

Together Learning Choices

A small-group intervention
with young people living with HIV/AIDS

Starter Kit

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Starter Kit

The Starter Kit is a tool provided to agency administrators to assist them in learning more about an intervention and to determine if the intervention would be appropriate for their agency and the clients they serve.

TLC Intervention Package

1. Three-Part *TLC Implementation Manual*

- ***TLC Implementation Manual* Part 1, *Introduction and Overview***
 - A brief overview of the intervention, the science behind it, its core elements, and its key characteristics.
 - A discussion of capacity issues related to implementing agencies, including a stakeholder's checklist and a budget with cost sheet.
 - Guidelines on implementing the intervention.
 - Information on evaluating the intervention including an evaluation plan, process and outcome monitoring methods, and sample instruments.
 - Several appendices with helpful implementation materials and CDC guidelines.
- ***TLC Implementation Manual* Part 2, *Staying Healthy Module***
 - An overview of the *Staying Healthy* module and the science behind it.
 - Session guides and Facilitators' notes.
- ***TLC Implementation Manual* Part 3, *Acting Safe* Module**
 - An overview of the *Acting Safe* module and the science behind it.
 - Session guides and Facilitators' notes.

2. Implementation Materials

3. TLC Implementation Plan

4. TLC Marketing DVD



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Introduction to TLC

Introduction and Background

TLC: Together Learning Choices is an evidence-based HIV prevention and health promotion intervention with young people (ages 13 to 29) living with HIV. **TLC** is delivered in small, closed groups using cognitive-behavioral strategies to change behavior. It provides young people with the tools and skills necessary to live their best life and to be able to make healthy choices. The goal of the intervention is to help participants maintain health, reduce transmission of HIV and infectious diseases, and improve their quality of life. **TLC** is a product of extensive collaboration among researchers, youth living with HIV/AIDS from diverse backgrounds and perspectives, and staff from public and private agencies that serve young people living with HIV/AIDS.

Originally **TLC** consisted of the following three sequential modules and totaled 31 sessions.

- The *Staying Healthy* module encourages healthy living by focusing on health maintenance and forging effective partnerships with health care providers.
- The *Acting Safe* module is dedicated to primary and secondary HIV prevention by addressing sex- and substance use-related risk behaviors.
- The *Being Together* module emphasizes emotional well-being and improving quality of life.
- The **TLC** Intervention Package contains the *Staying Healthy* and *Acting Safe* modules. The *Being Together* module is not a part of the Intervention Package. The text box beginning on page 5 contains an explanation of why this change was made.

Research on the Intervention

TLC was evaluated with 310 HIV-positive youth ages 13 to 24 (27% African American; 37% Latino) who were assigned either to an intervention or a comparison condition. Of the youth in the intervention condition, 73% attended at least one session. The detailed results of the research study can be found in the published articles included in Appendix A.

Following the *Staying Healthy* module, the number of positive lifestyle changes increased 45% and use of positive coping styles increased 18% among females in the intervention compared to females in the comparison condition. Seeking and obtaining social support increased 11% among both genders in the intervention as compared to those in the comparison condition. All these changes were statistically significant.

Following the *Acting Safe* module, intervention participants reported 82% fewer unprotected sex acts, 45% fewer sex partners, 50% fewer HIV-negative sex partners, and 31% less substance use than those in the comparison condition. Again, all of these changes were statically significant.

Research on the Intervention - *continued*

TLC modules should be implemented in the order in which the intervention was developed: the *Staying Healthy* module first, followed by the *Acting Safe* module. The optional module, *Being Together*, can be implemented last.

Modifications to the Intervention

During its preparation for use in the field, **TLC** was adjusted in the following ways to make implementation easier.

Materials for the *Being Together* module are not included as part of this intervention package. The module was not rigorously evaluated due to limited follow-up data and the outcomes were not linked to HIV risk reduction. However, the *Being Together* module significantly lowered overall emotional distress, expressions of emotional distress through physical symptoms and anxiety scores among youth in the intervention compared to youth in the comparison condition. In addition, youth in the intervention reported significantly less frequent use of nondisclosure as a coping mechanism than did youth in the comparison condition. The techniques used in this module may require extended training. For these reasons, *Being Together* is offered as an optional module. Materials, training and technical assistance for implementation may be obtained from the UCLA Center for Community Health, or the full module may be accessed at <http://chipts.ucla.edu>.

TLC was originally called Teens Linked to Care because it was designed to target teens and youth (ages 13 to 24) enrolled in HIV treatment programs. The intervention was renamed **TLC: Together Learning Choices** to better reflect the intervention's goals of linking HIV-positive young people to a broad range of care that includes emotional and social support as well as medical treatment.

TLC has been expanded to target HIV-positive young people from a wider age range (ages 13 to 29) who are receiving HIV-related services in a wider range of settings that include both medical clinics and social service agencies. The intervention addresses challenges faced by both HIV-positive adolescents and young adults and can be easily be adapted to a variety of settings, such as mental health centers.

It was also necessary to reduce the *Staying Healthy* and *Acting Safe* modules to eight sessions each, instead of the eight-to-twelve sessions that were originally offered. The Community Advisory Board that consulted with the **TLC** replication team strongly recommended a smaller number of sessions to make it feasible for agencies to implement the intervention and to successfully retain participants. This decision is consistent with the original research on **TLC** in which the mean number of sessions participants attended was 7.7 for *Staying Healthy* and 7.6 for *Acting Safe*. Seventy percent of participants attended at least six sessions of *Staying Healthy*, while 73% attended at least five sessions of *Acting Safe*. This decrease in number of sessions did not result in reduction or change to the content of the intervention. Other changes that were made to the original protocol include:

- Elimination of redundant concepts and activities.
- Addition of updated information on prevention technology, medical management of HIV, and common “club drugs”.
- Integration of a perspective that treats HIV as a chronic disease.
- Greater emphasis on non-scripted role plays.
- Incorporation of a Feel-Think-Do Framework that more explicitly highlights the intervention's underlying theory and the link between feelings, thoughts, and actions.

Note: All of the core elements shown to be responsible for **TLC's** effectiveness were maintained.

Underlying Theory and Principles

The **TLC** intervention is based on Social Action Theory. Social Action Theory asserts that a person's ability to change behaviors that endanger his or her health is influenced by the individual's cognitive capability (ability to think, reason, imagine, etc.) as well as environmental factors and social interactions that encourage or discourage the change process. Social Action Theory incorporates the principles that are expressed in traditional social-cognitive models of health-behavior change. These models include social-cognitive theory, the health belief model, and the transtheoretical model (stages of change), as well as theories related to social context, interpersonal relationships, and environmental influences.

With Social Action Theory as its foundation, **TLC** applies cognitive-behavioral strategies to maintaining health, reducing the risk for HIV and STI transmission or re-infection, and improving the quality of life of young people living with HIV. Strategies in the intervention include observing and imitating others as a means of learning new skills and improving old ones, building participants' belief that he or she can change a behavior (self-efficacy); and instilling the belief that changing behaviors will result in a desired outcome (response efficacy).

Feel-Think-Do (F-T-D) Framework

TLC applies the Social Action Theory by emphasizing awareness and identification of one's emotions, thoughts, and actions, which we refer to as the Feel-Think-Do Framework (F-T-D). F-T-D is a simple, low-literacy means of introducing more complex cognitive-behavioral concepts (e.g., emotional regulation, reframing, self-talk, problem-solving, assertive behavior and communication, triggers). It describes an interactive process. F-T-D is based on the idea that when we encounter a situation, we have a feeling about it (discomfort expressed through a reading on the Feeling Thermometer that is used throughout the intervention), a thought about it (what we say to ourselves), and what we do about it (the actions we take as a result of our feelings and thoughts). **TLC** participants are guided by F-T-D to recognize the connections between their thoughts and feelings and the behavioral choices they make, enabling them to more easily make behavioral changes.

For example, George is a young man living with HIV. His health is excellent and he intends to keep it that way. He returns to the HIV clinic every three months for a check-up. The visits consistently cause George to have strong feelings of discomfort. His discomfort manifests itself as a rapid pulse and flushed face. It causes him to lose patience with the clinic staff and he often glares at them. He also forgets questions he has and has difficulty expressing himself with his healthcare provider. His thinking can become negative: "This clinic will make my viral load come back and I'll never be able to control it." By the end of the visit, George is usually tense, embarrassed by his behavior, and unsure of how to gain control of the situation.

