

NIA: A Program of Purpose for African-American Men

A Video-Based Motivational Skills-Building HIV Risk Reduction Intervention for Inner-City African-American Men

Intervention Guide and Session Outlines

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A guide for the HIV risk reduction intervention reported in the article **Effectiveness of a Video-Based Motivational Skills-Building HIV Risk Reduction Intervention for Inner-City African-American Men** by Kalichman, S.C., Cherry, C. and Brown-Sperling, F. (1999). *Journal of Consulting and Clinical Psychology*, 67, 959–966.

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Introduction

This manual summarizes key issues involved in implementing theory-based HIV risk reduction skills building interventions delivered to inner-city African-American men. The intervention described here was tested in a randomized clinical study. Results were promising and were consistent with the results of other small group interventions for persons at-risk for HIV infection. The intervention can be implemented in a variety of settings and can be adapted for use in community programs, substance abuse treatment centers, and public health clinics.

Outcomes of a randomized trial testing the effects of this intervention are published in Kalichman S.C., Cherry, C., & Brown-Spelling, F. (1999). **Effectiveness of a Video-Based Motivational Skills-Building HIV Risk Reduction Intervention for Inner-City African American Men.** *Journal of Consulting and Clinical Psychology*, 67, 959–966.

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HIV Risk Reduction Intervention for Inner-City African-American Men

African-Americans living in urban areas are at increased risk for contracting HIV infection.

African-American men and women are disproportionately represented among U.S. AIDS cases; more than one-third of U.S. AIDS cases have occurred among African-American men and women. African-American heterosexual men and women are several times more likely to be diagnosed with AIDS than their white counterparts. HIV infection is also a leading cause of death among young African-American men and women. Increased risk for HIV infection among African-Americans has historically stemmed from higher rates of injection drug use and having injection drug using sexual partners, although new HIV infections are increasingly attributed to heterosexual contact with a non-injection drug using partner. In a cohort of African-American men and women in New York City, men demonstrated nearly twice the HIV infection rate of women (Brunswick et al., 1993). African-American men infected with HIV are unlikely to be tested for HIV antibodies and are therefore often unaware of their HIV serostatus (Brunswick et al., 1993).

There is a particular need for HIV prevention interventions targeted to African-American men.

African-American men living in inner-cities consistently demonstrate being misinformed about HIV transmission (Aruffo et al., 1991; DiClemente et al., 1988, 1992), and high rates of HIV sexual risk behaviors (El-Bassel & Schilling, 1991). For example, data from the National AIDS Behavioral Research Surveys have shown that 30% of African-American heterosexual men in U.S. inner-cities report having two or more sexual partners in the past year (Peterson et al., 1993). Despite high rates of HIV seroprevalence, misperceptions of risk, and high-rates of heterosexual transmission of HIV, there are few HIV prevention interventions targeted to African-American men. This is in contrast to the several HIV-related descriptive studies (e.g., Kalichman et al., 1992; Nyamathi et al., 1993) and HIV prevention interventions that have specifically targeted risk reduction among women of color (e.g., Hobfall et al., in press; Jemmott & Jemmott, 1992; Kelly et al., in press). However, women face numerous barriers in their efforts to reduce their risk for HIV infection, including men's willingness to wear condoms. Although women may become more effective in communicating the need to practice safer sex and can request, negotiate, or assert that a man should wear a condom, ultimately men control the use of condoms. Disproportionate control of males in power imbalanced heterosexual relationships sets limits on the success of women to effect risk reduction behavior change if men are resistant to wear condoms (Ulin, 1992). Women who suggest the use of condoms with a resistant sexual partner may raise partner suspicions about their monogamy or sexual histories, find themselves vulnerable to verbal and physical abuse (Mays & Cochran, 1988; Stuntzner-Gibson, 1991), and therefore experience rejection and the potential

loss of support from their relationship partners. **Placing the responsibility for HIV-risk reduction solely on women may be unfair and potentially less effective than establishing positive condom use attitudes among men to reduce risk for HIV infection.** Social and cultural issues specifically relevant to men of color are likely a necessary component in targeted HIV prevention interventions (Peterson & Marin, 1988). Such factors as male pride, racial and sexual identity, receiving respect, and maintaining sexual pleasure while reducing risk may be used to embed procedures for risk reduction. Values, beliefs, and roles held by men must be significantly and appropriately addressed for prevention efforts to produce risk behavior changes (DiClemente, 1992). Thus, interventions that target African-American men will require socio-cultural and gender specificity in addition to a sound theoretical intervention framework.

Videotapes have demonstrated promise for use in HIV prevention.

Videotapes have been widely used as a part of HIV prevention interventions. Most commonly, videotape message have been intended to convey information about HIV transmission, dispel myths about HIV and AIDS, emphasize the use of condoms, and challenge risk promoting attitudes. For the most part, videotapes have been included in group interventions as a means of presenting education information and stimulating discussion. For example, Wenger et al. (1992) randomly assigned college students to participate in either a one-hour AIDS education intervention which included an 11-minute videotape presentation, the education intervention plus HIV antibody testing, or a no intervention control group. Students who participated in the education groups with and without HIV testing increased the number of times they discussed HIV-risk with their sexual partners. However, the videotape only constituted one-tenth of the information presented. Similarly, Quirk et al. (1993) included a "Rap" videotape in combination with brochures as a means of presenting HIV-risk and risk reduction information in a prevention intervention for male and female adolescents and young adults. Results demonstrated improved knowledge and changed attitudes for participants in the videotape intervention. Changes in HIV-related knowledge and self-efficacy have been demonstrated in other videotape-based interventions (Maibach & Flora, 1993; Stevenson & Davis, 1994). Other studies have investigated the effects of more extensive videotape messages as a vehicle for delivering HIV-risk prevention interventions.

