good*
 - *They did not have a condom*
 - *Using a condom meant you had a disease*
 - *"Real men" don't worry about disease or use a condom**
- *Most men have to hide the fact they are gay because the community does not approve of men having sex with men. Some men are known to be gay, and are more "out" than others. But, they would still never show affection with another man in public.*
- *Because many of the men live with their extended families, they have to be secret about where, with whom and when they have sex. There are some "hook up" spots that are out of the way. The men know they can go there to have sex with other men and not get found out. They often do not have access to condoms in these places, though, unless they have one with them.*
- *There is one bar, El Matador, which is 10 miles out of town and is "gay friendly." Many of these men hang out there at night. There are also some parks where they meet to hang out and drink.*
- *They do not know a lot about HIV and STDs. Many believe myths about how HIV is transmitted, such as you can get it from a mosquito, you can't get infected if you are the insertive partner, and you can't get infected if you don't come inside your partner.*

- *Some have poor self-image and low self-esteem because having sex with a man is not accepted in their culture. It conflicts with traditional family and religious values. This could be a cause of depression and hopelessness seen in some of the men.*
- *“Machismo” beliefs drive their sex behavior and create conflicts with how the men see themselves. Men feel they have to have lots of sex and get drunk often, to prove their manhood. They also feel shame and guilt for being gay. This leads to depression, feeling alone, and low self esteem. The men do not feel they are valued and do not value themselves. This makes them reckless with their behaviors. They say, “I don’t care what happens to me.”*
- *The men only get tested for HIV or STDs if they are sick and have to go to the clinic. They do not see the point of knowing if they have HIV or an STD because they believe there is nothing they can do about it. Machismo also plays a role in this behavior. Men see using a condom or going to the clinic when they are not sick as being “weak.”*

Border Health Services next sets out to collect HIV behavior change interventions that may address their population’s HIV behavioral risk. They do a brief review of the DEBIs to see if any of them target Latino men who have sex with men. They do not find any DEBIs that are designed specifically for Latino men who have sex with men. But, they do find some DEBIs they think they can adapt for their population. The agency chooses four DEBIs – VOICES/VOCES, Mpowerment, Community PROMISE, and Popular Opinion Leader to learn more about. They also talk to other HIV prevention agencies in their area to see if they can suggest any evidence-based interventions. The agencies are not able to do so, because they never have done evidence-based interventions or DEBIs. Border Health Services goes to www.effectiveinterventions.org and downloads information on the four DEBIs.

Border Health Services also wants to learn about its population’s “readiness” to take part in interventions. They look at the information collected during the interviews with young Latino men who have sex with men and learn that:

- *There are about 100 to 150 young men who have sex with men in the community. Most hang out at El Matador. Men who have sex with men from other nearby, smaller towns also meet at El Matador.*
- *Most of the men do not have transportation. They have to use buses, get rides from friends, or hitchhike.*
- *While most of the men are seasonal farm workers, the population is somewhat stable; only 20 percent of men travel for other jobs.*
- *Because their work schedules vary, it is hard for the men to attend an intervention with many sessions.*
- *Their primary language is Spanish; only about 10 percent of the men know some English.*
- *Some of the men do not trust health care providers. The providers they trust the least are white males.*
- *Most of the men have low levels of education and cannot read in Spanish or in English.*
- *Many of the men will not go to a program or building that offers HIV/AIDS services for fear of being seen as infected and/or gay.*

Last but not least, Border Health Services looks at its “readiness” to provide interventions. They hold a meeting with their university partner to look at strengths and resources. They note that:

- *All staff persons speak both Spanish and English and are Latino.*
- *They have funding to support hiring one or two new staff persons.*
- *They have support from the university to help with adaptation; they can also translate materials into Spanish.*
- *Their Program Manager has a Masters in Public Health with a focus on Health Education, and has strong knowledge of behavior change interventions.*
- *Their Health Educator has a lot of knowledge about HIV and STDs, but low knowledge of behavior change interventions. She also has strong contacts with young Latino men who have sex with men in the community.*