If George were a participant in **TLC**, he would learn how F-T-D can help him gain control over this situation. George would first learn how to rate his feelings and emotions in terms of their likelihood to cause him discomfort. Then he would learn to distinguish different situations that lead to discomfort, and how his body reacts to different levels of discomfort (e.g., flushed face, sweaty palms, pounding head, etc.). Awareness that a certain event causes him discomfort can help George better prepare to deal with the situation.

For example, when he knows that a doctor's visit increases his feelings of discomfort, George can prepare by engaging in a relaxation exercise or positive self-talk prior to his visit to lower feelings of discomfort. He can also write down all the questions he has for his provider so he is able to remember them even if his discomfort levels increase.

A relaxation activity and/or positive self-talk can reduce the physical discomfort George's anxiety is causing. Self-talk and relaxation techniques, as well as reframing and stopping negative thoughts are some of the skills taught in **TLC** to control or stop thoughts. The problem-solving skills taught in **TLC** can help him identify a way to get his questions answered, such as writing down his questions as mentioned above. As a participant in **TLC**, George would also learn that his high discomfort levels lead him to act in an aggressive manner. In the intervention, he would not only learn to deal effectively with his discomfort, but also learn and practice more productive responses, such as assertive communication. Since George *feels* less discomfort, he is more likely to *think* rationally. **TLC** would teach George the skills he needs to be in control of this situation.

For example, George is a young man living with HIV. His health is excellent and he intends to keep it that way. Prior to returning to the HIV clinic for his three-month check-up, he now does three things. First, he makes a list of all the questions he has for his provider. Second, he says to himself "This clinic visit is an investment in my health." Before leaving, he spends three minutes breathing deeply to relax himself. At the clinic, George smiles to the staff and states what he needs in a clear, polite manner. If he starts feeling uneasy and becomes anxious about his viral load, he says to himself, "Whatever my viral load, we're all one team working to keep me healthy." instead of "My viral load is back and can't be controlled." He calmly discusses his health with his provider and receives answers to all of his questions. George leaves the clinic feeling in control of his clinic visit.

After participating in **TLC**, George will be able to gain control of this situation and handle it more effectively, creating positive outcomes. By taking control of the situation, George will feel good about himself and others will feel better about their interactions with him.

Goals of TLC

The overall goal of **TLC** is increasing behaviors that promote:

- Healthy living.
- Effectively dealing with the challenges of daily living.
- Positive feelings, thoughts, and actions.
- Developing daily routines to stay healthy.

The *Staying Healthy* module supports the overall goal of **TLC** by:

- Increasing positive health related behaviors.
- Increasing positive coping skills for a healthy future and for managing challenges associated with stigma.
- Improving communication skills for positive relationships with health care providers.
- Decreasing barriers to successful medication adherence.

The *Acting Safe* module supports the overall goal of **TLC** by:

- Reducing the number of unprotected sex acts.
- Reducing the number of sex partners.
- Decreasing the number of uninfected sex partners or partners of unknown status.
- Reducing risky drug use behaviors.

These goals are achieved through **TLC**'s core elements (see discussion of core elements in Section 4.2). During the sessions the participants see behaviors modeled, practice those skills, and as a result of skill acquisitions, are able to make the necessary behavioral changes.

Core Elements of TLC

Core elements are critical features of an intervention's intent and design and are responsible for its effectiveness. They must be maintained without alteration.

The following are core elements of **TLC**.

1. Development of emotional awareness through use of a Feeling Thermometer and identification of the link between feelings, thoughts, and actions (F-T-D Framework).
2. Teaching, modeling and practicing four **TLC** essential skills:
 - a. Personal Problem-Solving.
 - b. Short- and Long-Term Goal Setting.
 - c. Emotional Awareness and Regulation.
 - d. Assertive Behavior and Communication.

3. Consistent appreciation and reinforcement of positive participant behavior through the use of Thanks Tokens.
4. Identification of Ideal Self to help motivate and personalize behavior change.
5. Sessions delivered in small, highly participatory, interactive groups.

Through **TLC's** core elements, participants develop specific skills that give them a sense of control over their emotions and subsequent thoughts and actions. These skills are repeated and modeled in every session to provide participants with opportunities to practice the skills and ultimately apply them in everyday situations.

TLC Essential Skills

- **Personal problem-solving skills** are presented using a structured model called SMART, which involves five steps: 1. **S**tate the problem, 2. **M**ake a goal, 3. **A**chieve a list of all possible actions, 4. **R**each a decision, 5. **T**ry it and review it. Through this model, participants learn to analyze and identify different actions they might take toward solving a real-life problem. Participants are invited to bring up general problems to which they may be seeking solutions, or a difficult problem related to one of the sessions. The group applies the problem-solving format, selects a goal, identifies barriers, and plans the next steps. This newly learned life skill can be applied to a broad range of problems within and outside the context of HIV prevention.
- **Short- and long-term goal setting** occurs during the conclusion of sessions and usually focuses on a goal related to that session's activities or topic. Participants are taught the characteristics of good goals—realistic, clear, challenging but not impossible, and having an identifiable end-point. Once participants choose a goal, they identify the steps they will take before the next session to achieve that goal. A check-in period occurs in the first few minutes of the following week's session to discuss what happened. Not only is there the intrinsic reward of achieving one's goal (for those who do), but Facilitators reward (with praise and Thanks Tokens) the attempts that have been made. For those participants who did not achieve their goals, the check-in period allows them to analyze the reasons they were not successful.
- **Emotional awareness and regulation** is another central element of **TLC**. When young people are not able to identify their feelings accurately they are less able to deal with those feelings effectively. Many young people, for instance, describe feeling angry when they are, in fact, hurt and so their responses are likely to be more on the order of lashing out than acknowledging pain or hurt feelings and negotiating a solution to what has caused the hurt. **TLC** teaches participants how their thoughts, feelings, and actions influence each other. This awareness and techniques learned in **TLC** sessions help participants deal with their emotions and replace negative thoughts with positive thoughts, which leads to more positive and effective actions.
- **Assertive behavior and communication** are vital for effective and successful interactions with others. Verbal and non-verbal assertiveness facilitates the implementation of the skills taught in this intervention. For example, as a part of the choices we all have, we can choose to be passive, assertive, or aggressive. Participants are introduced to verbal and non-verbal assertiveness surrounding various life contexts (i.e., condom negotiation, interactions with health care providers, family members, etc.). Role plays are often utilized to provide participants with the opportunity to practice assertiveness. Facilitators repeatedly tie in verbal and non-verbal assertiveness skills with various session topics and model assertiveness skills whenever the opportunity arises.

TLC Learning Techniques

- **The Feeling Thermometer** is displayed on the wall during every session and helps participants assess and discuss their feelings of discomfort more effectively during the session. The Feeling Thermometer is a graphic design resembling a fever thermometer that has been enlarged and reproduced on a poster. The highest measurement on the Feeling Thermometer is 100 and it represents the most discomfort one can imagine feeling. That discomfort may be extreme anger, anxiety, excitement, nervousness, depression, or any other emotion that is experienced as discomfort. The bottom measurement is zero and this represents a total lack of discomfort, whether the associated feeling is happiness or calm or something else.



Linking Feeling Thermometer levels with situations being discussed or with recent experiences helps participants identify when their emotions are or have been highly charged and what situations are likely to result in those high extremes of feelings. The person at or near 100 on the thermometer is likely to find that his or her discomfort interferes with good judgment and sound decision-making. The person at or near zero on the thermometer is better able to think and make decisions regardless of how he or she labels the particular feeling or emotion. The purpose of the Feeling Thermometer is to increase participants' emotional awareness and self-regulation.

- **Thanks Tokens** are two-inch-square pieces of laminated cardstock with a design on one side (a star is used in **TLC**, but another design may be substituted if you prefer). When praising a participant for a meaningful contribution to the session, such as for speaking out on an issue or coming up with an idea, the Facilitator will accompany the praise with a Thanks Token. The intent is to pair a compliment with a tangible symbol of appreciation to draw the participant's attention to the fact that he or she has been complimented. The Facilitator explains why the Thanks Token was given, e.g., "I liked your suggestion of how we might explain that better," or "I appreciate how you spoke up on that," at the time it is handed to the participant.