In a study of 1,458 women outpatients sampled from prenatal and pediatric clinics in Kigali, Rwanda, Africa, participants viewed a 35-minute education videotape in small groups undergoing HIV antibody testing (Allen, Serufulira et al., 1992). The videotape included information about HIV transmission and the effective use of condoms and spermicides to reduce risk for HIV infection (Allen, Tice et al., 1992). Following the videotape, women participated in a group discussion facilitated by a physician and social worker. Results showed that declines in HIV seroconversion and gonorrhea rates among study participants were associated with the intervention, particularly for women whose sexual partners also underwent testing. This suggests that videotaped education in

combination with HIV antibody testing reduced sexual risk behaviors when procedures include specific instructions for the use of condoms, and when information occurs in a context which facilitates the integration of risk-related information with personal values. Allen et al. concluded that videotape messages provide an inexpensive educational and motivational tool for instructing persons about HIV and reducing personal risk for infection.

Brief videotape interventions have also shown promise in educating African-American male STD clinic patients about STD transmission, detection of STD symptoms, and methods of STD prevention (Solomon & DeJong, 1988, 1989). In general, videotape presentations have been among the most effective means of educating risk populations about STDs (Healton & Messeri, 1993). With respect to HIV prevention, three studies have used experimental designs to evaluate the effects of HIV-AIDS prevention videotapes on HIV-risk reduction. Solomon and DeJong (1989) randomly assigned inner-city STD patients, primarily African-American men, to either view a "soap opera style" (p. 453) videotape portraying condoms as socially acceptable and modeling effective communication skills to negotiate condom use, or to a no intervention control group. Results showed that persons who viewed the videotape increased their knowledge about HIV demonstrated more positive attitudes toward condom use, and could generate more strategies for negotiating condom use relative to persons who did not view the videotape. However, reductions in HIV-risk behaviors were not reported. In another study, Winett et al. (1992) developed a home-based videotape education program for young adolescents and their parents. The program was based on social learning theory and consisted of four 30-minute videotapes that focused on modes of HIV transmission, the link between substance use and HIV-risk, modeling problem solving skills, assertiveness skills, and role-play situations for family and adolescent practice. Forty-five families were randomly assigned to participate in the home videotape intervention or to a wait-list control group. Winett et al. reported increases in knowledge about HIV-risk and increases in behavioral skills related to risk reduction, both of which were maintained over a 6-month follow-up period. Unfortunately, HIV-risk-related behavior change was not reported. Finally, a third experimental study to test the effectiveness of HIV-risk reduction videotape messages was conducted with African-American women living in inner-city housing projects in Chicago. Kalichman et al. (1993) randomly assigned women to view one of three 20-minute AIDS information videotapes: (1) the first three segments of a standard public health service video message; (2) the exact same information and graphics used in the standard videotape but with ethnicity and sex of presenters matched to the study participants; and (3) the same basic HIV information as the other two conditions presented by the same three women as in the second condition, but with information couched in a context that stressed values and concerns specifically relevant to African-American women. The results showed that all three tapes increased knowledge about HIV and AIDS, but the videotape that highlighted a socio-cultural context resulted in significantly more women talking with friends about HIV and AIDS, requesting condoms from the investigators, and

obtaining HIV antibody testing. Unfortunately, like the other experimental tests of HIV information videotape messages, this study did not find change in sexual behaviors related to HIV risk. These interventions, however, were limited by either lacking theoretically based instruction for risk reduction (Solomon & DeJong, 1989; Kalichman et al., 1993), or targeting samples with relatively low base-rates of risk behaviors (Winnett et al., 1992).

Videotape interventions will be most effective when they are tailored to targeted populations.

Interventions based on social cognitive theory and cognitive behavioral principles must be couched in socially, culturally, and personally relevant terms and situations. If skills training applications are to be effective, it is essential that they make sense in the context of an individual's lifestyle and social relationships. To discern personally relevant contextual information, it has been recommended that intervention research be preceded by descriptive studies, both quantitative and qualitative, in order to elicit information about the socio-cultural factors that are related to HIV-risk producing situations (Fisher & Fisher, 1992). Effective HIV prevention interventions are those which adapt intervention content, descriptions of risk-producing situations, behavior change examples, and situational role play scenarios to match cultural, gender, and sexual orientation characteristics of participants, such that interventions fit the expectations and life situations of participants. In the case of videotape interventions, presentations should be tailored for cultural and gender appropriateness, salience, and relevance (Kalichman et al., 1993; Stevenson & Davis, 1994). Unlike face-to-face interventions which can be adjusted by group facilitators for alignment with participant characteristics, videotapes are standardized. Therefore, in order to achieve maximum salience and personal relevance, videotape interventions should be tailored to specific populations segments (Kalichman et al., 1993; Skinner et al., 1994).

Based on these identified needs and promising intervention avenues, the National Institute of Mental Health funded our research group in 1994 to test the effects of video-based HIV risk reduction intervention for inner-city African-American men. The intervention was grounded in the Information-Motivation-Behavioral Skills (IMB) model of HIV prevention and was delivered in small groups of men recruited from public health clinics. The following intervention guide was derived from this study.