Border Health Services Looks at the Information it Collected and Selects a DEBI to Adapt (Selection Stage Step 2)

Border Health Services pulls together all the information they collected about their population, interventions, and agency. They meet with their university partner to discuss which interventions best address their population's HIV behavioral risk. Their main goal is to get more men to wear condoms during anal sex. They know they need to address the behavioral determinants of their population's HIV transmission behavior. These include attitudes and beliefs about condom use, such as using a condom means you have HIV and you do not need to use a condom if you are "on top." They also know they need to give their population basic information about how you can get HIV. Border Health Services wants the DEBI they choose to counter some of the negative beliefs the men have about themselves. They also want a DEBI that will let them reach men where they hang out, since most of the men will not go to an HIV program. Outreach will have to be done in a way that does not attract attention (no outreach vans, community health workers or nurses doing outreach). They are open to looking at English language interventions, since they are able to translate them into Spanish.

Border Health Services and the university look more closely at four of the DEBIs they found. They are very interested in VOICES/VOCES because it targets condom use and is in Spanish. They also review three community-level interventions – Mpowerment, Popular Opinion Leader, and Community PROMISE. They decide VOICES/VOCES will not work since it is done in a clinic setting. They also decide that Mpowerment will not work because it calls for men to create a community center for men who have sex with men. This was something the men were scared to do. With Community PROMISE, they decide they do not have the resources to develop the role model stories and do ongoing evaluation.

Border Health Services and the university select the Popular Opinion Leader DEBI to adapt. They choose Popular Opinion Leader because it will let Border Health Services reach the men where they already hang out. The intervention also does not make everyone attend formal sessions. It only trains existing opinion leaders in formal sessions to carry out risk reduction conversations with their friends in the community. Border Health Services thinks this approach will help them to reach men who are not open to talking about HIV and safer behaviors. The opinion leaders can work to establish a norm that promotes condom use. Opinion leaders can let men know that using condoms is a sign of strength, and not a sign that you have disease or are weak. The opinion leaders will also be able to address other “myths” men have about HIV and their self-image. Border Health Services thinks they can recruit enough men to serve as opinion leaders. And, they think one or two of the men can be taught to be opinion leader trainers. Lastly, Border Health Services likes that they can address almost any social norm with Popular Opinion Leader. If they can get the men to use condoms more, they can then focus on getting the men to seek out HIV and STD testing and treatment.

Border Health Services Adapts their Intervention Activities (Adaptation Stage Step 1)

After selecting their intervention, Border Health Services reviews the Popular Opinion Leader materials more closely and decides the activities they need to adapt. They use the Decision Tool for Adapting Interventions to list the activities, describe how they will adapt them, and give their reasons for making the adaptations.

The Popular Opinion Leader intervention changes behavior by addressing and promoting social norms. Border Health Services decides they will increase condom use by having opinion leaders promote the idea that using condoms is a good thing to do. Using condoms means you are healthy and want to stay healthy. This will help to change the current idea that using condoms means

you are sick. They also want to help men value themselves and stay healthy so they can support their families. Being sick and infected does not allow them to fulfill their roles as “providers” or as “men.” They will talk about machismo in a way that makes having safer sex mean you are manly and strong. Lastly, they want the opinion leaders to stress there is nothing wrong with being gay, their lives have value, and their families and friends care about them.

Opinion Leader Training (Changing the “Who” “What,” “When,” “Where,” and “How”)

Border Health Services knows they need to make changes to the Popular Opinion Leader’s opinion leader training. Since their population knows very little about HIV, they decide to add a session to provide information about how you can get and prevent HIV. They also add another session for opinion leaders to talk about their sexuality and the struggles they face being gay/bisexual Latinos. In this session, they will also talk about how machismo affects the attitudes, beliefs and behaviors of Latino gay men. They think this session is key because most of the opinion leaders, as well as the men they will be talking to, have to hide their “true” identity. And, they think this session will help the opinion leaders talk to men about the value of being gay and Latino. This should help build support among the men and allow them to talk about the things that can put them at risk for HIV.