Each participant is also handed a packet of 20 Thanks Tokens at the beginning of each session. During the sessions, participants are asked to give a Thanks Token, along with a brief description of why, whenever another participant says or does anything he or she appreciates. In this manner, participants learn to deliver as well as receive compliments. When used consistently by both Facilitators and participants, Thanks Tokens leave most participants with positive feelings about themselves. It is important to note that Thanks Tokens are not a medium of exchange and are not "turned in" for anything of value. (Actually, participants will be asked to return the tokens at the end of the session so they can be reused in the next session.)

The key to everyone using the Thanks Tokens rests on the Facilitators' comfort with them. If the Facilitators like using them and do so at every opportunity, the participants will also use them. **TLC** has been designed so that Thanks Tokens are designated to be used multiple times in every session. However, Facilitators are also encouraged to use Thanks Tokens whenever any other opportunities to use them arise in a session.

TLC Learning Techniques - *continued*

Both the Feeling Thermometer and Thanks Tokens are also used in **Street Smart**, another evidence-based intervention available from CDC's Capacity Building Branch-Diffusion of Effective Behavioral Interventions. The same techniques are used in both interventions; however, their explanations in this manual are more detailed and reflect insight gained from field-testing the TLC intervention.

- **Identification of Ideal Selves** helps TLC participants pinpoint their values as they relate to the way they would like to see themselves behave. Participants are asked to consider those values as they think about the ways they would like to act in specific situations. The Ideal Self is used as a decision-making guide to help motivate and personalize behavior change. Appeals to one's Ideal Self occur throughout the sessions.
- **Role plays** allow participants to watch and/or practice positive responses to potentially problematic situations in an instructive and supportive environment. The TLC manual contains different types of role plays. A few are scripted and are used to introduce a particular session or topic. These scripted role plays should be practiced ahead of time and are to be acted by Facilitators, not participants.  Other role plays are not scripted but a scenario is described and participants are asked to act it out without preparation. These role plays give participants an opportunity to explore new ways of dealing with high-risk situations. Instructions for each role play are found within the session guides. Facilitators should not let a role play go beyond 10 minutes and should monitor it to assure that participants understand and keeping to the point.
- It is important to make every effort to avoid role playing of stereotypes. Many of the role play situations describe interactions between persons with specific characteristics. These role plays are not intended to stereotype individuals by gender, age, or race—in fact, the Facilitators are encouraged to reverse stereotype roles whenever possible. For example, have a female play the role of the person who does not want to use a condom, or have young men role play young women and women role play men. This gives participants an opportunity to explore others' experiences and points of view.

Key Characteristics of TLC

The following key characteristics are crucial activities and delivery methods for conducting **TLC**, however they may be tailored to meet the needs of different agencies and at-risk populations. Key characteristics of **TLC** include:

- **Use of incentives.** We recommend using incentives to encourage participants to return to sessions, but it is up to each implementing agency to decide whether or not to use incentives, what kind to use, and the estimated value of an incentive. The most appropriate incentive strategies are those that your community advisory group and your participant pool think will work best to encourage attendance and participation.
- **Time.** With practice, all sessions can be finished in the two-hour time period indicated in the ***TLC Implementation Manual***. Although the agencies that tested the **TLC** Intervention Package ended up extending the length of their sessions as a result of discussions running longer, it is recommended that the sessions be kept to two hours as much as possible.
- **Intervals between sessions** can be tailored to the needs and capacity of your agency and population. A general rule of thumb is to conduct sessions once a week. Biweekly also may work for you, but we do not recommend monthly sessions except in very unusual situations. Facilitators want to allow participants enough time to practice the skills learned in the group and make progress on their goals, but not so much time that they forget lessons or lose interest. When planning for the session frequency, there are several things to be considered:
 - Time for participants to think about what they have experienced.
 - Ability to retain participants.
 - Availability of both participants and Facilitators.

It is not recommended that an agency conduct all eight sessions in one day or a weekend.

- **Facilitators.** Two persons are needed to facilitate the groups. The same two Facilitators will be able to enhance group cohesiveness much better than having different Facilitators for different sessions. While it is preferable to have one Facilitator be male and one female (for purposes of modeling and providing a gender-specific point of view to the participants), that may not be possible in every circumstance. When necessary, same-gender Facilitators can conduct the sessions. If your group is all of one gender (all male, for instance), one of the Facilitators should be of this gender.
- **Group composition.** Implementing agencies may modify **TLC** with respect to the age, gender, and sexual orientation of participants. For example, if your agency's potential participant population is sufficiently large, you may wish to consider holding separate groups for younger (e.g., under 18) and older participants. You may not change **TLC** from a group to an individual delivery method (contact the UCLA Center for Community Health about similar interventions that are effective for individual use), but the composition of the group is flexible.
- **Group size.** We recommend that **TLC** groups be from four to eight participants in size, though slightly larger groups (up to 12) may be workable once your Facilitators have sufficient experience with the intervention to be comfortable with a larger group.

Key Characteristics of TLC - *continued*

- **Building Group Cohesion:** Building cohesion is essential to **TLC** because participants may disclose personal experiences and they need to feel safe and supported as they do so. Building cohesion lays the foundation for building trust and trust creates the safe and supportive environment necessary for **TLC**. The agencies that tested the intervention used a variety of cohesion building activities. Some agencies used introductory sessions; others used meals served before or after the sessions. Other ways to build group cohesion are using “energizers” or “getting to know you” activities before, during and after the sessions.
- **Food/Snacks:** Implementing agencies are encouraged to provide refreshments for their participants. This is not a core element but strongly recommended.
- **Visual Aids:** The use of visual aids like the wall charts supplied in the **TLC** Intervention Package can help in the comprehension and retention of concepts. Visual aids can also help participants who have low literacy skills. It is recommended that visual aids be simple and universally understood.
- **Location:** **TLC** can be held anywhere there is a private room with enough space to accommodate the participants, the role plays and a refreshment table. The venue and room should be handicapped accessible. For some communities, venues that advertise services for people living with HIV/AIDS are not good places to hold **TLC** sessions. Some participants have not disclosed their status and therefore would not attend sessions at a place that would compromise their privacy.

Why We Use Groups

The use of sessions delivered in highly participatory, interactive small groups is a core element of **TLC** and cannot be changed. **TLC** uses groups as the framework in which health seeking and prevention behaviors are learned, practiced and reinforced because:

- Seeing other young people struggling with the same issues counteracts the belief that “I am alone” or “nobody feels this way but me” and increases young people’s ability to learn new skills.
- Peer norms can be turned into an advantage in encouraging safer sex behaviors.
- Learning and practicing new skills in the supportive environment of **TLC** groups can enhance self-esteem.
- Practicing a skill in the presence of other young people tends to improve performance.
- Group interaction promotes a strong emotional experience, which facilitates learning.
- Learning in a participatory, non-judgmental, fun style with other young people can increase motivation.

Working with Adolescents in Group Settings

It is important to remember these points:

- Adolescence and young adulthood are times of experimentation. This frequently means engaging in unprotected sexual intercourse with multiple partners and using drugs or alcohol. For youth and young adults with HIV, these behaviors increase the risks both of infection with other sexually transmitted infections (STIs) and of re-infection with new strains of HIV. They also increase the probability of transmitting HIV and other STIs to their sexual partners.
- Developmental changes in behavior and ways of feeling, thinking and acting, as well as in the influence of peers, must be considered as essential elements in understanding and changing risky behaviors. Intervening with young people must include providing them with specific knowledge about HIV/AIDS and STIs and must build their awareness of their own feelings, thoughts and actions, so they can begin to apply this knowledge to their own lives. Building coping skills and providing access to resources are other essential elements of successful intervention programs.



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Getting Started

This section describes what agencies must have in place to effectively implement **TLC: Together Learning Choices**. It is suggested that agencies wanting to implement **TLC** form a community advisory group recruited from community members, members of the target population, members of the agency's Board of Directors, and agency staff members. This group's role will be to inform and assist with all aspects of the pre-implementation and implementation process described below.

Organizational Assessment Activities

Conducting a needs assessment is the process of collecting information that describes the factors that put a population at risk and the resources they lack to address those factors. This type of assessment is conducted before implementing the **TLC** intervention and will provide important data on the need for **TLC** in a particular community or at a particular agency. A needs assessment can also provide insight into how **TLC** may need to be tailored to best serve your audience.

Agency capacity issues such as staffing, space, and budget, and developing an implementation budget are central getting-started activities. It is important to note that these activities do not need to happen strictly in the order they appear in this manual; they may happen simultaneously.

