

HIV PREVENTION TOOLKIT

Tools to assist your organization to implement and improve HIV prevention programs in your community

ENGLISH



Go Green!
Only print if necessary



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Proyecto IDEAS is a capacity building assistance program led by JSI Research & Training Institute and funded by the Centers for Disease Control and Prevention (CDC) under grant # U65/CCU123717-05 to provide capacity building assistance (CBA) to health departments and organizations offering HIV prevention programs for the Latino/Hispanic community in Colorado, Iowa, Kansas, North Dakota, South Dakota, Missouri, Montana, Nebraska, Utah and Wyoming. As a result and in an effort to provide you with more effective tools in the prevention of HIV, we wish to present you with the Proyecto IDEAS HIV Prevention Tool-kit!

This kit was created in order to share information that could benefit your department or organization in implementing and improving HIV prevention services and other programs. We have collected a wide variety of tools related to the Diffusion of Effective Behavioral Interventions (DEBIs), cultural competence, needs assessments, facilitation techniques and a number of other content areas into one resource for your organization's convenience and use. We hope you find the resources we have compiled to be extremely useful, and that you share them with a variety of current and future staff members.

If you have any questions, comments, or would like more information about our services or training in any of these skill areas, please contact us at proyectoideas@jsi.com or your CBA provider.

Sincerely,

JSI Proyecto IDEAS Team



It is important for organizations implementing HIV prevention interventions to know the basic information about this virus. The following information describes the difference between HIV and AIDS and includes some other basic information related to the topic.

HUMAN – it can be transmitted among human beings

IMMUNODEFICIENCY – a malfunctioning defense system

VIRUS – an extremely small organism that enters and lives inside living cells in order to survive

There is no medicine or vaccine to prevent HIV, though there are drugs that help control the effects of the virus.

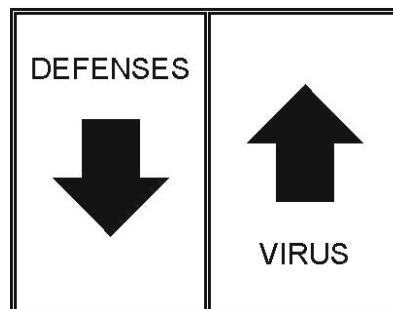
When a virus enters a healthy human body, the human body creates defenses to fight against that specific virus. At the same time, the body will create defenses to prepare the body in case the same virus tries to enter the body again.

HIV AND THE IMMUNE SYSTEM

The human immune system is a collection of mechanisms within the body that protects us from viruses and other agents such as bacteria. The immune system needs to distinguish these agents from the body's own healthy cells and tissues in order to function properly. When a person acquires HIV, it attacks the immune system and changes its function to reproduce HIV instead of creating more defenses.

Since HIV enters the body's cells, one would have to destroy the cell in order to eliminate the virus.

When an individual is infected with HIV, the defenses in his/her body, called "T-cells", will decrease and the virus will replicate in the cells. At some point, medicine will be needed to maintain the virus load low and the defenses high.



The immune system is considered deficient when it can no longer fight off infections and diseases. People with a deficient immune system are more susceptible to a wide range of infections, most of which are rare among people with a healthy immune system. These infections associated with severe immunodeficiency are known as opportunistic infections because they take advantage of a weakened immune system.

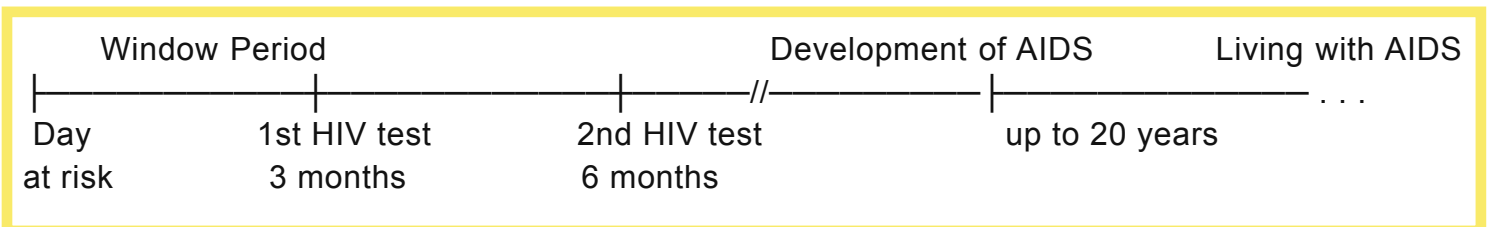
HIV CONTRACTION AND TRANSMISSION

HIV is a virus that constantly changes and because it is inside the cell it cannot be recognized as an external body. These are two important reasons why HIV tests look for HIV antibodies (the natural defenses against HIV) instead of the virus itself. Depending on the person's immune system, it can take a window period of 3 months after the individual has been infected with HIV for an HIV test to detect the antibodies.

HIV is carried by blood, semen, vaginal fluids and breast milk and can be transmitted through the exchange of any of these fluids between two or more people with at least one of the individuals already infected (see table on page 4).

If a person has HIV it does not mean that he or she has AIDS. HIV is not the same as AIDS and with proper care, treatment and medicine it can take as long as 20 years for a person infected with HIV to develop AIDS.

HIV TO AIDS TRANSITION



The timeline above looks at a continuum from the exact date of infection of a single exposure, however most people don't know the exact date when they got infected. As a result, during the window period a person should take precautions as if he/she was already infected with HIV since that person can transmit the virus to others as early as 24 hours after being infected even if it cannot be detected by a test. This means that a person can be infected and infect others without knowing it.

Many testing counselors recommend taking a second test six months after the day of exposure. This is enough time for the HIV antibodies to develop. If the person is infected with HIV, a test will certainly identify it in this second test.

AIDS

ACQUIRED – it was obtained from someone else

IMMUNE – refers to the defense system

DEFICIENCY – below standards

SYNDROME – combination of typical major symptoms

AIDS is not a disease, but a combination of symptoms. AIDS is not what kills people. It is the opportunistic diseases which take advantage now that the immune system is weak.

Only a doctor can diagnose a person with AIDS when the patient has his/her T-cell count drop below 200 cells per cubic millimeter. This means that the HIV is replicating and the immune system is significantly weakened, and as a result extremely susceptible to opportunistic infections.

It is important to know that the natural development of HIV will be to reproduce. This is the moment when the cells invaded by HIV are destroyed and the virus spreads throughout the body. Nevertheless, there are cases of people who have lived up to 20 years without developing AIDS, while others might develop AIDS sooner.

HIV PREVENTION METHODS

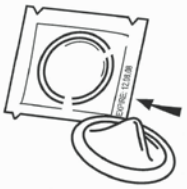





There has been tremendous progress in decreasing the risk of HIV transmission from blood transfusion including questioning of donors concerning HIV risk behaviors, use of the confidential exclusion option, and laboratory meticulous testing of each donated unit of blood.

The current rate of HIV seropositivity in the blood donor population is approximately 0.5 per 10,000 donations, a value extremely low after the introduction of routine HIV antibody screening in 1985.

The following chart illustrates the types of risk, the behaviors and the prevention methods.