HIV Prevention in Groups

The first face-to-face HIV education programs occurred in groups. Conducted by community-based organizations, particularly grass-roots organizations of gay men living in AIDS epicenters, the earliest HIV prevention programs provided information about this new threat to community and personal health, and instruction in how to prevent HIV infection. Early group interventions used a variety of techniques to raise awareness and motivate behavior change, with a particular emphasis on reducing numbers of sex partners.

Well-organized peer led HIV prevention workshops were developed in the middle 1980's, just a few years into the AIDS crisis. Founded in 1985, *STOP AIDS* used a "Tupperware Party" approach to hold prevention groups in homes of volunteers. Gay Men's Health Crisis was also among the first agencies to organize small group education programs that emphasized techniques for eroticizing safer sex. One of the first safer sex workshops was *Hot, Horny, and Healthy*; also a peer led program delivered in community settings. Group discussions focused on how AIDS was affecting gay men and how men could maintain sensual and erotic sex lives while remaining safe from the scourge of AIDS. These first safer sex workshops blended basic information about sexual transmission risks with personal, expressive, and emotional discussions of homophobia, sex roles, relationships, and values.

The next generation of group interventions went beyond risk education to emphasize characteristics of partners, situations, and relationships that contribute to risk. Focusing on persons at greatest risk for HIV infection, namely gay and bisexual men, and injection drug users and their sex partners, small group interventions incorporated hands-on, practical learning experiences to rehearse risk reduction behaviors.

Direct experience with condoms, identifying situational barriers to behavior change, and role playing communication with sex partners, for example, were geared toward building confidence in one's ability to initiate and maintain behavioral changes. Second generation group interventions were therefore built upon the AIDS education and awareness activities of first generation interventions, but with a greater emphasis on relationship skills, sexual situations, and interpersonal interactions. Skills building is the key element that has moved AIDS education to more effective HIV prevention.

Why Prevention in Small Groups?

Groups allow for peer interaction

Small group interventions bring people with a common risk history together. Group members influence each other in ways that educators and counselors cannot. Just as peers influence risk-taking behavior, peers also influence preventive actions. The group experience can have powerful effects on individual behavior.

Groups offer teachable moments

Individuals can observe others, share experiences, practice new skills, and receive feedback from peers in the group. Bringing together people who are facing similar challenges to reducing their risk for HIV offers opportunities for shared learning.

The group environment can shape behavior

The HIV prevention group represents a slice of a community. The group also becomes a community itself. Groups challenge perceptions that promote risk and shift attitudes to support prevention.

Groups are a familiar venue for service delivery

Many community services are provided through groups; support groups, education workshops, substance abuse treatment groups, and so forth. HIV risk reduction group interventions can be built upon these existing structures or can be infused into existing services.

What is a Small Group?

- Groups consist of 4 to 16 people of common backgrounds who sit in a circle or semi-circle to share a common experience.
- One or two skilled facilitators lead groups, one of whom must match the gender and ethnicity of the majority of group members.
- HIV prevention groups are not classes, lectures, or forums.
- Groups create a context through which people can interact, examine their risks, develop skills to reduce their risks, and receive feedback from others.
- Groups can be held almost anywhere that has a private room big enough to comfortably seat people in a circle or semi-circle.

Evidence for Group Intervention Effectiveness

HIV risk reduction interventions based on theories of behavior change and delivered to small groups have been demonstrated effective with a variety of at-risk populations. Studies have consistently shown that these prevention interventions lead to reductions in unprotected intercourse and increased use of condoms. Observed changes are often stronger than those found in other areas of health promotion. Scientific reviews have shown these approaches to be effective. The US Office of Technology Assessment (1995) concluded:

Interventions developed through in-depth preliminary work with the target population that consist of small group programs that are interactive and include skills development, have been among the most successful at reducing risky sexual and drug-related behaviors. (p.2)

A National Institutes of Health Consensus Panel (1997) concluded:

(Group) Interventions are effective for reducing behavioral risk for HIV/AIDS. These interventions should be widely disseminated. Their application in practice settings may require careful training of personnel, close monitoring of fidelity of procedures, and ongoing monitoring of effectiveness.

Some of the key intervention studies and their findings are listed below.

Study	Intervention and Effects
Kelly et al. (1)	12 sessions with MSM increased use of condoms from 23% of anal intercourse acts at pre-test to 77% use at 8-month follow-up.
Peterson et al. (2)	3 3-hour sessions for African-American MSM reduced unprotected intercourse from 46% of men at pre-test to 20% one year later.
Kelly et al. (3)	4 sessions with African-American women reduced unprotected sex and increased condom use from 26% to 56% at 3-months.
Carey et al. (4)	4 sessions with African-American women reduced unprotected vaginal intercourse and increased condom use over 3-months.
DiClemente & Wingood (5)	5 2 hour sessions with African-American women increased consistent condom use from 20% to 37% at 3-months.
Rotheram-Borus et al. (6)	20 sessions with runaway adolescents increased consistent use of condoms from 33% to 63% at 6-months follow-up.
Jemmott et al. (7)	5 hour workshop for African-American adolescents reduced high risk sex over a 3-month period.