Agency Capacity Issues

The first thing to do before implementing this intervention is to address the agency capacity issues, starting with securing the "buy-in" of agency stakeholders.

Buy-In

Securing "buy-in" is crucial because it assures the support of agency administration and facilitates the allocation of agency resources for implementing the intervention. Obtaining "buy-in" is most effectively accomplished with an intervention champion. A champion is a mid- to upper-level administrator within the agency who serves as the intervention's spokesperson, anticipates and answers questions about the need for the intervention, and is familiar with the resources needed to implement the intervention. The champion can be an individual or a group of people, but regardless of the number of champions, their central purpose is convincing agency staff and others that implementing **TLC** would enhance the quality of prevention services provided by the agency and that the agency is capable of implementing the intervention. The champion must have excellent knowledge of the intervention including its costs, core elements and key characteristics. The champion can use the **TLC** marketing DVD and other information presented in the intervention package to gain the support of stakeholders, and to answer any questions or concerns they might have about **TLC**.

A stakeholder's checklist is provided to guide agencies and the intervention champions in obtaining support and ensuring the successful implementation of **TLC**. Stakeholders may include volunteers on your Board of Directors/Executive Board, people in your community, other local agencies, your staff, and funders whose decisions and actions could impact the successful implementation of this intervention.

Stakeholder's Checklist

1. Assess the community to determine whether they will support the core elements of **TLC**.
2. Identify your stakeholders:
 - a. Your agency's Board of Directors/Executive Board.
 - b. Staff members from your agency who will have a role in the operation of the intervention:
 - Administrators who will obtain support.
 - Supervisors who will monitor the intervention.
 - Staff who will interact with participants at any level.
 - c. Local agencies from which you could recruit participants, Facilitators or both:
 - Agencies offering support groups for young people living with HIV/AIDS.
 - Health care providers and mental health professionals serving people living with HIV/AIDS.
 - Social service agencies reaching people living with HIV/AIDS.
 - Organizations of people living with HIV/AIDS and organizations which may have members who are living with HIV/AIDS.
 - d. Organizations which could provide assistance or other resources:
 - Vendors for incentives and refreshments.
 - Agencies, vendors, printers, publishers, broadcasters and others who can advertise the intervention.
 - Agencies that can provide a venue for the intervention.
 - Agencies that can provide child care.
 - Agencies that can provide transportation.
 - Agencies that can provide informed volunteers for your community advisory group to help tailor the intervention.
 - Other collaborating agencies to provide information for Resource Packets.
 - e. Agencies with which your organization needs to maintain good community or professional relationships:
 - Local health department.
 - Local medical and mental health associations.
 - Your funding source(s).
 - Others.

3. Getting stakeholders informed, supportive and involved:
 - a. Getting them informed about the intervention:
 - Decide in advance what specific roles you want each stakeholder to play. Who you will ask to:
 - ◆ Provide financial support.
 - ◆ Refer people living with HIV/AIDS to the intervention.
 - ◆ Serve as an intervention Facilitator.
 - ◆ Be a resource to whom you can refer participants.
 - ◆ Join your community advisory group.
 - ◆ Help tailor the intervention for your target population.
 - ◆ Assist in advertising the intervention.
 - ◆ Provide a room in which the sessions can be held.
 - ◆ Supply refreshments for participants.
 - ◆ Donate small incentives or prizes for participants.
 - ◆ Speak supportively about **TLC** in conversations with their associates.
 - Send letters that tell stakeholders about **TLC**, its importance, that your agency will be making the intervention available, the specific role(s) you think that they may play in the success of the intervention, and invite them to learn more.
 - Call in two weeks and assess their interest. If they are interested, schedule a time to meet (e.g., one-on-one, lunch-and-learn at your agency with a group of other stakeholders, presentation at their agency for several of their staff or association members).
 - Hold the meeting, show the **TLC** Marketing DVD if the setting and time allow, answer questions.
 - b. Getting them supportive
 - Describe several specific roles they could play.
 - Emphasize the benefits of their involvement to themselves, their agency, the community and people living with HIV/AIDS, and answer questions.
 - Invite them to commit to supporting **TLC** by taking on one or more roles.
 - Keep track of commitments.

Stakeholder's Checklist - *continued*

- c. Getting them involved
 - Soon after meeting, send a thank-you letter that specifies the role(s) to which they committed. If they did not commit, send a letter thanking them for their time and interest and ask them to keep the letter on file in case they reconsider later.
 - Provide immediate and specific work assignments to people who committed to a role that is important to pre-implementation.
 - For people who committed to roles that begin later in the process, provide progress updates and a projected time frame for their involvement.
 - Hold periodic celebratory meetings for supporters to acknowledge the value of their contributions, update them on the intervention's progress and keep them engaged.

Budget

Another getting-started activity is determining the cost of implementing the intervention. Implementing **TLC** requires the allocation of resources for: a 50 percent Full Time Equivalent (FTE) paid, experienced Program Manager, two 50-100 percent FTE Facilitators, and one optional 50 percent FTE Program Assistant. We estimate that each Facilitator will need to attend 40 hours or five days of training for each **TLC** module. Facilitators will also need time to prepare for sessions, conduct them and debrief after they are completed. The original intervention study also provided participants with a per session incentive, but this is not required to implement **TLC**. The intervention involves the use of an easel, easel paper, markers, forms and handouts and one small prize to be given away through a random drawing at the end of each session. **TLC** is not a high-maintenance intervention and can be made feasible for almost all agencies.

Cost Sheet

A cost sheet has been provided to highlight possible costs associated with implementing **TLC**. This is meant only as a guide. Depending on the number of times you implement the intervention or the specific needs of your agency, these figures will vary from organization to organization. The cost sheet assumes that your agency already has access to intervention participants. If this is not the case, you will need to add recruitment costs. It also assumes that there will be no donations, volunteers or in-kind contributions, and includes costs/values as if everything will need to be paid for by the agency.

Categories for Provider Costs to Implement the TLC Intervention

Categories	Pre-Implementation (start-up)		Implementation (intervention delivery)	
PERSONNEL	# Staff	% time or # hrs/wk (% FTE time spent on intervention)	# Staff	% time or # hrs/wk (% FTE time spent on intervention)
SALARIED				
PROGRAM MANAGER	1	75%	1	50%
FACILITATOR	2	50%	2	100%
PROGRAM ASST.	1	50%	1	50%
FRINGE BENEFITS		25%		25%
FACILITY(IES)		(% time used for intervention)		(% time used for intervention)
RENT				
OFFICE	\$ x	% =	\$ x	% =
SMALL GROUP MEETING SPACE	0		\$ x	# sessions = (inc. pre-sessions)
UTILITIES	\$ x	% =	\$ x	% =
TELEPHONE/FAX	\$ x	% =	\$ x	% =
MAINTENANCE	\$ x	% =	\$ x	% =
INSURANCE	\$ x	% =	\$ x	% =
EQUIPMENT		(% time used for intervention)		(% time used for intervention)
COMPUTER	\$ x	% =	\$ x	% =
COPIER	\$ x	% =	\$ x	% =
EASEL	\$ x	% =	\$ x	% =
EQUIPMENT MAINTENANCE	\$ x	% =	\$ x	% =
INTERNET SERVICE PROVIDER	\$ x	% =	\$ x	% =
SUPPLIES				
POSTAGE & MAILING	\$		\$	
COPYING & PRINTING	\$		\$	
OFFICE SUPPLIES:				
PAPER (WHITE)	1 ream x	\$ /ream =	5 reams x	\$ /ream =
PAPER (COLORED)	0		3 reams x	\$ /ream =
CERTIFICATE PAPER	0		1 pkg. x	\$ /pkg. =
PENS	1 dozen x	\$ /doz. =	3 dozen x	\$ /doz. =
NAME BADGES	0		100 x	\$ /each =
EASEL PAPER	0		2 pads x	\$ /pad =
MARKERS	0		1 pkg. x	\$ /pkg. =
PUSH PINS	0		1 box x	\$ /box =
MASKING TAPE	0		1 roll x	\$ /roll =
POCKET FOLDERS	0		10 x	\$ /each =
TEACHING SUPPLIES				
ANATOMICAL MODELS				
MALE	10 x	\$ /each =	0	
FEMALE	10 x	\$ /each =	0	
LUBRICANT	0			
CONDOMS				
MALE	0		2 dozen x	\$ /doz. =
FEMALE	0		2 dozen x	\$ /doz. =
PRINTED MATERIALS				
FORMS	0		3	
INFORMATION SHEETS/FLIERS	5 gross x	\$ /grs. =	0 x	\$ /each =
OTHER MATERIALS				
PRIZES	0		8 x	\$ /each =
CATERING/REFRESHMENTS			80 x	\$ /person =
RECRUITMENT (OF STAFF/VOLUNTEERS)				
ADVERTISING	10 column inches x	\$ /inch =	10 column inches x	\$ /inch =
TRAVEL				
MILES TO/FROM INTERVENTION LOCATION (if other than regular work place)	# miles x	¢/mile =	# miles x	¢/mile =