In Popular Opinion Leader, the opinion leaders are taught about the theories and research behind the intervention. Border Health Services does not think this will work with their opinion leaders because they do not have much education. So, they decide to give a basic talk on the theory and research, using pictures to show how the process of diffusion (spreading messages and information) works. Popular Opinion Leader also teaches the opinion leaders how to carry out risk reduction conversations using demonstrations and role-play practice. Border Health Services decides to modify the way their opinion leaders will have their risk

reduction conversations. This is because Latino communication is not as direct as mainstream American culture. They show opinion leaders how to start and carry out conversations in a way that is closer to how Latinos talk to each other.

Border Health Services hires and trains two young gay Latinos who are highly respected in the community. These young men become trainers and provide support to the opinion leaders. Having these young men on board helps Border Health Services to gain buy-in from the community and the men they want to reach.

Border Health Services translates all training and other materials for the Popular Opinion Leader intervention into Spanish, because most of the men speak Spanish only. Also, since most of the men do not read, they plan to do all of the training verbally and with simple pictures and diagrams.

The opinion leader training has four weekly sessions. The research Border Health Services did found that it was hard for men to go to a lot of sessions due to changing work schedules. So, they decide to do the opinion leader training during a one-day “retreat.” They give rides to the retreat, which are held at a local community center. This location was picked to increase attendance because it was not an AIDS service organization or an agency that dealt with HIV prevention. Border Health Services knows the men will not come to these types of locations.

Border Health Services designs green-colored T-shirts, buttons, and bags that have the phrase “Se Un Hombre” (Be A Man) on them as incentives. The color is the same as the jerseys of a popular local soccer team. Border Health Services thinks the men will like these materials, but will not make them stand out as being with an HIV prevention program.

Border Health Services uses the Decision Tool for Adapting Interventions that follows to record their adaptations.

Border Health Service's Decision Tool for Adapting Interventions: <i>Popular Opinion Leader Adaptations</i>					
Activity	"What"	"Who," "When," "Where," "How"	"Why" (Intent)	How the Activity Will Be Adapted	Justification for Adaptation
Delivering opinion leader training in 4 weekly sessions	N/A	The opinion leader training is delivered in four, 2-hour sessions; one session per week	Having four sessions provides enough time to prepare opinion leaders; makes it easier for opinion leaders to attend since it is only a few hours a week; opinion leaders have time between sessions to practice what they learn. The 4 sessions with time in between them allows for effective skills building and learning.	The 4 sessions will be combined into a one-day retreat format.	Since the opinion leaders do not have a set work schedule, they may not attend all 4 sessions. By doing all the sessions in one day, they will get the whole opinion leader training. We will provide more time for the men to practice their risk reduction conversations and receive feedback to make up for not having time to practice between sessions.
Using logo materials	Items, such as hats, T-shirts, key rings, etc. that have images and/or phrases that are related to the intervention	Opinion leaders wear the logo materials when they are socializing with their friends	The logo materials help "brand" and promote intervention. They are designed to be eye-catching and spark interest and questions. They can help opinion leaders start risk reduction conversations. They can also be used as incentives and gifts for opinion leaders.	We will develop T-shirts, hats, and bags that have the "Se Un Hombre" on them. All materials will be the same color green as the local soccer team.	"Se Un Hombre" is used because it leads to a conversation where opinion leaders can give the message that being a man means staying healthy and being a provider. It also is used to reinforce that you can be gay and still "be a man." The color is popular among many local young Latinos.
Opinion leader training: presentation of <i>Popular Opinion Leader</i> theory and background	Overview of the diffusion of innovation theory and <i>Popular Opinion Leader</i> research	PowerPoint presentation and discussion given during Session 1	This activity helps increase opinion leader's knowledge about how the intervention works. It shows how key people can affect others. Men will be more likely to buy-in to <i>Popular Opinion Leader's</i> approach.	Posters showing pictures of how an idea spreads in a social network will be shown to the men. Our staff will also use an example of how a hit song becomes okay to play at clubs and parties (and is later replaced by another hit song).	Since many men have low levels of education and cannot read, it was felt that the discussion should be kept simple and rely more on images and pictures, as well as examples. We also felt it was not important to present all the research findings to gain buy-in. In fact, we felt that the men will be bored if information is too technical or too drawn out.