Type of risk	Risk Behavior	Prevention methods
Infected sexual partner	Unprotected sexual vaginal, anal, or oral sex	<ul style="list-style-type: none"> - Abstinence - Practice only non-penetrative sex - Use male or female condoms correctly from the beginning of the penetration - Use dental dams for oral sex - Reduce the number of sexual partners in combination of correct use of condoms in every sexual encounter - Monogamy with a non-infected sexual partner
Infected injecting partner	Sharing needles, syringes, sharp instruments, or preparation equipment	<ul style="list-style-type: none"> - Avoid injecting drugs - Always use new and disposable needles and syringes - Do not share drug-preparation equipment with others - Clean all equipment with water, then chlorine and clean water again - Do not share cleaning equipment with other people
Infected Mother to child	During pregnancy, delivery, or breast feeding	<ul style="list-style-type: none"> - Seek medical supervision throughout pregnancy - Treatment with antiretroviral drugs during the last period of the pregnancy - Caesarian section - Avoiding breastfeeding, using powder milk instead or any other approved breastfeeding replacement. - Antiretroviral prophylaxis regiment for newborns

HOW TO USE A MALE CONDOM

	<p>1. Always check the expiration date on your condoms before using them!</p> <p>To open, tear along one side of the foil, making sure not to rip the condom inside and carefully remove the condom.</p>
	<p>2. Put the condom on when the penis is erect, before there is any contact between the penis and your partner's body. Fluid released from the penis, even during the early stages of an erection including pre-semen as well as semen during an ejaculation can contain sperm and organisms that can cause sexually transmitted infections (STIs) and/or pregnancy.</p>
	<p>3. Air trapped inside a condom could cause it to break. To avoid this, squeeze the closed end of the condom between your forefinger and your thumb and place the condom over the erect penis.</p> <p>Be sure that the roll of the condom is on the outside!</p>
	<p>4. While still squeezing the closed end, use your other hand to unroll the condom gently down the full length of the penis. Make sure the condom stays in place during sex. If it rolls up, roll it back into place immediately.</p> <p>If the condom comes off, withdraw the penis and put on a new condom before intercourse continues.</p>
	<p>5. Soon after ejaculation, withdraw the penis while it is still erect by holding the condom firmly in place. Remove the condom only when the penis is fully withdrawn.</p> <p>Keep both the penis and condom clear from contact with your partner's body.</p>
	<p>6. Dispose of the used condom hygienically. Tie a knot in the middle of the condom to avoid exposure to semen. Wrap the condom in a tissue and place it in a trash can (do not flush it down the toilet).</p> <p>NEVER USE THE SAME CONDOM MORE THAN ONCE!</p>

If you have any questions, please contact us at proyectoideas@jsi.com or contact your CBA provider.

CAPACITY BUILDING AND THE DIFFUSION OF EFFECTIVE BEHAVIORAL INTERVENTIONS (DEBI)

What is capacity building?

Capacity building is a key strategy for the promotion and sustainability of health prevention programs. It refers to the skills, infrastructure, and resources of organizations and communities that are necessary to affect and maintain behavior change, thus reducing the level of risk for disease.

What types of services are offered?

The Capacity Building Division at the CDC facilitates numerous services that are free to all health departments and their grantees as well as directly funded grantees. Some examples of these services are listed in the table below. Notice that these services can be grouped in four key areas:

- 1) Services that address the organizational infrastructure;
- 2) Services that help you implement evidence-based interventions;
- 3) Services that help you strengthen access to and utilization of HIV prevention services; and
- 4) Training that strengthens the capacity of community planning groups as well as ensures parity, inclusion and representation of all affected populations.

SAMPLE SERVICES OFFERED BY THE CDC CAPACITY BUILDING BRANCH

1) *Strengthening Organizational Infrastructure for HIV Prevention*

- Organizational assessment
- Fiscal management
- Proposal development/grant writing
- Human resources management
- Information systems and data management
- Program policy development
- Volunteer recruitment and management
- Board development and training
- Cross-cultural communications
- Program marketing and public relations
- Organizational quality assurance and monitoring
- Strategic planning
- Resource development
- Licensing and certification issues for HIV rapid testing

SAMPLE SERVICES OFFERED BY THE CDC CAPACITY BUILDING BRANCH

2) Strengthening Interventions for HIV Prevention

- Cultural appropriate adaptation and implementation of science-based interventions
- Quality assurance and evaluation of effective HIV prevention interventions
- Needs assessment, priority-setting and preparation for the delivery of interventions
- Development of effective health communication messages and community-based research methods
- Development of effective staff training and linkages to racial/ethnic minority researches

3) Strengthening Community Access and Utilization of HIV Prevention Services

Training and technical assistance to build capacity to:

- Implement selected models locally
- Conduct needs assessments
- Conduct readiness assessments and preparation
- Develop materials and resources
- Test health messages and conduct medical outreach
- Mobilize and develop multi-sector partnership
- Conduct quality assurance and evaluation
- Develop service linkages to counseling and testing sites

4) HIV prevention community planning and improving the parity, inclusion and representation of racial/ethnic minority populations in the community planning process

Training and Technical Assistance to CPGs, HDs, and CBOs can include the following:

- Use of data for decision making and prioritization strategies
- Public speaking and persuasion
- Group and meeting facilitation
- Leadership development
- Assertiveness skills training
- Consensus building
- Partnership and coalition building
- Cultural sensitivity
- Parliamentary procedures, meeting processes, and group facilitation
- Process management
- HIV Prevention Community Planning Guidance training

How do I access these services?

If you are a directly funded grantee, just contact your program officer and he/she will instruct you on how to obtain CBA services. If you receive HIV prevention services funding through your local health department, please contact a representative of your State Health Department and ask them how to obtain these CBA services for HIV Prevention.

Why DEBI?

The Centers for Disease Control and Prevention (CDC) compiled interventions for change behavior that are proven to be effective and are also science-based. These interventions have been proven effective through research studies that showed positive behavioral (e.g., use of condoms; reduction in number of partners) and/or health outcomes (e.g., reduction in the number of new STD infections).

The idea is to bring science-based, individual, community and group level HIV prevention interventions to community-based services and state and local health departments to promote healthy behaviors in the communities.

Why adaptation?

In order to be able to implement any of the evidence-based behavioral interventions, facilitators need to be trained in the intervention, and most of the time, receive technical assistance and other capacity building strategies around the interventions to adapt them for the particular target population. Capacity Building Assistance (CBA) providers funded by the CDC can help you in your journey.



Change behavior theories apply to everybody, but the way the messages are sent, the language, and the fact that they need to be culturally appropriate suggest that adaptation is a very important step in order to have an intervention that is successful if well implemented.

All the interventions can be adapted to different populations as long as the core elements remain intact.

What are core elements?

They are those elements that define the “soul” of the intervention, if they were to be modified the intervention would be a reinvention. Core elements cannot be changed.

What are the characteristics?

Characteristics can be changed: the number of sessions, length of the session, or any other item, except for the core elements, that you might need to change in order to better accommodate the training to your target population's availability.

Why would you need to adapt an intervention?