Notes on Categories for Provider Costs

- Intervention delivery costs are based on an average of 10 participants times eight sessions per module. **TLC** should be implemented in the order in which it was developed: the *Staying Healthy* module first, followed by the *Acting Safe* module. The third module, *Being Together*, which is optional, can be implemented last.
- Numbers of printed and other materials are calculated as follows: for each module implemented you will need approximately 10 sheets of paper (forms, handouts, evaluation) per person. For each session you also will need one name badge and one serving of refreshments per participant. One prize is awarded at each session.
- Both Facilitators will need to be compensated for their time spent recruiting, screening participants, training (four days per module) and practicing during pre-implementation. Intervention delivery time includes review before each session, travel to the sessions, session time and debriefing time. It also assumes weekly sessions for eight weeks, plus a week for preparation and wrap-up.
- Figures are based on one implementation of *Staying Healthy* and *Acting Safe* to one target population.



How To Conduct TLC Sessions

This section addresses the actual delivery of **TLC: Together Learning Choices** to youth.

Recruitment of Participants

It is important for your agency to have a recruitment plan in place that details how participants will be recruited, including recruitment venues, recruitment/marketing tools, and number to be recruited. The plan should also draw upon ideas and techniques used in the past to recruit and retain participants in programs. Your community advisory group should be able to provide your agency with the answers to some recruiting questions, such as:

- Where is the best place to recruit?
- What are the best recruiting strategies for your populations?
- What might motivate members of the target population(s) to attend **TLC**?

Participant Retention

Keeping participants engaged in the intervention can be a difficult task. The Facilitators have much of the responsibility for making sure that all participants:

- Have a chance to contribute to discussion.
- Have a chance to participate in activities.
- Have a chance to have their thoughts heard.
- Feel welcomed, safe and supported.

Facilitators also should work hard to maintain enthusiasm and sincerity when presenting **TLC** activities. The attitudes of the Facilitators are important motivation for participants to return to the group.

Incentives can also provide motivation for young people to keep attending **TLC** group sessions. Incentives will vary by agency, based on resources, agency policy and needs of the specific target group. Some agencies have been successful in soliciting incentives from local businesses. Seeking in-kind donations helps promote the mission of the agency in the community. It also gives local businesses an opportunity to participate in a larger HIV prevention effort.

Participant Retention - *continued*

Ways to increase retention and attendance at **TLC** group sessions can include reminders such as telephone calls, text messaging group members the day before a session, sending an "e-vite" invitation, etc. Facilitators may want to discuss reminders with the group to find out what form of contact is best.

Attendance Policy

TLC is a closed group. Once the sessions begin, participants cannot be added to the group. Participants should not miss two consecutive sessions. Each session builds on the previous session. Missing more than one session undermines the participant's ability to fully grasp the skills, making it difficult to participate in the other sessions.

Implementing agencies need to develop attendance policies that support the goals of **TLC** and clearly communicate these to participants and other stakeholders in the intervention.

Pre-Assessment Interviews

Pre-assessment interviews are an opportunity for your agency to interview potential **TLC** participants and assess their readiness to participate in the intervention. The interviews can be conducted by the Facilitators in a private room where the potential participant can freely answer questions in a welcoming and supportive environment. During the interviews, Facilitators ask potential participants about their previous group experience and their ability to handle conflict. The pre-assessment interviews provide Facilitators with an opportunity to assemble a group of participants whose personalities work well together. Additionally, during the pre-assessment interviews, participants can have their questions about **TLC** answered. Some sample interview questions are:

- What has been your experience with support groups or discussion groups?
- What do you like most/least about groups?
- How do you handle tension or conflict within a group of people?
- How long have you been diagnosed with HIV?
- How comfortable are you discussing HIV issues in a group setting?

Participants newly diagnosed with HIV may not be ready for the intervention. They may require referrals to medical care or individualized counseling.

Resource Packets

Participants in **TLC** may have questions and needs that cannot be addressed during the **TLC** sessions. Because of this, agencies may decide to create a Resource Packet to distribute to each participant. Packets should describe services and other resources available in their community. If used, the Facilitators should encourage participants to make use of these resources and remind them of the packet at the end of each session.

Following is a list of the types of materials that might be included.

- Business card or other contact information for the Facilitator and the sponsoring agency.
- Information on the limits of confidentiality and relevant notification laws.
- An introduction to the **TLC** intervention and why it is being implemented by this agency.
- A list of key agencies providing services to young people living with HIV/AIDS.
- A variety of resource brochures specific to the community. (e.g., information about where in the immediate area to find HIV/AIDS services assistance with housing, food, medical treatments, prescriptions, etc.).
- Up-to-date information on transmission of HIV, HIV medications, and HIV therapy/treatment.
- Printouts from websites of interest to participants.
- List of contributors of any donated food, gift certificates, or coupons.
- Any other materials that might serve as a resource to participants.

Some agencies have reported that its **TLC** participants do not like to receive take-home materials that mention HIV or AIDS. Implementing agencies should assess the merits and feasibility of posting the Resources Packet on a website with URL not associated with HIV/AIDS.

Pre-Delivery Checklist

This pre-delivery checklist is a quick reference of items that should be in place before **TLC** is delivered.

- Participants recruited.
- Participants assigned to groups.
- Location selected and room set-up.
- Table for food/snacks (prepared).
- Sessions scheduled.
- Pre-assessment interviews completed.
- Facilitation coordination and practice sessions held and completed.
- Resource Packets compiled and copied (if used).
- Supplies on-hand.
- Condoms, condom models and lubricant (lube) on-hand.
- Incentives obtained.
- Other intervention materials on-hand, prepared, copied, enlarged.
- Wall Charts posted.

Arranging for the Sessions

Number of Participants

- Four to 12 participants, of either or both sexes.

Number of Facilitators

- Two, preferably one male and one female.

Number of Sessions

- Eight group sessions in each module.

Frequency of Sessions

- It is recommended that sessions for each module be held once a week. However, how frequently the sessions are held will depend on the needs and specific circumstances of the participants and agencies.

Length of Sessions

- Each session should be at least two hours.
- It is recommended that there be a “social time” with refreshments after each session. This will make the sessions more fun and will encourage participants to engage further with one another and with the intervention. If held in advance with food removed when the session starts, it also encourages participants to be on time.

Physical Space and Atmosphere

- The atmosphere in a clinic or agency is a part of the intervention. Sessions should be conducted in a large, comfortable room protected from interruptions. In a safe atmosphere, peers support each other, learn from each other and build each other’s self-esteem. Thus, group cohesion is supported in every session. The goal is for participants to build trust in each other and the Facilitators by asking questions and sharing their real-life experiences related to the issues being addressed in the sessions. They are more likely to do this if the sessions are held in a friendly, informal atmosphere where confidentiality is promised.

Participant Seating

- Participants should sit in a closed circle so that eye contact and interaction are encouraged and so it is easy to distribute Thanks Tokens.
- Avoid having all male or female participants sitting together to create balance.
- Split up cliques (groups of friends) or assign to another group, where possible.
- Place a disruptive participant next to a Facilitator.

- Materials and Equipment
- Session-specific materials are described in the beginning of each session guide.
- Some materials are used in all sessions and some materials are specific to particular sessions.
- Items used across all sessions include:
 - Thanks Tokens.
 - Prizes.
 - Feeling Thermometer.
 - Easel Paper and markers.
 - Weekly Goal Cards.
 - Wall Charts: Ground Rules, Using Thanks Tokens, Guidelines for Good Goals, SMART Problem-Solving Steps, Weekly Log.

Facilitator Guidelines

Facilitators are encouraged to become very familiar with the content of the intervention. Until Facilitators feel confident with the intervention content, using the script as written is encouraged. Once Facilitators become comfortable with the intervention, they can summarize the material in their own words, making sure to use language consistent with the target population and including all the main points. Writing session notes on index cards is recommended. However, the use of index cards and summarizing should only be undertaken if Facilitators have practiced the sessions multiple times and feel very comfortable with the intervention content.