Key Elements of Effective Interventions

- The curriculum is derived from behavioral theories of risk reduction. All group interventions that have been shown to successfully reduce high-risk behavior have been theory-based.
- Successful groups are held in safe and accessible places.
- Group facilitators are credible and skilled in group dynamics.
- Effective group interventions educate, motivate, and build skills.
- Effective interventions are tailored to the lives and culture of group participants.
- The group experience is intensive and interactive. Information is delivered through the process of the group.
- Group facilitators do not lecture. The role of the facilitator is to weave the intervention content into the group process. The facilitator listens more than she or he speaks.
- Effective groups create a safe place for people to examine themselves and openly share experiences. Groups are built upon trust and confidentiality.
- Skills building groups require an average of 6 hours of contact. Effective interventions have been delivered in 4 90-minute sessions, 2 3-hour sessions, as well as single 6-hour workshops.
- Successful group interventions are fun. Information is placed in a context that is relevant to the life of the person. Effective group interventions are tailored to fit the world of the group members.
- Incentives for participating can include food, opportunities to meet new people, having time away from children, and interacting with others.

Theories of Behavior and Behavior Change

Successful HIV risk prevention interventions are grounded in sound behavioral theory. Although other models have been useful in developing HIV prevention activities, The Theory of Reasoned Action and Social Cognitive Theory have been the most influential. In addition, the Information-Motivation-Behavioral skills framework provides clear directions for designing the content of HIV prevention programs.

Theory of Reasoned Action. The Theory of Reasoned Action broadly explains human behavior and has been applied to many health-related behaviors. Attitudes about behaviors and perceived norms for practicing behaviors form intentions, which are only one step away from engaging in a specific behavior. Intentions are the product of attitudes, beliefs, and perceptions, all of which are influenced by social interactions and experiences. Attitudes and beliefs shared among members of a community, or social norms, serve as important social forces that influence intentions and behavior.

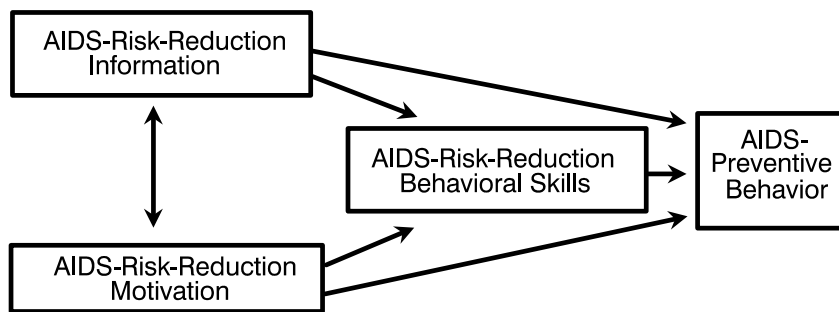
Application to Groups. Groups are environments where attitudes and beliefs can be challenged and changed. Norms are shaped in groups, which in turn effect behavior.

Social Cognitive Theory. Social Cognitive Theory is based on the notion that behaviors, environment, attitudes, and beliefs are interactive and interdependent. There are constant interactions between a person's behaviors, thoughts and feelings, and the environment around them. Social Cognitive Theory emphasizes the role of self-efficacy beliefs, defined as "one's capabilities to organize and execute the courses of action required to produce given attainments" (Bandura, 1997, p. 3). Self-efficacy is related to the confidence one has in performing specific actions. Self-efficacy can be enhanced by observing others successfully perform an action and its consequences. Social Cognitive Theory also highlights the complexity of behavior, where thoughts and feelings influence behavior, and behavior affects the environment, which in turn influences thoughts and feelings, and so forth. The concept that thoughts, behaviors, and the environment are constantly changing each other is called reciprocal determinism.

Application to Groups. Skills development through modeling, practice, and feedback are effectively delivered in groups for the purpose of building self-efficacy to perform risk-reducing actions. Group facilitators and peers model new behaviors through demonstrations and interactions. Practice sessions include role-plays and behavioral rehearsals, providing first hand experience with skills in a social setting. Feedback and reinforcement in the group build self-efficacy for practicing behaviors in the real world.

Information-Motivation-Behavioral Skills (IMB) Model

In a model derived to explain HIV risk reduction behavior, Fisher and Fisher (1992) proposed a three factor conceptualization of AIDS-preventive behavior: information, motivation, and behavioral skills (IMB). The IMB model states that information about modes of HIV transmission and methods of preventing transmission is a necessary precursor to risk reduction behavior. Motivation to change also directly affects whether one acts on information about risk and risk reduction. Finally, the model states that behavioral skills related to preventive actions are a common pathway for expressing information and motivation in AIDS preventive behaviors. The IMB model assumes that information and motivation activate behavioral skills to ultimately enact risk reduction behaviors. The IMB is therefore constructed from elements found in other theories, but configured specifically for HIV risk reduction.



Application to Groups. Groups provide a context for delivering all aspects of information, motivation, and behavioral skills building. Group exercises and activities serve as vehicles for educating, motivating, and facilitating skills development.

The IMB Model formed the basis for the content of our intervention targeted to inner-city men.

Dimensions of Our Group Intervention Content – Process – Context

Content

The content of an intervention lives in the curriculum, goals, objectives, activities, and exercises. In theory-based HIV prevention interventions, the content is represented in informational, motivational, and skills building activities. Our intervention for men incorporated these dimensions as they were captured in the following concepts.

Information

- Educational materials concerning HIV infection and AIDS, HIV transmission risks, preventive behaviors, and dispelling myths.
- Information is least effectively delivered in lectures and most effectively delivered in interactive exercises – games, myths and facts flash cards, and videos with accompanying discussion.
- Videotapes effectively educate about basic HIV-AIDS information. Videos can also increase interest and motivation for behavior change. Videotapes can maintain attention and stimulate discussion. Group discussions following videotapes are important for integrating information.