Most likely the intervention was researched in an urban or rural setting, with a particular ethnic group, etc. If you are trying to implement the same intervention in another setting or different ethnic group you might need to adapt it to your target population's particular culture.



DESCRIPTION OF BEHAVIORAL INTERVENTIONS, INCLUDING THE THEORY BEHIND THEM, LEVEL TARGET POPULATION AND CORE ELEMENTS (Interventions are not listed in any particular order).

LEGEND	All population	Men and Women of color	Youth	MSM	Heterosexual	Men	Women
	Non injector drug users	People living with HIV/AIDS	Commercial sex worker	IDUs	Run away	Homeless	

Community PROMISE

TARGET POPULATION



INTERVENTION LEVEL

Community Level



Community PROMISE is a community-level HIV prevention intervention that relies on peer advocates distributing role model stories of positive behavior change to members of the target population. The intervention is based on Stages of Change and other behavioral theories, and can be implemented with various populations including IDUs, MSM, sex workers, and partners of high risk individuals.

- Community identification process to collect information about HIV/STD risk behaviors and influencing factors in their community.
- Creating role model stories based on personal accounts from individuals in the target population who have made positive behavior change.
- Recruiting and training peer advocates from the target population to distribute role model stories and prevention materials.
- Continuous formative evaluation to capture behavior change within the target population.

Mpowerment	TARGET POPULATION	INTERVENTION LEVEL
<div data-bbox="289 499 578 577" data-label="Image"> </div> <p data-bbox="131 779 782 1115">Mpowerment is a intervention for young men who have sex with men. The intervention combines informal and formal outreach, discussion groups, creation of safe spaces, social opportunities, and social marketing to reach a broad range of young gay men with HIV prevention, safer sex, and risk reduction messages.</p>	<div data-bbox="959 279 1013 331" data-label="Image"> </div> <ul data-bbox="834 415 1495 1087" style="list-style-type: none"> • Recruiting a core group of young gay men to design and carry out project activities. • Establishing a project space where many of the project activities can be held. • Conducting entertaining, venue-based (e.g. bars, community events) outreach by teams of young gay men. • Sponsoring social events to promote community building among young gay men. • Convening peer-led, one-time discussion groups. • Conducting a publicity campaign about the project within the community. 	<p data-bbox="1203 285 1463 317">Community Level</p>

Popular Opinion Leader (POL)	TARGET POPULATION	INTERVENTION LEVEL
<div data-bbox="354 1430 532 1528" data-label="Image"> </div> <p data-bbox="131 1629 782 1917">Popular Opinion Leader (POL) is a community-level HIV prevention intervention designed to identify, enlist, and train opinion leaders to encourage safer sexual norms and behaviors within their social networks of friends and acquaintances through risk reduction conversations.</p>	<div data-bbox="867 1272 1081 1329" data-label="Image"> </div> <ul data-bbox="834 1402 1495 1745" style="list-style-type: none"> • Identify and recruit Popular Opinion Leaders to advocate risk reduction. • Train cadres of Popular Opinion Leaders to conduct risk reduction conversations. • Support and reinforce successive waves of Popular Opinion Leaders to reshape social norms. 	<p data-bbox="1203 1283 1463 1314">Community Level</p>

Real AIDS Prevention Project (RAPP)

TARGET POPULATION



INTERVENTION LEVEL

Community Level



Real AIDS Prevention Project (RAPP) is a community mobilization program designed to reduce risk for HIV and unintended pregnancies among women in communities at high risk by increasing condom use. This intervention relies on peer-led outreach activities, including: stage based encounters, role model stories and brochures, community networking, referrals, safer sex discussions, and condom distribution. RAPP is based on the transtheoretical model of behavior change.

- Conducting community outreach using peer networkers.
- Having one-on-one, safer sex discussions based on the client's stage of readiness to change.
- Using printed stories about community members and safer sex decisions (role model stories).
- Obtaining program support from community organizations and businesses (community networking).
- Sponsoring small group activities, such as safer sex gathering and HIV prevention presentations.

Healthy Relationships

TARGET POPULATION



INTERVENTION LEVEL

Group Level



Healthy Relationships is a five-session, small-group intervention for men and women living with HIV/AIDS. It is based on Social Cognitive Theory and focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills.

- Defining stress and reinforcing coping skills with people living with HIV/AIDS across three life areas:
 - Disclosing to family and friends.
 - Disclosing to sex partners.
 - Building healthier and safer relationships.
- Using modeling, role-play and feedback to teach and practice skills related to coping with stress.
- Teaching decision-making skills around the issue of disclosure of HIV status.
- Providing participants with Personal Feedback Report, based on the Initial Assessment Survey, to motivate change of risky behaviors and continuance of protective behaviors.
- Using movie-quality clips to set up scenarios around disclosure and risk reduction to stimulate discussions and role-plays.

Holistic Health Recovery Program (HHRP+)

TARGET POPULATION



INTERVENTION LEVEL

Group Level



Holistic Health Recovery Program (HHRP) is a 12-session, manual-guided, group-level intervention for HIV positive and HIV negative injection drug users. The intervention is based on the Information, Motivation, Behavior (IMB) model of behavior change to promote health and improve quality of life.

- Skills to reduce harm of injection drug use and unprotected sexual activities.
- Negotiation skills to reduce unsafe sexual behaviors with sexual partners and teaches skills to heal social relationships.
- Decision making and problem solving skills using cognitive remediation strategies.
- Goal setting skills including developing action plans to achieve goals.
- Skills to manage stress, including relaxation techniques and understanding what aspects of the stressful situation can, and cannot, be controlled.
- Skills to improve health, health care participation, and adherence to medical treatments.
- Skills to increase clients' access to their own self-defined spiritual beliefs, in order to increase motivation to engage in harm reduction behaviors.
- Skills to increase awareness of how different senses of self can affect self-efficacy and hopelessness.

Many Men, Many Voices (3MV)

TARGET POPULATION



INTERVENTION LEVEL

Group Level



Many Men, Many Voices (3MV) is a seven-session, group-level STD/HIV prevention intervention for gay men of color. The intervention addresses behavioral influencing factors specific to gay men of color, including cultural/social norms, sexual relationship dynamics, and the social influences of racism and homophobia.

- Educate clients about HIV risk and sensitize to personal risk.
- Develop risk reduction strategies.
- Train in behavioral skills.
- Train in partner communication and negotiation.
- Provide social support and relapse prevention.

VOICES/VOCES

TARGET POPULATION



INTERVENTION LEVEL

Group Level



VOICES/VOCES is a single-session video-based intervention designed to increase condom use among heterosexual African American and Latino men and women who visit STD clinics. Participants, grouped by gender and ethnicity, view an English or Spanish video on HIV risk behaviors and condom negotiation, take part in a facilitated discussion on barriers to and negotiation of condom use, and receive samples of condoms.

- Viewing culturally-specific videos portraying condom negotiation.
- Conducting small group skill-building sessions to work on overcoming barriers to condom use.
- Educating program participants about different types of condoms and their features.
- Distributing samples of condoms identified by participants as best.