Border Health Services Finds Out if its Adaptations Will Work (Adaptation Stage Step 2)

Border Health Services does a practice run of their opinion leader training, which they give to their agency and university staff and some young gay Latinos. One thing they see right away is the training is too long to be done in one day. People in the pilot test feel most opinion leaders will not want to spend a whole day going to a training. Plus, there is a lot to cover, and people may not take in as much towards the end of a long day. So, Border Health Services changes the opinion leader training to a two-day retreat.

People in the pilot test also feel there needs to be more role-play scenarios to help the opinion leaders start risk reduction conversations. Most of the conversations are staged to take place at a bar or a party. Border Health Services creates other role-plays, so the opinion leaders can have conversations at work, at a soccer game, and at community events. Border Health Services also designs a role-play about talking about getting tested and treated for HIV and STDs. They do this because the people who went through the pilot test think it is important to help men get tested and treated.

Border Health Services Puts their Intervention to the Test (Adaptation Stage Step 3)

Border Health Services wants to find out if their intervention will give them their desired results. They develop an implementation plan with a timeline for opinion leader training and follow-up (booster) sessions. The plan outlines times for opinion leaders to get together and report on their progress and talk about problems. The plan also includes evaluation activities. They decide to collect information on three main areas: opinion leader training; opinion leader's experiences with carrying out risk reduction conversations; and changes in the intervention population's condom use.

Border Health Services staff speaks with the opinion leader trainers at the end of each training event, to see how the

sessions went. They learn the men like the training. And, the men really like the session where they talk about their sexuality and the struggles they face as gay Latinos. But, the session is too short to give all the men a chance to talk. Border Health Services decides to add more time to this session. They also add more time to the booster sessions to talk about these things.

During the booster sessions, the opinion leaders share they had some trouble having conversations at first, but got better with time and practice. They also share they do not know enough about STDs to answer basic questions. Most of the men they talked to wanted to know about STDs. So, Border Health Services decides to add a STD 101 talk to their booster session, as well as to the opinion leader training. They will also teach opinion leaders how to refer men to STD and HIV testing and treatment services.

After six months of doing the Popular Opinion Leader intervention, the university helps Border Health Services to do a knowledge, attitudes, beliefs and behavior survey with about 50 young, gay Latinos. The survey shows the men did raise their knowledge about HIV transmission and prevention. It also shows the men now feel they are at risk for HIV. The survey finds the men have a better self-image, and also have better attitudes toward using condoms. But, even with these changes, condom use is still low. Few of the men say they carry condoms with them or can get condoms. To improve access to condoms (and hopefully condom use), Border Health Services gives their opinion leaders condoms to hand out during their conversations. Border Health Services is also gets El Matador to keep a box filled with free condoms in its restrooms.

Border Health Services hopes that with these changes to the Popular Opinion Leader DEBI, they will be able to lower the rates of unprotected anal intercourse among young, migrant Latino men. If condom use among these men increases over time, they will try setting in place a new norm around getting tested and treated for HIV and STDs. The staff at Border Health Services feels good about their efforts! They think they are making a real difference in lives of young gay Latinos in the community.