Motivation

- Information can be motivating when it is personally relevant – linked to the life of the person.
- Presenting local epidemiological data in a simple straightforward manner can increase awareness about the extent of AIDS.
- Videotape presentations of people living with HIV who are matched to the gender and ethnicity or the group can heighten awareness. Such tapes show people with HIV telling their stories to convey a message about “AIDS in our community”.
- Activities that allow people to reflect back on their own behavior and how their behavior may be placing them at-risk for HIV can help motivate behavior change.

Behavioral skills

HIV prevention behavioral skills are actions that can be performed to reduce HIV risks. The process of behavioral skills building includes three steps:

- **Modeling:** Demonstrations of successful behaviors performed by other people like oneself.
- **Practice:** Acting out and rehearsing skills in the group setting.
- **Feedback:** Reinforcing, supportive responses and suggestions following practice.

Risky situation management skills

Identifying risk situations or “triggers” such as partner characteristics, places, substance use, and moods or feelings raises awareness and is the first step to risk avoidance. Activities involve having group members reflect on their own behavior and risky situations to learn signs that may signal risks in the future.

Problem solving skills

Problem solving deals with risky situations and barriers to risk reduction. Steps to problem solving include: brainstorming solutions, evaluating options, prioritizing options, setting goals, planning strategies, implementing a strategy, and revising the strategy as needed. Steps to problem solving are illustrated in the group.

Condom use and safer sex skills

Education about male and female condoms, their proper use, and lubricants using hands-on behavioral rehearsal.

Group facilitators using anatomical models demonstrate correct condom application. Following modeling, members practice correct condom placement in the group.

Group experience with condoms should be fun and anxiety reducing.

Handling condoms in a group of peers can reduce embarrassment about condoms and shift negative attitudes to greater acceptance.

Communication skills

Communication skills building occurs through the same three steps as behavioral skills: modeling, practice, and feedback.

Negotiating safer sex

Discussing safer sex options and finding an agreeable level of safety.

Sexual assertiveness

Getting one's needs met while acknowledging a partner's feelings and exhibiting mutual respect.

Risk refusal

Refusing to practice unsafe sex without provoking negative reactions from partners.

Communication skills are developed in role-play situations that allow persons to initiate risk reduction communications. Role-plays can use stem-situations as a framework in which to respond. An example role play stem-situation:

While out with some friends and having fun, you unexpectedly run into an ex-partner from your past. You had sex with this person many times before. They start telling you how much they missed being with you and that they think of you often. Then they say that they are not currently partnered. You are feeling good and the mood seems right for the two of you to get together. Because you still like this person and have feelings for them you are wanting to be with this person. The person says "Let's say we have some times like we used to... I really want you..." What would you say...

Movie clips for role-plays. Another way to stimulate role-plays for communication skills building is to use scenes edited from popular films. Scenes that precede a sexual interaction, or prelude to sex scenes, offer examples that people can identify with and can relate to. Scenes are shown for participants to place themselves in the situation and state what they would say to make the situation safer.

Personally generated role-play scenes. Participants can generate scenes from their own lives where it was difficult to practice safer sex. The group member can try new communications out in the safe space of the group.

Group Process

- The group process is the conduit through which the intervention content flows. Process is the active ingredient in a small group intervention.
- Effective group processes keep AIDS in perspective. AIDS will not be the top agenda item for most people who attend a prevention group. Acknowledging other pressing issues such as discrimination, prejudice, homophobia, unemployment, substance abuse, violence, and other social ills that form the context of AIDS increases intervention credibility. It can also be pointed out that of all social problems and personal threats, AIDS is one that can be completely personally controlled.
- Powerful feelings are usually associated with AIDS. Effective groups process feelings of anger, distrust, resentment, fear, and ambivalence.

Group facilitators

Group facilitators are the essential ingredients to effective groups.

Roles of the group facilitator

- Acts as a catalyst for change.
- Inspires, informs, and motivates individuals to self-examine and initiate change.
- Guides persons to integrate prevention in their lives as well as in their communities.
- Manages the group process and delivers the intervention content.
- Enhances the experience of each group member.
- Serves as a resource to the group.

Qualities of effective facilitators

Personal characteristics

Genuine	Insightful about self
Attracted to groups	Appealing to others
Believable	Authentic
Honest	Trustworthy
Flexible	Active listener
Empathetic	Sober or in recovery

Group skills

Able to promote communication	Understands group dynamics
Able to adapt to existing structures	Capable of belonging to the group
Can let go of personal agendas	Authentic and generous
Able to manage and control problems	Discloses appropriately
Appreciates people's lives	Open to sharing
Focused more on others than self	Willing to maintain eye contact
Has a modulated voice	Effectively uses humor
Understanding and nonjudgmental	Respectful of group members
Is aware of differences	Negotiates power in group
Willing to provide candid feedback	Has a network of services
Does not rely on "recipes"	Assures comfort
Follows up on identified needs	Takes time to learn from the group

Qualities of ineffective facilitators

Oriented toward individuals more than groups
Places personal needs before group needs
Anxious in groups
Overly charismatic – needing to be the center for the group
Has an “us versus them” mentality
Views self above the group
Needs to dominate the discussion
Inflexible and non-adaptive
Physically and emotionally removed
Lacks sensitivity to the needs of others

Training and supporting facilitators

- Effective group facilitation is emotionally draining. HIV prevention groups deal with issues of poverty, loss, drugs, and sex.
- Group facilitators can benefit from their own support group with a skilled facilitator to help them express and deal with issues, solve problems, and trouble shoot.
- Supervision for a broad range of facilitator skills is important for ongoing success.
- Organizations need to have ongoing mechanisms for assessment and reassessment of facilitators. Opportunities for feedback and ongoing facilitation skills development are essential.
- Technical assistance to group facilitators should be available for dealing with issues and problems as they arise.
- Co-facilitators maximize group interactions and prevent facilitators from becoming overwhelmed.