Together Learning Choices (TLC)

TARGET POPULATION



INTERVENTION LEVEL

Group & Individual Levels



Together Learning Choices (TLC) is a group-level intervention based on cognitive-behavioral strategies to change behavior for young people living with HIV. This program helps young people living with HIV identify ways to increase use of health care, decrease risky sexual behavior and drug and alcohol use, and improve quality of life. It emphasizes how contextual factors influence ability to respond effectively to stressful situations, solve problems, and act effectively to reach goals.

- Help clients develop awareness and identify feelings, thoughts and actions.
- Teach, model, and practice 4 core skills (emotional regulation, SMART problem solving, goal setting, and assertiveness).
- Reinforce positive client behavior through the use of thanks tokens.
- Help clients identify their ideal self to help motivate and personalize the behavior change.
- Deliver sessions in highly participatory, interactive small groups.

SISTA Project



SISTA is a group-level, gender and culturally relevant intervention, designed to increase condom use among heterosexually active African American women. Five peer-led group sessions are conducted that focus on ethnic and gender pride, HIV knowledge, coping, and skills training around sexual risk reduction behaviors and decision making. The intervention is based on Social Learning theory as well as the theory of Gender and Power.

TARGET POPULATION



INTERVENTION LEVEL

Group Level

- Conduct small group sessions to discuss the session objectives, model skills development, role play women’s skills acquisition.
- Utilize skilled facilitators to implement group sessions.
- Utilize cultural and gender appropriate materials to acknowledge pride, enhance self worth in being a woman from x culture.
- Train women in sexual assertion skills, so that they can demonstrate care for partners and negotiate safe behaviors.
- Teach women proper condom use—SISTA is designed to foster positive attitudes and norms towards consistent condom use and provide women appropriate instruction for placing condoms on their partner.
- Discuss cultural and gender triggers that may make it challenging for women to negotiate safer sex.
- Emphasize the importance of partner involvement in safer sex—the homework activities are designed to involve the male partner.

Safety Counts



Safety Counts is a client-centered intervention for users of illicit drugs that aims to reduce risk of becoming infected with or transmitting HIV and hepatitis viruses. The intervention is a behaviorally focused, seven-session intervention, including both structured and unstructured activities in group and individual settings over four to six months. The intervention can be implemented with both HIV-negative and HIV-positive clients.

TARGET POPULATION



INTERVENTION LEVEL

Group & Individual Levels

- Group Sessions 1 & 2 (one session each).
- Individual Behavioral Counseling Session (one session minimum).
- Social Events (2 minimum).
- Follow-Up (2 minimum).

Street Smart

TARGET POPULATION



INTERVENTION LEVEL

Group & Individual Levels



Street Smart is a multi-session, skills-building program to help runaway and homeless youth practice safer sexual behaviors and reduce substance use. Sessions address improving youth's social skills, assertiveness and coping mechanisms through exercises on problem solving, identifying triggers, and reducing harmful behaviors. Agency staff also provide individual counseling and trips to community health providers.

- Enhancing affective and cognitive awareness, expression and control.
- Teaching HIV/AIDS risk hierarchy and its personal application.
- Identifying personal triggers, using peer support and small group skills-building sessions.
- Building participant's skills in problem solving, personal assertiveness, and HIV/AIDS harm reduction.

¡Cuidate!

TARGET POPULATION





INTERVENTION LEVEL

Group Level



¡Cuidate! The word ¡Cuidate! which means “take care of yourself,” is the theme of this culturally-based program designed to reduce HIV sexual risk among Latino youth (13 – 18 years old). The ¡Cuidate! program incorporates cultural beliefs that are common among Latino subgroups and associated with sexual risk behavior. The intervention is based on Social Cognitive Theory, Theory of Reasoned Action and Theory of Planned Behavior.

- Incorporating the theme of ¡Cuidate! — taking care of oneself and one's partner, family and community—throughout the program.
- Using culturally-and linguistically-appropriate materials and activities to show and emphasize core Latino cultural values, specifically familialism and gender-roles, and how those are consistent with safer sex behavior.
- Incorporating activities that increase knowledge and influence positive attitudes, beliefs, and self-efficacy regarding HIV sexual risk-reduction behaviors.
- Modeling and practicing the effective use of condoms.
- Building participants' skills in problem solving, negotiation of safe sex, and refusal of unsafe sex.
- Delivering sessions in highly participatory, interactive small groups.

Focus on Youth	TARGET POPULATION	INTERVENTION LEVEL
		<p>Group Level</p>
<p>Focus on Youth (FOY) and ImPACT. FOY is an intervention that provides youth with the skills and knowledge they need to protect themselves from HIV and other STDs. The curriculum, founded on the Protection Motivation Theory, uses fun, interactive activities such as games, role plays, and discussions to convey prevention knowledge and skills. There is also a short component for parents, Informed Parents and Children Together (ImPACT), that assists them in areas such as parental monitoring and effective communication.</p>	<ul style="list-style-type: none"> • Delivering the intervention to Youth in community based- settings. • Two skilled facilitators to implement the Youth group. • Using “social networks” to strengthen peer support. • Using culturally appropriate interactive activities proven as effective learning strategies to help youth capture the important constructs in the theory. • Including a family tree to contextualize and personalized abstract concepts. • Enabling participants to learn and practice a decision making model. • Training participants in assertive communication and refusal skills related to negotiation of abstinence or safer sex behaviors. • Teaching proper condom use skills. • Involvement of the youth’s parents or other significant adults in the intervention. 	

Informed Parents and Children Together (ImPACT)	TARGET POPULATION	INTERVENTION LEVEL
<p>This is a component for parents with their youth</p>	<p>Parents</p>	<p>Individual Level</p>
<p>ImPACT is a short component of FOY for parents, Informed Parents and Children Together (ImPACT), that assists them in areas such as parental monitoring and effective communication.</p>	<ul style="list-style-type: none"> • Delivering intervention one-on-one to parent guardian in the home or other community based setting. • Using a facilitator whom parents find credible. • Delivering intervention prior to youth beginning FOY or before session 3. • Before session 3. • Use of an entertaining documentary that shows the challenges and importance of parents monitoring and talking to their children 12 -15 about sex, abstinence, STD’s and condoms. 	

Informed Parents and Children Together (ImPACT)

TARGET POPULATION

Parents

INTERVENTION LEVEL

Individual Level

This is a component for parents with their youth

ImPACT is a short component of FOY for parents, Informed Parents and Children Together (ImPACT), that assists them in areas such as parental monitoring and effective communication.

- Video must be watched with Parent/Guardian, and Youth.
- Enabling Parent/Guardian and Youth to learn and practice communication skills.
- Teaching Parent/Guardian and Youth proper condom use skills.
- Distributing and guiding parent/guardian and Youth through a resource guide that discusses communication, parental monitoring, proper condom use and STD/HIV among young African Americans.

Respect

TARGET POPULATION



INTERVENTION LEVEL

Individual Level



RESPECT is the first individual level intervention to be added to the DEBI project. The RESPECT intervention utilizes a client-focused, interactive HIV risk reduction counseling model based on Project RESPECT. The intervention is designed to support risk reduction behaviors by increasing the client's perception of his/her personal risks and by emphasizing incremental risk-reduction strategies.