Resources

- **CDC's Diffusion of Effective Behavioral Interventions (DEBI) Web Site** – Contains information on all available DEBIs, DEBI training, Capacity Building Assistance program, technical assistance programs, and other HIV prevention-related resources.
www.effectiveinterventions.org
- **CDC's Compendium of Evidence-Based HIV Prevention Interventions** – CDC's Division of HIV/AIDS Prevention has a Prevention Research Synthesis Team that has developed a compendium of over 60 evidence-based HIV behavior change interventions.
www.cdc.gov/hiv/topics/research/prs/index.htm
- **CDC's Replicating Effective Programs Project** – A web site that has information about evidence-based interventions. The site provides HIV prevention interventions that have been tested and proven to work, and have been packaged by the Project. This site also has resources related to training, technical assistance, and implementation of these packaged interventions.
www.cdc.gov/hiv/topics/prev_prog/rep/index.htm
- **National Network of STD/HIV Prevention Training Centers (NNPTC)** – Funded by CDC, this regional group of centers was created in partnership with health departments and universities to increase the knowledge and skills of health professionals in the areas of sexual and reproductive health. The NNPTC has 10 training centers that provide STD clinical training and behavioral intervention training. All training course offerings are listed on the web site, along with other training resources, web cast announcements, and a quarterly newsletter. For men who have sex with men, there is a Prevention and Management

of STDs in Men Who Have Sex With Men Toolkit for Clinicians available.

<http://depts.washington.edu.nnptc>

- **Institute for HIV Prevention Leadership** – Information on community assessment, planning and implementing interventions, and building evaluation capacity. Has web-based self-study modules and guides including a Planning and Implementing Interventions workbook and a guide on Community-based Assessment for HIV Prevention Workers. www.ihpl.org
- **U.S. Census Bureau** – National source for population-related information. www.census.gov
- **National Health Interview Survey (NHIS)** – Information on a broad range of health topics that can be used to track health status, health care access and progress toward achieving national healthcare objectives. www.cdc.gov/nchs/nhis.htm
- **CDC's Behavioral Risk Factor Surveillance System (BRFSS)** – The world's largest, ongoing telephone health survey system tracks health conditions and risk behavior in the U.S. Data are collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. If you are working with a younger population, you may find CDC's Youth Behavioral Risk Factor Surveillance System helpful, available through the Division of Adolescent and School Health. <http://cdc.gov/brfss>
www.cdc.gov/HealthyYouth/yrbs/index.htm

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Notes

Notes

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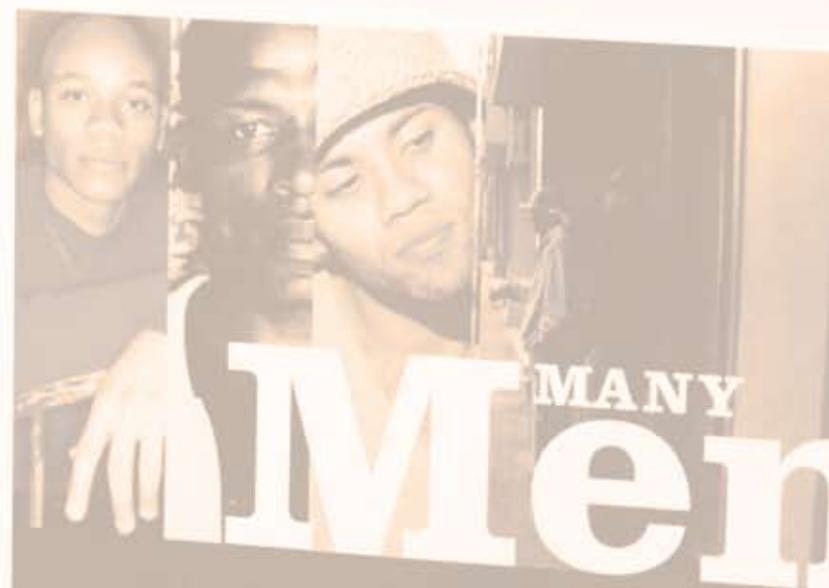
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