Context

Assuring a good fit between intervention content, group process, and the lives of group members.

- Language is a key aspect of group context. Terms must be familiar and clearly relevant to the individuals in the group.
- Keeping AIDS in its place in terms of other often more pressing social problems. Poverty and substance abuse are among the factors that form the context of AIDS.
- Rituals and other cultural practices from the lives of participants bring the intervention content closer to the person.
- The group itself can help shape intervention context. The group can explore values and meaning of safer sex and AIDS.

Examples of contextual aspects of the group from research include:

Peterson et al. dedicated an entire session to self-esteem and dealing with issues of being an African-American man who has sex with men.

Kelly et al. included children, family, and communal responsibility as the frame for information and skills building for African-American women.

DiClemente and Wingood read poems written by African-American women in their women's groups.

Kalichman et al. discussed social problems facing men and women living in the inner city and the relative controllability of such challenges.

Jemmott et al. used a basketball game as the context for AIDS educational activities for adolescents. Personal responsibility and pride were themes that framed much of the intervention content.

Overcoming Barriers to Groups

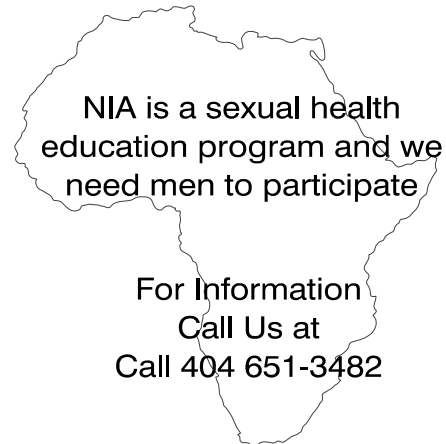
Marketing

Letting people know about a prevention group can be as easy as distributing flyers, placing ads in targeted media, and soliciting referrals from other service providers.

The figure to the right provides a sample flyer used to recruit African-American men for a group intervention.

NIA

A Program of Purpose for African-American Men



Getting people to come

Multiple session groups face great challenges of getting people to commit to the group and show up for sessions.

Incentives help. Providing food for the group, childcare, T-shirts, caps, food to take home, paper goods, and other products are all examples of incentives. Some funding agencies have recently allowed budgets to pay people for coming to prevention groups. Cash is a very effective incentive for participating in prevention groups.

Session Outlines for NIA: HIV Risk Reduction Intervention for Inner-City African-American Men

Session I

Introduction to the Program and HIV-AIDS Risk Reduction Education

Explanation of the Program

This program is designed to inform people about AIDS and ways that they can protect themselves and others from the deadly virus that causes AIDS.

The program has 3 main goals:

1. To educate people about AIDS and it is affecting their community
2. To bring groups of men together to share information and experiences about AIDS
3. To help people learn new ways that they can protect themselves and others from AIDS

The group will provide a laboratory for all members to learn from the group leaders, resources brought in for the group experience, and most importantly, from each other.

The rules of the group:

- The group belongs to the members
- No one will be required to share, but all are encouraged to share
- Sitting in a circle will help make the group a more open experience
- The role of the group leaders is to bring resources to the group, provide information, and facilitate open discussions
- All information and discussion in the group will remain confidential. Each member takes an oath for respecting each others rights to privacy

Introduction to AIDS

Questions to stimulate discussion:

- What information have you heard about AIDS? Where did you hear it?
- Who is at risk for AIDS?
- How does AIDS affect people?
- What are the ways that a person can protect themselves from AIDS?

Introduce educational videotape “When Men Talk About AIDS”

- View video that shows a group of men asking questions about AIDS that are answered by a female AIDS educator
- Discussion following “When Men Talk About AIDS”
- Discuss the issues raised in the tape
- Was any of the information new for you? Any surprises?
- Facilitate a general questions and answers session.
- Encourage participants to ask questions and facilitate group discussion for answers

Introduce the book “*Answering Your Questions About AIDS*”

Give each participant a copy of the book

Go through the table of contents with the group and explain that the book will be used at the start of each session to review questions and answers that each group member may have.

Because the book is written on a 9th grade reading level, most group members should be able to read this book.

AIDS Myths and Facts Activity

- Use Myths and Facts flash cards
- Show one side of card to group and ask whether it is a myth or fact AND WHY.
- It is important for the participants to explain why they believe the statement is either a myth or fact.
- Ask group for agreement / disagreement. For persons who disagree about whether the statement is a myth or fact, they too must explain why. Facilitators should provide accurate answer and move on to the next card until all cards are used.
- Complete exercise by asking group members if there are any additional myths about AIDS they have heard that were not included in the cards.

HIV Continuum Activity

Introduce this activity by asking the group to name all of the ways that a person can get HIV-AIDS. Because this activity comes after the education videotape and the myths and facts activity, most participants should say through drug needles and sex.