Facilitator Responsibilities

Facilitators have specific functions and tasks to perform before and during the sessions.

Responsibilities include:

1. **Use the session guides.**
 - The text that is **bold** is what facilitators should say or convey to the participants. The text that is not bold are cues for the facilitators to implement the activities.
 - Know the material well enough that you are familiar with the concepts and do not need to read the text directly.
 - Translate material into your own words once you become skilled at facilitating the activities.
 - Practice often.
2. **Manage the operation of the session.**
 - Provide the knowledge needed.
 - Apply your skills to the session contents and be familiar with the material beforehand.

Facilitator Responsibilities - *continued*

- Be on time and stay on time.
- Manage communications in the session.
- Be prepared. Have all materials ready for that session and organized so that you can access them when you need them.
- Provide a safe emotional space.
- Be enthusiastic, optimistic and communicate your belief in the intervention.
- Be a good role model.
- Be empathic, but stay in your role.

3. Recognize and reward positive behavior.

- Use supportive statements when you “catch someone doing something good.”
- Use Thanks Tokens to acknowledge participants’ positive actions.
- Support participants’ efforts to move their behavior in the desired direction.

4. Challenge disruptive or problematic behavior.

- Enforce Ground Rules to maintain order and a safe environment.
- Use group processes to set and reinforce group norms.

5. Elicit participants’ assessment of their feelings.

- Use the Feeling Thermometer to help participants recognize how they feel—their level of discomfort.
- Help participants label what feeling they are experiencing—anger, depression, guilt, pleasure, sexual arousal, etc.

6. Encourage participation.

- Use Ground Rules (especially “confidentiality”) to ensure the existence of a safe environment. This will help participants feel more comfortable addressing sensitive topics.

7. Show participants how to act effectively.

- Model the skills TLC teaches.
- Demonstrate coping and other skills.
- Use role playing based on the participants’ experiences to help peers learn from each other.
- Practice problem-solving frequently.

- Demonstrate effective communication and interactive behaviors, including assertiveness.
- Help participants practice new ways of thinking, feeling and acting.

8. Create concern in participants about:

- Unsafe sexual and substance-use behaviors.
- Other forms of unhealthy behavior and lack of adherence to health-promoting behavior.
- Involvement in risky situations and with risky partners.

9. Build group cohesion through:

- Showing appreciation to participants for their contributions (e.g., Thanks Tokens).
- Communicating clear expectations regarding how group members treat each other and how they participate—talking, sharing, role playing, checking feelings.
- Encouraging self-disclosure through supportive statements, teaching communication skills, modeling, using the Feeling Thermometer, and demonstrating acceptance of group members regardless of the feelings and content expressed.
- Having group members give each other praise, recognize what is positive about each other, provide constructive feedback, and share.

Facilitator Processes

Listed below are suggestions for dealing with specific aspects of group process and group functioning:

1. Have one Facilitator direct the activities while the other monitors the process.

Functions of the Co-Facilitator include:

- Giving feedback.
- Keeping focus on tasks at hand.
- Making sure everyone is participating in group.

2. Co-Facilitators may switch roles regularly during the group, but both Facilitators should be equally prepared and equally responsible for all materials and activities.

3. Support each other and work as a team.

4. Equally share the content and process parts of the session.

5. Pay attention to each other’s non-verbal as well as verbal communications. Yield to your Co-Facilitator if it looks like he or she wants to say something or take the next part for some reason.

6. You don’t have to be an expert and have all the answers. It’s OK to say, “I don’t know.” You could also say that you will try to have an answer by the next session.

Facilitator Processes - *continued*

7. Facilitators establish control from the beginning, indicating that they will:

- Direct the activities.
- Set the pace.
- Ensure group members' self-control.
- Prevent self-harm by participants, harm to other group members, and destruction of property.

8. Facilitators encourage behavior change by providing knowledge, support and reinforcement.

9. Facilitators are not therapists, counselors or pastors. They cannot and must not try to reorganize personalities or heal dysfunctional families.

10. When tempted to share personal information from your own life; ask yourself:

- Is this clearly helpful to the group?
- Is it directly relevant to the topic or skill being learned?
- Is there time?
- Does the content involve material I am comfortable having most people know I am struggling with?

If the answer to any one of these questions is “no,” don't share the information.

11. Specific tips:

- Frequently reward desirable behaviors.
- Be supportive.
- Give compliments.
- Be non-judgmental.
- Encourage group cohesion.
- Model appropriate assertive behavior.
- Be firm.
- Illustrate points through modeling.
- Share personal experiences in a limited fashion.
- Keep language simple.
- Encourage participants to share their own experiences.
- Build on participants' strengths.

- Listen.
- Let the participants do the reacting, responding, thinking and analyzing.
- Be flexible.
- Keep trying. If one approach doesn't work, find another one.

12. Things to note about participants:

- Are they paying attention? Watch for participants' non-verbal communications indicating interest or attention. Examples: eye contact, facial expressions, nodding head, body language open and toward speaker.
- Are they truly listening, not just looking as if they are? Listen for verbal cues indicating understanding, such as appropriate responses to questions and participation in discussion.
- Do they ask questions relevant to the content of the conversation?
- Do they make statements that reflect the content or emotion being expressed?
- Translating: Putting concepts into simpler, more precise, concise or common language, without changing the meaning of the experience.
- Reframing: Presenting an experience from a different perspective that promotes a change in the meaning of that experience. For example, a smoker who is trying to quit feels like a failure because one day she smoked two cigarettes. The smoker's previous typical number of daily cigarettes was 40, so the listener helped her reframe the situation as a 95% success on that day.
- Probe for barriers using active listening: What are the true barriers that participants had in coming to the group? What were their fears about participating? For example: "You sound like you've given this some thought. What do you think is the worst thing that can happen to you if you come to group?" Or, "You sound like you are not sure. What do you think is the worst thing that could happen to you?"
- Overcoming barriers: Participant says he or she has no time. Validate his or her feelings, then probe about what conflicts he or she has and problem-solve the situation with them (using the SMART Problem-Solving Steps) while emphasizing the value of the group. Identify what other participants said they wanted or got from the groups and use these as selling points.
 - Social support: Making new friends.
 - People like me: Meeting other HIV-positive people my age.
 - Information: Learning more about HIV, living with HIV, resources available.
 - Helping others (altruism): Desire to help others with HIV, provide support to others.



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CDC Information and Guidelines

- The ABC's of Smart Behavior
- CDC Content and Review Guidelines for HIV Programs
- Male Latex Condoms and Sexually Transmitted Diseases
- CDC Statement on Nonoxynol-9 Spermicide Contraception Use-US (1999)
- CDC Statement for Study Results of Product Containing Nonoxynol-9 (2000)



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The ABCs of Smart Behavior

To Avoid or Reduce the Risk for HIV

A Stands for abstinence.

B Stands for being faithful to a single sexual partner.

C Stands for using condoms consistently and correctly.



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CDC Content and Review Guidelines

for HIV Programs

Centers for Disease Control and Prevention

Revised Interim HIV Content Guidelines for AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments and Educational Sessions for CDC Assistance Programs

I. Basic Principles

Controlling the spread of HIV infection and the occurrence of AIDS requires the promotion of individual behaviors that eliminate or reduce the risk of acquiring and spreading the virus. Messages must be provided to the public that emphasize the ways by which individuals can protect themselves from acquiring the virus. These methods include abstinence from illegal use of IV drugs as well as from sexual intercourse except in a mutually monogamous relationship with an uninfected partner.

For those individuals who do not or cannot cease risky behavior, methods of reducing their risk of acquiring or spreading the virus must also be communicated. Such messages are often controversial. The principles contained in this document are intended to provide guidance for the development and use of HIV/AIDS-related educational materials developed or acquired in whole or in part using CDC HIV prevention funds and to require the establishment of at least one Program Review Panel by state and local health departments, to consider the appropriateness of messages designed to communicate with various groups. State and local health departments may, if they deem it appropriate, establish multiple Program Review Panels to consider the appropriateness of messages designed to communicate with various groups.