- Conduct one-on-one counseling, using the RESPECT protocol prompts.
- Utilize a "teachable moment" to motivate clients to change risk-taking behaviors.
- Explore circumstances and context of a recent risk behavior to increase perception of susceptibility.
- Negotiate an achievable step which supports the larger risk reduction goal.
- Implement and maintain quality assurance procedures.

Modelo de Intervención Psicomédica (MIP)

MIP

Psycho Medical Intervention Model

Modelo de Intervención Psicomédica (MIP) is a HIV/AIDS Psycho-Medical Intervention Model for injection drug users based on Motivational Interviewing, Role Induction, Stages of Change, Social Learning Theory, and other Cognitive Behavioral theories and Case Management.

TARGET POPULATION



INTERVENTION LEVEL

Individual Level

- Conduct community assessment and out reach to identify sites for potential participant recruitment and enlist the support and cooperation of proven existing community resources.
- Employ an induction process that covers basic orientation topics and includes an assessment at the beginning of each session of the participant's stage of readiness to seek access to health services and to reduce HIV risk.
- Use motivational interviewing techniques and apply underlying theories and approach.
- Use a Self-Assessment Readiness instrument or evaluation tool at each session to affirm and increase the participant's self-efficacy and gauge the participant's readiness to take meaningful action.
- Counselor and Case Manager interaction and collaboration to identify and intervene on problems related to social support, integration of services and retention.
- Conduct a minimum of 6 sessions and 1 booster, and provide for additional contacts, if necessary.
- Conduct a booster session that reviews the participant's achievements, needs, strengths, and outstanding issues and includes an exit plan with specific strategies to maintain healthy behaviors and enhance self-efficacy.

Partnership for Health

TARGET POPULATION



INTERVENTION LEVEL

Individual Level



Partnership for Health

Partnership for Health (PfH) uses message framing, repetition, and reinforcement during patient visits to increase HIV positive patients' knowledge, skills, and motivations to practice safer sex. The program is designed to improve patient-provider communication about safer sex, disclosure of HIV serostatus, and HIV prevention.

- Providers delivering the intervention to HIV-positive patients in HIV outpatient clinics.
- The clinic adopting prevention as an essential component of patient care.
- All clinic staff trained to facilitate prevention counseling into standard practice.
- Waiting room posters and brochures used to reinforce prevention messages delivered by the provider.
- Supportive relationships built and maintained between the patient and the provider.
- During routine visits, the provider initiates at least a 3- to 5-minute discussion with the patient or client about safer sex that focuses on self-protection, partner protection, and disclosure.
- The provider incorporates good communication techniques and use of consequences-framed messages for patients or clients engaged in high risk sexual behavior.
- Referrals provided for needs that require more extensive counseling and services.
- The prevention message integrated into clinic visits so that every patient is counseled at every visit.

Defend Yourself!

TARGET POPULATION



INTERVENTION LEVEL

Community Level



d-up: Defend Yourself! is a community-level intervention for Black men who have sex with men (MSM). d-up! is a cultural adaptation of the Popular Opinion Leader (POL) intervention and is designed to change social norms and perceptions of Black MSM regarding condom use. d-up! finds and enlists opinion leaders whose advice is respected and trusted by their peers. They are trained to change risky sexual norms in their own social networks. Opinion leaders participate in a four-session training and endorse condom use in conversations with their friends and acquaintances.

- Direct d-up! to an identified at-risk target population in well-defined community venues where the population's size can be assessed.
- Use key informants and systematic observation to identify the target population's social networks and to identify the most popular well-liked and trusted persons in each network.
- Over the life of the program, recruit and train as opinion leaders 15% of the persons from each friendship group in the social network that is found in the intervention venue.
- Raise opinion leaders' awareness of how negative social and cultural factors impact Black MSM's sexual behavior in order to promote a norm of positive self-worth in their social networks and to address these biases in their conversations, as needed.
- Teach opinion leaders skills for putting risk reduction endorsement messages into everyday conversations with friends and acquaintances.

Defend Yourself!

TARGET POPULATION





INTERVENTION LEVEL

Community Level



d-up: Defend Yourself! is a community-level intervention for Black men who have sex with men (MSM). d-up! is a cultural adaptation of the Popular Opinion Leader (POL) intervention and is designed to change social norms and perceptions of Black MSM regarding condom use. d-up! finds and enlists opinion leaders whose advice is respected and trusted by their peers. They are trained to change risky sexual norms in their own social networks. Opinion leaders participate in a four-session training and endorse condom use in conversations with their friends and acquaintances.

- Teach opinion leaders the elements of effective behavior change messages that target attitudes, norms, intentions, and self-efficacy related to risk. Train opinion leaders to personally endorse the benefits of safer sex in their conversations and to offer practical steps to achieve changes.
- Hold weekly sessions for small groups of opinion leaders to help them improve their skills and gain confidence in giving effective HIV prevention messages to others. Instruct, model, role-play, and provide feedback during these sessions.
- Have opinion leaders set goals to hold risk reduction conversations with at-risk friends and acquaintances in their own social network between weekly sessions.
- Review, discuss, and reinforce the outcomes of the opinion leaders' conversations at later training sessions.
- Use logos, symbols, or other items as "conversation starters" between opinion leaders and others.

Safe in the City	TARGET POPULATION	INTERVENTION LEVEL
 <p>Safe in the City is a 23-minute HIV/STD prevention video very effective among diverse groups of STD clinic patients. It can be easily integrated into the clinic waiting room, requires very little staff time to set up with no disruption to clinic flow, and requires no counseling or small-group facilitation. The video contains three vignettes that model young couples of diverse racial and ethnic backgrounds and sexual orientations in various types of relationships negotiating safer sexual behaviors. The intervention also includes posters that direct patients' attention to the video. Safe in the City aims to increase condom use and other safer sex behaviors, and thereby reduce infections among viewers. It is based on Social Cognitive Theory, the Information-Motivation-Behavioral Skills model, and Theory of Planned Behavior.</p>		<p>Group Level</p> <ul style="list-style-type: none"> • Increase knowledge and perception of HIV/STD risk. • Promote knowledge of correct condom use. Promote positive attitudes toward condom use. Promote knowledge of correct condom use. • Increase intentions to use condoms. • Build self-efficacy for testing, facilitating partner testing and treatment. • Build self-efficacy for practicing safer sex, and the acquisition, negotiation, and use of condoms. • Build skills for facilitating partner testing and treatment. • Build skills for practicing safer sex, and the acquisition, negotiation, and use of condoms. • Model appropriate behaviors around practicing safer sex.

Besides the interventions mentioned above, there are many others that are effective for individual and community level behavioral change.

If you have any questions or would like assistance regarding DEBI, please contact us at proyectoideas@jsi.com or your CBA provider.

NEEDS ASSESSMENT & READINESS CHECKLIST FOR COMMUNITY BASED ORGANIZATIONS

The tools in this section have been created to help your organization determine which type of capacity building assistance (CBA) will most effectively improve your organization's ability to address the needs of the communities you serve and gauge your organization's readiness to implement Effective Behavioral Interventions (EBIs).