- This activity focuses on sexual behaviors that can transmit HIV.
- The activity involves each group member receiving a card with a sexual behavior printed on it with a velcro backing. Participants then place their Sex
- Behavior cards on the Risk Continuum under the risk label “No Risk”, “Low Risk” Medium Risk”, High Risk”, or “Very High Risk” they believe it should be.
- After all cards are placed on the continuum have the group discuss the placements and rearrange as a result of the group discussion.
- The final continuum should have the Unprotected Vaginal and Unprotected Anal Intercourse cards under the “Very High Risk” category. Under high

risk, should be Unprotected Oral Sex and Vaginal and Anal Intercourse with Condoms.

- All other behaviors should be under Low Risk and No Risk categories.
- The completed continuum provides a visual for the very few high risk sex activities compared to the very many low-no risk behaviors.
- The group should discuss the completed continuum.

Discussion of how condoms can reduce the risk of sexual intercourse.

Condoms place a barrier between the virus and another person.

HIV does not penetrate latex when the latex is not torn.

Sing water-based lubricants increases the safety of condoms.

Anything containing oil will degrade the latex and make condoms less effective.

- **Defining risky sexual behaviors**
- Group generates an array of sexual behaviors as risky for contracting and transmitting HIV.
- Although there are ambiguities, each participant will recognize the relative risks posed by various behaviors.
- Discuss individual definitions of safer and safe sex.

Identify sex behavior options that reduce risks, including:

- Not having sex (abstain)
- Having orgasm without intercourse - Mutual Masturbation.
- Using condoms during sex.
- Introduce the use of problem solving skills practiced in previous sessions for managing sexual risks.

End Session I

Ask the group if there are any more questions or comments.

For a homework assignment, ask the group to come back with 2 questions they found most informative in the book *Answering Your Questions about AIDS*.

Session II

Behavioral Skills to Reduce AIDS Risk

Reintroduce group members

Review what was covered in Session I

Ask members which 2 questions they found most interesting as they started to look through the *Answering Your Questions* book.

Use group process to discuss the questions and answers that group members bring up.

Introduce the videotape “HIV-AIDS Infecting and Affecting our Community”

View video that shows five men infected with HIV all representing different transmission modes and stages of HIV disease

Discuss the tape by focusing on what these men seemed to be experiencing and how HIV has affected their lives.

Use the group to bridge a discussion about what people can do to reduce their risks for HIV and other STDs. The discussion should be broad-based, but should include condoms as an option for reducing risks.

What a person can do to reduce their risks for HIV-STDs will depend very much upon the situation.

Ask the group to think about situations that may place people at risk and to think about what it is about the situations that they think make it risky.

Have the group process various aspects of relationships and sexual situations that can influence their risk.

The aspects of situations that can increase risks for unsafe sex are called “Triggers”.

Identifying and managing triggers

- Triggers are aspects of a situation that suggest, promote, or facilitate unsafe sex.
- Group generates potential triggers - factors in situations that can lead to, promote, or signal potential risks.

- Include among types of triggers: people, places, aspects of the environment, moods, substances....
 - People who influence our behavior can be triggers - name some potential people who can serve for triggers for unsafe sex.
 - Have group generate list of People Triggers.
 - Managing people as triggers requires communication skills, such as assertiveness and negotiation skills covered earlier.
 - Place triggers involve where you are and what is going on around you.
 - Have group identify places that can serve as triggers.
 - Moods and Feelings can also be triggers with very powerful reasons for risky behavior, including thoughts and temptations.
 - Have group generate list of mood and feeling triggers.
 - Substances can also be triggers to risky behavior. Drugs and alcohol are examples of substances that can affect our ability to make decisions and lowers inhibitions.
 - Have group brainstorm list of Substance triggers.
 - Group members identify personal triggers and record them in their Personal Risk Reduction Plan along with strategies for managing each trigger.
 - Have group members record their triggers and place sexual values handout in their sexual Personal Risk Reduction Plan.

- Using problem-solving to manage triggers
- Review steps to problem-solving as applied to trigger management:
 - Identify the sexually risky situation and its triggers.
 - Identify the goal for that situation.
 - Brainstorm alternative courses of action.
 - Evaluate choices.
 - Act on the best choice.
- Walk through each step to address sexual risk producing situations generated by the group.

Safer sex alternatives

- Although understanding personal risky situations can help avoid risks, and negotiating with a partner can address interpersonal issues in sexual situations, personal choices of what to do and not to do with a partner are important aspects of any given sexual situation.
- Review what creates risks for partners and self and what activities are safer and those that are safe.
- Use decisional balance and problem solving skills from previous sessions to apply to safer sex decisions.
- Brainstorm safer sex activities and how they can become incorporated into sexual relationships.
- Group shares views and experiences of having satisfying sex lives as a person living with HIV.
- Address issues of drug cultures, survival sex, and shared responsibility for safer sex as appropriate within a group.

Condom skills and other alternatives to unsafe sex

- Continue discussion of safer sex alternatives.
- Discuss the pros and cons of condoms using group process and brainstorming.
- Dealing with condom anxiety and condom aversions:
Acknowledge that many people with AIDS develop aversions toward condoms because they can symbolize AIDS and death.
Negative images of condoms can be directly addressed through desensitization techniques incorporated with methods for eroticizing condom use.
- Group discussion of how condoms can be easier if eroticized- made fun and sexy to use.
- Elicit examples of ways participants have made or think they can make condom use more erotic with their partners.
- Revisit condoms pros and cons generated earlier and use problem solving techniques for addressing each disadvantage.