A. Written materials (e.g., pamphlets, brochures, curricula, fliers), audiovisual materials (e.g., motion pictures and videotapes), pictorials (e.g., posters and similar educational materials using photographs, slides, drawings or paintings) and marketing, advertising, Web site-based HIV/AIDS educational materials, questionnaires or survey instruments should use terms, descriptors or displays necessary for the intended audience to understand dangerous behaviors and explain practices that eliminate or reduce the risk of HIV transmission.

B. Written materials, audiovisual materials, pictorials and marketing, advertising, Web site-based HIV/AIDS educational materials, questionnaires or survey instruments should be reviewed by a Program Review Panel established by a state or local health department, consistent with the provisions of section 2500(b), (c) and (d) of the Public Health Service Act, 42 U.S.C. Section 300ee(b), (c) and (d), as follows:

SEC. 2500. USE OF FUNDS.

(b) Contents of Programs.--All programs of education and

information receiving funds under this title shall include information about the harmful effects of promiscuous sexual activity and intravenous substance abuse and the benefits of abstaining from such activities.

(c) Limitation.--None of the funds appropriated to carry out this title may be used to provide education or information designed to promote or encourage, directly, homosexual or heterosexual sexual activity or intravenous substance abuse.

(d) Construction.--Subsection (c) may not be construed to restrict the ability of an educational program that includes the information required in subsection (b) to provide accurate information about various means to reduce an individual's risk of exposure to or to transmission of, the etiologic agent for acquired immune deficiency syndrome, provided that any informational materials used are not obscene.

C. Educational sessions should not include activities in which attendees participate in sexually suggestive physical contact or actual sexual practices.

D. Program Review Panels must ensure that the title of materials developed and submitted for review reflects the content of the activity or program.

E. When HIV materials include a discussion of condoms, the materials must comply with Section 317P of the Public Health Service Act, 42 U.S.C. Section 247b-17, which states in pertinent part:

“educational materials . . . that are specifically designed to address STDs . . . shall contain medically accurate information regarding the effectiveness or lack of effectiveness of condoms in preventing the STD the materials are designed to address.”

II. Program Review Panel

Each recipient will be required to identify at least one Program Review Panel, established by a state or local health department from the jurisdiction of the recipient. These Program Review Panels will review and approve all written materials, pictorials, audiovisuals, marketing, advertising and Web site materials, questionnaires or survey instruments (except questionnaires or survey instruments previously reviewed by an Institutional Review Board--these questionnaires or survey instruments are limited to use in the designated research project). The requirement applies regardless of whether the applicant plans to conduct the total program activities or plans to have part of them conducted through other organization(s) and whether program activities involve creating unique materials or using/distributing modified or intact materials already developed by others. Materials developed by the U.S. Department of Health and Human Services do not need to be reviewed by a panel. Members of a Program Review Panel should understand how HIV is and is not transmitted and understand the epidemiology and extent of the HIV/AIDS problem in the local population and the specific audiences for which materials are intended.

A. The Program Review Panel will be guided by the CDC Basic Principles (see Section I above) in conducting such reviews. The panel is authorized to review materials only and is not empowered either to evaluate the proposal as a whole or to replace any internal review panel or procedure of the recipient organization or local governmental jurisdiction.

B. Applicants for CDC assistance will be required to include in their applications the following:

1. Identification of at least one panel, established by a state or local health department, of no less than five persons who represent a reasonable cross-section of the jurisdiction in which the program is based. Since Program Review Panels review materials for many intended audiences, no single intended audience shall dominate the composition of the Program Review Panel, except as provided in subsection d below.

In addition:

a. Panels that review materials intended for a specific audience should draw upon the expertise of individuals who can represent cultural sensitivities and language of the intended audience, either through representation on the panel or as consultants to the panels.

b. Panels must ensure that the title of materials developed and submitted for review reflect the content of the activity or program.

c. The composition of Program Review Panels must include an employee of a state or local health department with appropriate expertise in the area under consideration, who is designated by the health department to represent the department on the panel.

d. Panels reviewing materials intended for racial and ethnic minority populations must comply with the terms of a-c above. However, membership of the Program Review Panel may be drawn predominantly from such racial and ethnic populations.

2. A letter or memorandum to the applicant from the state or local health department, which includes:

a. Concurrence with this guidance and assurance that its provisions will be observed.

b. The identity of members of the Program Review Panel, including their names, occupations and any organizational affiliations that were considered in their selection for the panel.

C. When a cooperative agreement/grant is awarded and periodically thereafter, the recipient will:

1. Present for the assessment of the appropriately identified Program Review Panel(s) established by a state or local health department, copies of written materials, pictorials, audiovisuals and marketing, advertising, Web site HIV/AIDS educational materials, questionnaires and surveys proposed to be used. The Program Review Panel shall pay particular attention to ensure that none of the above materials violate the provisions of Sections 2500 and 317P of the Public Health Service Act.

2. Provide for assessment by the appropriately identified Program Review Panel(s) established by a state or local health department, the text, scripts or detailed descriptions for written materials, pictorials, audiovisuals and marketing, advertising and Web site materials that are under development.

3. Prior to expenditure of funds related to the ultimate program use of these materials, assure that its project files contain a statement(s) signed by the chairperson of the appropriately identified

Program Review Panel(s) established by a state or local health department, specifying the vote for approval or disapproval for each proposed item submitted to the panel.

4. Include a certification that accountable state or local health officials have independently reviewed written materials, pictorials, audiovisuals and marketing, advertising and Web site materials for compliance with Section 2500 and 317P of the Public Health Service Act and approved the use of such materials in their jurisdiction for directly and indirectly funded community-based organizations.

5. As required in the notice of grant award, provide to CDC in regular progress reports, signed statement(s) of the chairperson of the Program Review Panel(s) specifying the vote for approval or disapproval for each proposed item that is subject to this guidance.

D. CDC-funded organizations, which are national or regional (multi-state) in scope or that plan to distribute materials as described above to other organizations on a national or regional basis, must identify a single Program Review Panel to fulfill this requirement. Those guidelines identified in Sections I.A. through I.D. and II.A. through II.C. outlined above also apply. In addition, such national/regional panels must include, as a member, an employee of a state or local health department.

[Federal Register Doc. 04-13553, Filed 6-15-04, 8:45 am]



For more information
CDC's National Prevention Information Network
800) 458-5231 or www.cdcnpin.org

CDC National STD/HIV Hotline
(800) 227-8922 or (800) 342-2437
En Español (800) 344-7432
www.cdc.gov/std

Fact Sheet for Public Health Personnel:

Male Latex Condoms and Sexually Transmitted Diseases

In June 2000, the National Institutes of Health (NIH), in collaboration with the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and the United States Agency for International Development (USAID), convened a workshop to evaluate the published evidence establishing the effectiveness of latex male condoms in preventing STDs, including HIV. A summary report from that workshop was completed in July 2001 (<http://www.niaid.nih.gov/dmid/stds/condomreport.pdf>). This fact sheet is based on the NIH workshop report and additional studies that were not reviewed in that report or were published subsequent to the workshop (see "Condom Effectiveness" for additional references). Most epidemiologic studies comparing rates of STD transmission between condom users and non-users focus on penile-vaginal intercourse.

Recommendations concerning the male latex condom and the prevention of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), are based on information about how different STDs are transmitted, the physical properties of condoms, the anatomic coverage or protection that condoms provide, and epidemiologic studies of condom use and STD risk.

The surest way to avoid transmission of sexually transmitted diseases is to abstain from sexual intercourse, or to be in a long-term mutually monogamous relationship with a partner who has been tested and you known is uninfected.

For persons whose sexual behaviors place them at risk for STDs, correct and consistent use of the male latex condom can reduce the risk of STD transmission. However, no protective method is 100 percent effective, and condom use cannot guarantee absolute protection against any STD. Furthermore, condoms lubricated with spermicides are no more effective than other lubricated condoms in protecting against the transmission of HIV and other STDs. In order to achieve the protective effect of condoms, they must be used correctly and consistently. Incorrect use can lead to condom slippage or breakage, thus diminishing their protective effect. Inconsistent use, e.g., failure to use condoms with every act of intercourse, can lead to STD transmission because transmission can occur with a single act of intercourse.

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

Sexually Transmitted Diseases, Including HIV

Sexually transmitted diseases, including HIV

Latex condoms, when used consistently and correctly, are highly effective in preventing transmission of HIV, the virus that causes AIDS. In addition, correct and consistent use of latex condoms can reduce the risk of other sexually transmitted diseases (STDs), including discharge and genital ulcer diseases. While the effect of condoms in preventing human papillomavirus (HPV) infection is unknown, condom use has been associated with a lower rate of cervical cancer, an HPV-associated disease.