THERE ARE FOUR AREAS (FA) FOR CBA AND THEY ARE ALL INCLUDED IN THESE TOOLS:

FA1 - To improve the capacity of CBOs to strengthen and sustain organizational infrastructures that support the delivery of effective HIV prevention services and interventions.

FA2 - To improve the capacity of CBOs and health departments (HDs) to adapt, implement and evaluate effective HIV prevention interventions for individuals whose behavior places at risk for acquiring or transmitting HIV.

FA3 - To improve the capacity of HDs, CBOs and other stakeholders to implement strategies that increase access to and utilization of HIV prevention and risk – reduction and avoidance services for populations at high risk for STDs and HIV.

FA4 - To increase the capacity of Community Planning Groups (CPGs) and HDs to effectively involve HIV – infected and affected individuals in community planning, and to increase Parity, Inclusion and Representation (PIR) on CPGs.

...all of which are addressed by the following tools.

The Community-Based Organization Capacity-Building Assistance Needs Assessment for HIV/AIDS Prevention Programs tool helps determine your organization's program demographics, resources, capacity, fiscal management, evaluation processes, partnerships, and a number of other areas that will help identify which forms of capacity-building will best assist your organization and the populations you serve.

The Capacity-Building Assistance Process Checklist will help gauge your organization's preparedness to implement EBIs, while helping identify areas that require assistance in order to effectively implement these programs. The results of this checklist will help a CBA provider establish a framework from which to approach your organization's internal development and implementation process for EBIs.

If you have any questions, would like assistance in completing these assessments, or want to request capacity-building services, please contact us at proyectoideas@jsi.com or your capacity building assistance provider.

**COMMUNITY-BASED ORGANIZATION
CAPACITY BUILDING ASSISTANCE
NEEDS ASSESSMENT
FOR HIV/AIDS PREVENTION PROGRAMS**

This needs assessment will help to determine what types of capacity building assistance (CBA) will best help your organization to better meet the HIV Prevention needs of the populations you serve. The information collected can be used to conduct a diagnostic assessment of your organization and to develop a plan for CBA activities.

AGENCY INFORMATION

Agency Name: _____

Contact Name: _____

Job Title: _____

Address (City, State, Zip): _____

Work Phone: _____ Fax: _____

E-mail Address: _____ Web Site: _____

Would you like to receive information via e-mail? _____ Yes _____ No

Board President: _____

Executive Director: _____

Alternate Contact: _____

How long has the agency been in operation? **(Check one)**

_____ < 1 year _____ 1-3 years _____ 3-5 years _____ 5-10 years _____ >10 years

Does the agency have 501(c)(3) status? _____ Yes _____ No

If yes, when did it receive its designation? _____

What is the agency's current budget? **(Check one)**

_____ \$0- \$100,000 _____ \$100,001-\$499,000 _____ \$499,001-\$1,000,000 _____ >\$1,000,000

What is the agency's source of income? **(Check all that apply)**

_____ Federal _____ State or Local _____ Private Foundations _____ Generated Revenue

SECTION I. PROGRAM DEMOGRAPHICS

The questions in this section of the needs assessment will identify the geographic location and the types of services offered by your HIV/AIDS prevention program.

1. For how many years has your organization provided HIV/AIDS prevention programs?
(Check one response only)

- Less than one-year 1-3 years 4-6 years
 7-10 years More than 10 years

2. In the blanks below, please provide us with the following information about your primary location (headquarters) as well as your service areas:

- a. City and State of Primary Location: _____
 b. City and State of Service Areas: _____

3. Which of the following **BEST** describes your organization’s HIV/AIDS prevention service area?
(Check one response only)

- Primarily inner city Rural and urban
 Primarily urban Remote
 Primarily suburban Other (*specify*) _____
 Primarily rural

4. In the blank spaces below, write the **LETTER** of the category which **BEST** describes the primary and secondary racial/ethnic populations targeted by your organization’s HIV/AIDS prevention programs:

- ____ 1. Primary racial/ethnic population ____ 2. Secondary racial/ethnic population
- | | |
|------------------------------------|--|
| a. African American (non-Hispanic) | e. Alaskan Native |
| b. Asian/Pacific Islander | f. Native American |
| c. Caucasian (non-Hispanic) | g. Native Hawaiian |
| d. Hispanic/Latino | h. No specific racial/ethnic population targeted |

5. How many members of each ethnicity are on your board of directors? **(Please provide actual numbers)**

- | | |
|--|---|
| ____ a. African American | ____ f. Native American/American Indian |
| ____ b. Hispanic/Latino | ____ g. Alaskan Native |
| ____ c. Pacific Islander | ____ h. Native Hawaiian |
| ____ d. Caucasian (non-Hispanic) | ____ i. Other (<i>specify</i>) _____ |
| ____ e. Asian American (excl. Native Hawaiian) | |

10. Of the populations identified in Question 9, what are the top three populations served?
(Please write the names from the list above)

1. _____ 2. _____ 3. _____

SECTION II. ORGANIZATION RESOURCES

Community Based Organizations vary in the number of personnel and other resources they have dedicated to HIV/AIDS prevention programs.

11. Which best describes your organization’s budget for its HIV prevention programs this fiscal year?
(Check one only)

- | | |
|--|--|
| <input type="checkbox"/> Under \$100,000 | <input type="checkbox"/> \$1 million-\$1,999,999 |
| <input type="checkbox"/> \$100,000-\$249,000 | <input type="checkbox"/> \$2 million-\$4,999,999 |
| <input type="checkbox"/> \$250,000-\$999,000 | <input type="checkbox"/> \$5 million or more |

12. From where does the majority of your HIV Prevention funding come? *(Check one only)*

- Federal government (e.g., CDC or HRSA) Program Announcement _____
- State government (e.g., State Department of Health)
- Local government
- Private foundations
- National affiliate organization
- Other *(please specify)* _____

13. How many full time staff does your organization have dedicated to HIV prevention? *(Check one only)*

- | | |
|-------------------------------|---------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> 11-15 |
| <input type="checkbox"/> 1-3 | <input type="checkbox"/> 16-20 |
| <input type="checkbox"/> 4-6 | <input type="checkbox"/> More than 20 |
| <input type="checkbox"/> 7-10 | |

14. In a typical week, how many volunteers are actively involved in your organization’s HIV prevention program? *(Circle one only)*

- | | |
|-------------------------------|---------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> 11-15 |
| <input type="checkbox"/> 1-3 | <input type="checkbox"/> 16-20 |
| <input type="checkbox"/> 4-6 | <input type="checkbox"/> More than 20 |
| <input type="checkbox"/> 7-10 | |

15. To what extent do you feel that your organization has an adequate amount of the following resources? (*Place an "x" in the most responsive column*)

	Not at all adequate	Barely adequate	Adequate to some extent	Adequate	Very adequate
Computer and software					
Internet access (e.g., e-mail, World Wide Web)					
Audiovisual equipment (e.g., projectors, VCRs, TVs)					
Educational videos, films, or audiocassettes					
Physical space for your organization					
Other (<i>please specify</i>)					

CAPACITY BUILDING ASSISTANCE DEFINITIONS

The following definitions will allow us to identify which types of HIV/AIDS capacity building assistance will be most useful to your organization.