Proper use of male condoms

- Explain why it cannot be assumed that everyone knows how to use a condom.
- Explain why it is important to be comfortable with condoms and how handling them in the light, with peers, can increase comfort and increase proper use.
- Play the video ***It's all about condoms*** to demonstrate condom application and sensitive group to condom use. Discuss reactions to the video and the products that were presented.
- Facilitators model correct condom use on a wooden penis models. Exaggerating each step, demonstrating slowly, talking through each step of application:

- First choose a latex condom.
- Make sure you check the expiration date on the package or box.
- Next, open the package being careful not to tear the condom or use your nails or teeth.
- Check to see which way the condom rolls.
- Place the condom on the head of the penis, making sure the reservoir tip sticks out
- Pinch the reservoir tip to let all the air out.
- Slowly unroll the condom all the way down to the base of the penis.
- If lubrication is desired, choose water based (e.g., KY jelly etc.) rather than oil based (e.g., Vaseline) lubricant.
- Removal:
 - Hold the condom at the base of the penis and pull out of your partner before the penis goes soft.
 - Roll the condom up and remove it, making sure that the fluid doesn't spill out.
 - Dispose of the condom in the trash can.
- Group members practice applying and removing condoms with facilitator guidance and feedback from other group members.

Lubricants for latex condoms

- Discuss in detail the importance of lubricants and the difference between water-based and water-soluble lubricants.
- Demonstrate how oil-based lubricants dissolve latex condoms.
- Display a variety of possible lubricants and discuss each one for their use with latex condoms.

Proper use of female condoms

- Using the same rationale and steps as the male condom, discuss and apply skills training for the female condom.
- Include both its use during vaginal and anal intercourse, but note that when used during anal intercourse the inner ring must be removed and that its safety and effectiveness for this use has not yet been tested.
- Discuss the pros and cons of the female condom.
- Allow group to practice application of female condoms on anatomical models.

Play the video *AIDS Education for African-American Men* to reinforce safer sex messages and to end group on an up-beat, fun note!

End Session II

Ask the group if there are any more questions or comments.
For a homework assignment, ask the group to come back with 2 questions they found most informative in the book *Answering Your Questions about AIDS*.

Session III

Communication and Negotiation Skills

Reintroduce group members

Review what was covered in Session II

Ask members which 2 questions they found most interesting as they started to look through the *Answering Your Questions* book.

Use group process to discuss the questions and answers that group members bring up.

Sexual communication skills building

- Open discussion about what constitutes sexual communication, both verbal and non-verbal.
 - Focusing on verbal, review characteristics of assertive communication.

- Discuss issues of sexual coercion and pressures to practice unsafe sex.
- Open discussion of barriers to being assertive and negotiating safer sex in various types of relationships.
- Identify viable solutions to identified barriers.
- Role play effective responses to risky situations, first using example scenarios followed by participant generated scenarios.

Example scenario

Imagine that you are in a long-term sexual relationship with a person . The two of you had been using condoms since you started having sex. You feel good about yourself and your life with this person. One evening your partner tells you that he/she wants to experience an even higher level of closeness with you and wants to have unprotected intercourse, just this one time. You have very strong feelings for this person and the idea of taking your relationship to another level is very appealing to you.

Role play what you would say to this partner in this situation

- Have the group generate additional scenarios to practice communicating with seropositive and seronegative sex partners.
- Using steps of modeling, practice, and guided feedback, participants will be instructed in sexual assertiveness, negotiating safer sex, refusal of unsafe sex.
- Include the following steps in negotiation/assertiveness role plays:
 - Acknowledging partner's point of view.
 - Firmly stating own point of view - such as refusal to practice unsafe sex.
 - Explaining the reason for refusal - such as concern for health and safety of self and partner.
 - Suggest alternative safer sex activities.
 - Seek agreement from partner.

Play movie clips video for continued practice of communication skills, as well as trigger identification and problem solving skills. Using the scenes presented in the movie clips, as participants to identify triggers in the situation, generate safer sex options, and state a line that the man could have said to initiate condom use. Play each movie clip through once, and then repeat for skills practice.

All of the scenes are from PG and R-rated motion pictures with African-American men and women, including *Boyz in the Hood*, *Jason's Lyric*, *Coming to America*, and *Rage in Harlem*. The use of these clips in group settings for the purpose of education and without profit is legal under fair-use statutes. Following a brief introduction by the facilitators to set-up the scenes, the movie clips (2-3 minutes each) are shown one-at-a-time. Scenes are stopped at points where participants are asked what the man in the scene could say or do at that moment to create a safer sex experience.

- Continue sexual communication role plays using movie clips for remaining time in session.

End Session III

Ask the group if there are any more questions or comments.
For a homework assignment, ask the group to come back with 2 questions they found most informative in the book *Answering Your Questions about AIDS*.

Session IV Review, Reinforcement, and Wrap-up

Reintroduce group members

Review what was covered in Session II

Ask members which 2 questions they found most interesting as they started to

look through the *Answering Your Questions* book.

Use group process to discuss the questions and answers that group members bring up.

This session is dedicated to reviewing all of the information, motivation, and behavioral skills building that occurred in Session I-III.

Each participant should be encouraged to discuss what he or she thought was most and least useful. Participants should be reinforced for having come to the group and for making an effort to change their behavior to reduce risks for HIV and other STDs.

Repetition and reinforcement should therefore be the focus of this session.

Participants should be asked to verbally state at least one goal that they have as they leave the group.

Goals can include talking with others about what they learned, getting tested for HIV, seeking further education and prevention experiences, using condoms more, having fewer sex partners, or anything else that signals movement toward HIV-STD risk reduction.