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

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

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

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

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

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

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

HIV / AIDS

HIV, the virus that causes AIDS

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

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

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

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

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

Discharge Diseases, Including Gonorrhea, Chlamydia, and Trichomoniasis.

Discharge diseases, other than HIV

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

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

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

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

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

Genital Ulcer Diseases and Human Papillomavirus

Genital ulcer diseases and HPV infections

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

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

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

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

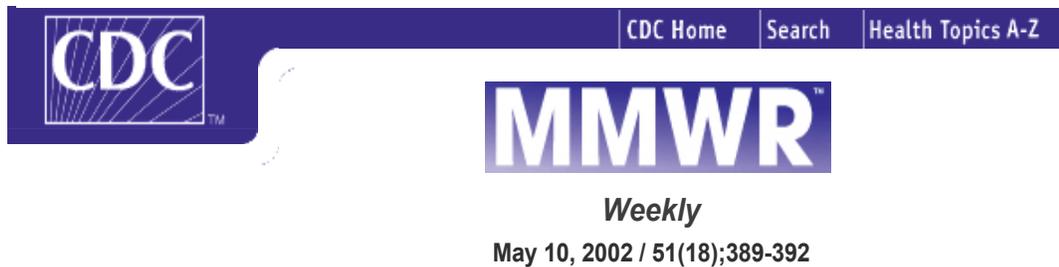
Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms can protect against the transmission of syphilis and genital herpes. However, some other epidemiologic studies show little or no protection. Many of the available epidemiologic studies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

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

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

Department of Health and Human Services

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



Nonoxynol-9 Spermicide Contraception Use --- United States, 1999

Most women in the United States with human immunodeficiency virus (HIV) become infected through sexual transmission, and a woman's choice of contraception can affect her risk for HIV transmission during sexual contact with an infected partner. Most contraceptives do not protect against transmission of HIV and other sexually transmitted diseases (STDs) (1), and the use of some contraceptives containing nonoxynol-9 (N-9) might increase the risk for HIV sexual transmission. Three randomized, controlled trials of the use of N-9 contraceptives by commercial sex workers (CSWs) in Africa failed to demonstrate any protection against HIV infection (2--4); one trial showed an increased risk (3). N-9 contraceptives also failed to protect against infection with *Neisseria gonorrhoeae* and *Chlamydia trachomatis* in two randomized trials (5,6), one among African CSWs and one among U.S. women recruited from an STD clinic. Because most women in the African studies had frequent sexual activity, had high-level exposure to N-9, and probably were exposed to a population of men with a high prevalence of HIV/STDs, the implications of these studies for U.S. women are uncertain. To determine the extent of N-9 contraceptive use among U.S. women, CDC assessed data provided by U.S. family planning clinics for 1999. This report summarizes the results of that assessment, which indicate that some U.S. women are using N-9 contraceptives. Sexually active women should consider their individual HIV/STD infection risk when choosing a method of contraception. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections.

CDC collected information on types of N-9 contraceptives purchased and family planning program (FPP) guidelines for N-9 contraceptive use. The national FPP, authorized by Title X of the Public Health Service Act, serves approximately 4.5 million predominantly low-income women each year. Program data for 1999 were obtained from all 10 U.S. Department of Health and Human Services (HHS) regions on the number of female clients and the number of female clients who reported use of N-9 contraceptives or condoms as their primary method of contraception. CDC obtained limited purchase data for 1999 for specific N-9 contraceptives and program guidelines from eight state/territorial FPPs within six HHS regions. State health departments, family planning grantees, and family planning councils were contacted to request assistance in collecting data on purchasing patterns of the 91 Title X grantees; of the 12 FPPs that responded, eight provided sufficient data for analysis.

In 1999, a total of 7%--18% of women attending Title X clinics reported using condoms as their primary method of contraception. Data on the percentage of condoms lubricated with N-9 were not available. A total of 1%--5% of all women attending Title X clinics reported using N-9 contraceptives (other than condoms) as their primary method of contraception (Table 1). Among the eight FPPs that provided purchase data, most (87%) condoms were N-9--lubricated (Table 2). All eight FPPs purchased N-9 contraceptives (i.e., vaginal films and suppositories, jellies, creams, and foams) to be used either alone or in combination with diaphragms

or other contraceptive products. Four of the eight clinics had protocols or program guidance stating that N-9--containing foam should be dispensed routinely with condoms; two additional programs reported that despite the absence of a clinic protocol, the practice was common. Data for the other two programs were not available.

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

Editorial Note:

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

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

The findings in this report are subject to at least two limitations. First, data on specific products and patterns of contraceptive use were limited; CDC used a nonrepresentative sample of regions and states that voluntarily provided data, and specific use patterns of the contraceptives could not be extrapolated from these data. Second, data correlating use of N-9 contraceptives with individual HIV risk were not available.

Prevention of both unintended pregnancy and HIV/STD infection among U.S. women is needed. In 1994, a total of 49% of all pregnancies were unintended (9). Furthermore, 26% of women experience an unintended pregnancy during the first year of typical use of spermicide products (1). In 1999, a total of 10,780 AIDS cases, 537,003 chlamydia cases, and 179,534 gonorrhea cases were reported among U.S. women. Contraceptive options should provide both effective fertility control and protection from HIV/STDs; however, the optimal choice is probably not the same for every woman.

N-9 alone is not an effective means to prevent infection with HIV or cervical gonorrhea and chlamydia (2,7). Sexually active women and their health-care providers should consider risk for infection with HIV and other STDs and risk for unintended pregnancy when considering contraceptive options. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections. In addition, women seeking a family planning method should be informed that latex condoms, when used consistently and correctly, are effective in preventing transmission of HIV and can reduce the risk for other STDs.

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Table 1

TABLE 1. Number of women using male condoms or nonoxynol-9 (N-9) products as their primary method of contraception, by Title X Family Planning Region — United States, 1999

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

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

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

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Table 2

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

State/territory	No. of clients served	Physical barrier method		N-9 chemical barrier methods				
		Condoms with N-9	Condoms without N-9	Gel	Vaginal		Jelly	Foam
					Film	Insert		
Puerto Rico	15,103	148,072	5,000	12,900	0	NA*	12,841	2,400
New York†	283,200	1,936,084	NA	0	73,788	NA	3,112	23,830
West Virginia	60,899	1,300,000	9,360	0	0	NA	1,200	9,900
Florida	193,784	3,920,000	560,000	0	468,720	NA	5,760	25,920
Tennessee	111,922	9,985,480	717,000	0	64,500	10,500	750	0,750

Tennessee	111,223	2,003,100 [†]	117,000	0	94,000	12,020	700	2,700
Michigan	166,893	631,000	254,000	0	0	NA	1,000	1,200
Oklahoma	58,392	708,480	0	0	394,560	NA	1,200	0
Oregon	57,099	151,900	276,000	345	25,764	2,074	272	3,007

* Not available.

[†] 41 of 61 grantees responded.

[‡] Purchasing by family planning and sexually transmitted disease programs are combined and cannot be separated.

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Notice to Readers: CDC Statement on Study Results of Product Containing Nonoxynol-9

During the XIII International AIDS Conference held in Durban, South Africa, July 9--14, 2000, researchers from the Joint United Nations Program on AIDS (UNAIDS) presented results of a study of a product, COL-1492,* which contains nonoxynol-9 (N-9) (*I*). N-9 products are licensed for use in the United States as spermicides and are effective in preventing pregnancy, particularly when used with a diaphragm. The study examined the use of COL-1492 as a potential candidate microbicide, or topical compound to prevent the transmission of human immunodeficiency virus (HIV) and sexually transmitted diseases (STDs). The study found that N-9 did not protect against HIV infection and may have caused more transmission. The women who used N-9 gel became infected with HIV at approximately a 50% higher rate than women who used the placebo gel.

CDC has released a "Dear Colleague" letter that summarizes the findings and implications of the UNAIDS study. The letter is available on the World-Wide Web, <http://www.cdc.gov/hiv>; a hard copy is available from the National Prevention Information Network, telephone (800) 458-5231. Future consultations will be held to re-evaluate guidelines for HIV, STDs, and pregnancy prevention in populations at high risk for HIV infection. A detailed scientific report will be released on the Web when additional findings are available.

Reference

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

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