Capacity Building is a process that increases the core competences that are essential to increasing the effectiveness and sustainability of HIV prevention within an organization or community.

Capacity Building focuses on increasing the abilities of key personnel to plan and implement interventions and maintain the infrastructural systems and resources necessary to support intervention activities (All focus areas).

1. **ORGANIZATIONAL CAPACITY BUILDING ASSISTANCE FOR HIV PREVENTION** is the process that results in increasing the core competencies of individuals associated with organizations to design and implement effective HIV prevention interventions or services. Organizational Capacity Building Assistance has two content areas:
 - ✓ Organizational Infrastructure Development and Assessment (Focus Area 1).
 - ✓ Intervention Design, Development, Implementation, and Evaluation (Focus Area 2).

2. **COMMUNITY CAPACITY BUILDING ASSISTANCE FOR HIV PREVENTION** is the process that results in increasing the core competencies of community stakeholders to provide leadership and support in developing and sustaining the infrastructure and resources base necessary for HIV prevention. Community Capacity Building Assistance has two content areas:
 - ✓ Community Capacity-Building for HIV Prevention (Focus Area 3).
 - ✓ HIV Prevention Community Planning Effectiveness and Participation (Focus Area 4).

SECTION III. ORGANIZATIONAL MANAGEMENT CAPACITY

16. Which of the following do you think your **ORGANIZATION** is in need of? (*Place an “x” in the appropriate columns*)

Yes	No	Unsure	
			A needs assessment to identify gaps in services
			Assistance on how to write grants
			Assistance on how to manage programs by objectives.
			Assistance on how to evaluate programs
			Strategies on how to develop a strategic plan
			Assistance on how to access and apply research
			Assistance on how to assess data to improve prevention programs
			Assistance on developing programs
			Assistance on how to recruit and train board members
			Assistance on effective ways to raise funds
			Other (<i>please specify</i>) _____

17. Does your organization have? (*Place an “x” in the appropriate box*)

	Yes	No	Don't Know
Mission Statement			
Long-range plan			

18. How would you rate your organization's fundraising capabilities?

Low Average High

19. Does your organization have a computerized accounting system?

Yes No Don't Know

20. How many grants and/or funded contracts did your organization have for HIV Prevention during the last and current year (fiscal or calendar)?

None 1-2 3-4 5-6 7 or more

21. Does your organization outsource (contract) with another agency for the following fiscal management services? **(Place an “x” in the appropriate box)**

Yes	No	Don't Know	
			Payroll
			Bookkeeping
			Tax Planning/Maintenance
			Investments
			Fund Raising

22. To what extent does your organization encounter these barriers in preparing applications for HIV Prevention funding? **(Place an “x” in the appropriate box)**

	Not at all	Rarely	To some extent	Often	To a great extent
Lack of time					
Writer's block					
Lack of grant writing skills					
Lack of community support					
Limited staff					
Lack of board/administrative support					

23. What are the top **FIVE ORGANIZATIONAL MANAGEMENT** capacity building assistance needs of your organization? **(Write one letter in each of the boxes below)**

1 2 3 4 5

- | | |
|-------------------------|--|
| a. Board development | i. Program Planning and development |
| b. Grant writing | j. Leadership Development |
| c. Proposal development | k. Volunteer recruitment, development, and retention |
| d. Program evaluation | l. Staff training and development |
| e. Resource development | m. Management information services |
| f. Media/publicity | n. Incorporation process |
| g. Fiscal management | o. Team Building |
| h. Strategic planning | p. Other _____ |

24. What capacity building delivery mechanisms could better help your organization?

- Information transfer (newsletters, technical report, conference announcement)
- Skills building (trainings of staff, board members, volunteers)
- Technical consultation (on-site, telephonically, or written documents)
- Technical services
- Technology transfer

SECTION IV. HIV PREVENTION INTERVENTIONS DESIGN, DEVELOPMENT, IMPLEMENTATION AND EVALUATION

25. Which of the following are significant barriers to providing HIV prevention programs for your organization? *(Place an "x" in the appropriate box)*

	Not significant at all	Barely Significant	Significant	Somewhat Significant	Very Significant
Fear of lack of confidentiality					
Unsupportive public attitudes					
Limited staff or volunteers					
Denial of risk among target population					
Target populations not aware of services					
Lack of program planning and development					
Small size of target population					
Discrimination against target population					
Lack of funding for programs for target populations					
Language barriers					
Lack of organization support					
Other <i>(please specify)</i>					

26. Which of the following facilitate the provision of HIV prevention programs by your organization?
(Place an "x" in the appropriate box)

	Not at all	Rarely	To some extent	Often	To a great extent
Large size of target population					
Increased number of staff or volunteers					
Awareness of risk among target population					
Target population aware of services					
Funding for programs for target populations					
Supportive public attitudes					
Ability to reach multilingual populations					
Organizational support					
Other (please specify)					

27. Does your organization evaluate its HIV prevention programs?

Yes

No

Don't Know

28. If **YES**, which methodologies does your organization employ for evaluating its HIV prevention efforts? *(Place an "x" in the appropriate box)*

	Not at all	Rarely	To some extent	Often	To a great extent
Pre- and post-tests					
Needs assessments					
Surveys					
Focus groups					
Experimental/experimental designs					
Interviews					
Talking circles					
Case studies					
Observations					
Other (please specify)					

29. To what extent does your organization face these barriers in evaluating HIV prevention programs?
(Place an “x” in the appropriate box)

	Not at all	Rarely	To some extent	Often	To a great extent
Lack of knowledge about evaluation					
No staff available for evaluation					
Lack of funding for outside consultants					
Inability to identify appropriate evaluation consultants					
Unwillingness to give time or resources to evaluation					
Other <i>(please specify)</i>					

30. What capacity building assistance needs are most important to help your **ORGANIZATION** overcome these barriers? *(Check all that apply)*

- Understanding basic evaluation methodologies
- Understanding how to translate evaluation findings for program improvement
- Identifying training opportunities for internal staff
- Acquiring information about identifying and working with evaluation consultants
- Justifying the use of organizational resources for evaluation
- Other *(please specify)* _____

SECTION V. COMMUNITY CAPACITY

31. Which of the following do you think your **COMMUNITY** is in need of? *(Place an “x” on the appropriate line)*

- | Yes | No | Unsure | |
|-----|-----|--------|---|
| ___ | ___ | ___ | a. Understanding the community planning process |
| ___ | ___ | ___ | b. Community leadership development |
| ___ | ___ | ___ | c. Developing networks, partnerships and coalition building |
| ___ | ___ | ___ | d. Community mobilization strategies needs assessment |
| ___ | ___ | ___ | e. Community resource inventory |
| ___ | ___ | ___ | f. Infrastructure development |
| ___ | ___ | ___ | g. Policy development and analyses |
| ___ | ___ | ___ | h. Service integration and linkages |
| ___ | ___ | ___ | i. Other <i>(please specify)</i> _____ |

32. Are there any coalitions or networks of HIV Prevention service providers in your area? **(Circle one)**

1. Yes 2. No 3. Don't Know

33. How would you grade your **COMMUNITY'S** response to the HIV/AIDS epidemic? **(Circle one)**

- A. Superior B. Above Average C. Average D. Below Average F. Failure

34. What are the top **THREE COMMUNITY** capacity building assistance needs of your organization? **(Write one number in each of the spaces provided below)**

___ a. ___ b. ___ c.

- | | |
|---|--------------------------------------|
| 1. Community Leadership | 9. Community mobilization strategies |
| 2. Partnership Building | 10. Community Needs Assessments |
| 3. Consensus Building | 11. Community Resource Inventory |
| 4. Communication Networks | 12. Management information services |
| 5. Using Data for Decisions | 13. Incorporation process |
| 6. Policy Analysis | 14. Other (please specify) _____ |
| 7. Conflict Management | |
| 8. Understanding the Community Planning Process | |

35. Which of the following are significant barriers to providing **HIV prevention programs for your COMMUNITY?** **(Place an "x" in the appropriate box)**

Not at all	Rarely	To some extent	Often	To a great extent	
					Fear of lack of confidentiality
					Unsupportive public attitudes
					Limited staff or volunteers
					Denial of risk among target population
					Target populations not aware of services
					Lack of program planning and development
					Small size of target population
					Discrimination against target population
					Lack of funding for programs for target populations
					Language barriers
					Lack of organization support
					Other (please specify)

36. Which of the following facilitate the provision of HIV prevention programs in your **COMMUNITY**?
(Place an “x” in the appropriate box.)

Not at all	Rarely	To some extent	Often	To a great extent	
					Large size of target population
					Increased number of staff or volunteers
					Awareness of risk among target population
					Target population aware of services
					Funding for programs for target populations
					Supportive public attitudes
					Ability to reach multilingual populations
					Organizational support
					Other <i>(please specify)</i>

SECTION VI. COLLABORATION

Collaboration is when two or more organizations work together to improve HIV prevention efforts.

37. What other organizations do you currently collaborate with? *(Circle all that apply.)*

- a. State Health Department
- b. Local Health Department
- c. Testing Centers
- d. Community Planning Groups
- e. Ryan White Planning Body
- f. Other HIV/AIDS organizations
- g. NRMOS
- h. Nat'l org. (e.g., Red Cross)
- i. Community health clinics
- j. Hospitals
- k. Managed Care Organizations
- l. Other health organizations (e.g. mental health, drug treatment program)
- m. Gay/Bisexual/Lesbian Organization
- n. Women's Organizations
- o. Transgender organizations
- p. Youth Organizations
- q. Cultural/arts organizations
- r. Businesses
- s. Labor Unions
- t. Indian Health Services
- u. CDC
- v. Other (please specify) _____

38. What are some of the factors that have enabled coordination/collaboration with other entities?
(Circle all that apply)

- a. Other organizations have the expertise
- b. Credibility desired
- c. Resources needed
- d. Funders encourage collaboration
- e. Work with same target population
- f. Similar organizational philosophies
- g. Past or current experiences of working together
- h. Personal relationships with staff from other organizations
- i. Other *(please specify)* _____

39. What are the barriers to coordination/collaboration with other entities? **(Circle all that apply)**
- a. Work with different target populations
 - b. Other organizations do not want to collaborate
 - c. Competition/ "turf" issues
 - d. Personal relationships
 - e. Conflict of organizational philosophies
 - f. Lack of expertise of other organizations
 - g. Lack of credibility of other organizations
 - h. Other organizations do not want to work with an organization which serves our population(s)
 - i. Geographical location
 - j. Other **(please specify)** _____
40. What would most help your organization overcome these barriers? **(Circle all that apply)**
- a. Developing networks in your community
 - b. Improving information exchange and referrals
 - c. Developing memorandum of understanding/collaboration agreements
 - d. Finding resources for collaborative projects
 - e. Diversity/cultural competence
 - f. Service coordination
 - g. Other **(please specify)** _____

SECTION VII. HIV PREVENTION COMMUNITY PLANNING GROUP

HIV Prevention Community Planning Groups are established bodies of community representatives, including organizational, local, county and state representatives who meet regularly to discuss and develop a comprehensive plan for HIV prevention for their community.

41. Is your organization aware of the HIV Prevention Community Planning Group in your area?
(Circle one)
- a. Yes b. No c. Don't know
42. Does your organization: **(Circle all that apply)**
- a. Participate in the community needs assessment
 - b. Identify individuals for membership in the community-planning group (CPG)
 - c. Have a representative as a member of the CPG
 - d. Know the criteria or methods used in selecting members for the regional CPG
 - e. None of the above
 - f. Other **(please specify)** _____

43. What barriers have prevented your organization from participating in your region's CPG? **(Circle all that apply)**

- a. Did not know about the HIV Community Planning Process and the existence of CPGs
- b. Turf issues
- c. Personal relationships
- d. We are unfamiliar/uncomfortable with the way meetings are conducted
- e. Lack of understanding of the functions, roles and responsibilities of the HIV Prevention CPG
- f. Lack of information on how to become a member of the group or other ways to get involved
- g. Dissatisfied with issues related to parity, inclusion and representation
- h. Conflict of interest
- i. Not applicable
- j. Other **(please specify)** _____

IF YOU CHOSE 'A' FOR THE ABOVE QUESTION, PLEASE SKIP TO QUESTION #45.

44. To what extent are your clients/constituency represented in the HIV Community Planning Group that serves your jurisdiction?

Not at all	Rarely	To some extent	Often	To a great extent	
					Directly represented by my ORGANIZATION
					Directly represented by members of that community
					Represented by individual who works with that community
					Represented in theory/paper, but not actually appropriately represented
					Not represented
					Not sure
					Other (please specify)

45. What assistance would help your organization to participate in the community planning process? **(Circle all that apply)**

- a. Working with the Health Department/CPG on Parity, Inclusion and Representation
- b. Understanding of the functions, roles and responsibilities of the HIV Prevention CPG
- c. Understanding and using epidemiologic information for planning decisions
- d. Understanding the needs assessment process
- e. Creating an effective multicultural planning process
- f. Our role as a planner and advocate
- g. How to get appointed to the CPG
- h. Other **(please specify)** _____

CAPACITY BUILDING ASSISTANCE PROCESS CHECKLIST

This checklist will help the capacity building assistance (CBA) provider and the community based organization (CBO) recognize the potential areas where they may need assistance to implement DEBI interventions. It will also help the CBA provider develop and/or utilize a framework for providing CBA to the CBOs conducting DEBI interventions. This Checklist should be used in conjunction with the Agency Readiness Self-Assessment. A separate checklist should be completed for each of the DEBI interventions to be implemented by the CBO. The Agency Readiness Self-Assessment sheets were developed by the Academy for Educational Development and they can be found at www.effectiveinterventions.org.

SECTION I. CBO PREPARATION

1. Which DEBI intervention are you planning to implement? **(Check only one)**

- | | |
|--|--|
| <input type="checkbox"/> Many Men/Many Voices | <input type="checkbox"/> Mpowerment |
| <input type="checkbox"/> Popular Opinion Leader (POL) | <input type="checkbox"/> Community PROMISE |
| <input type="checkbox"/> Real AIDS Prevention Project (RAPP) | <input type="checkbox"/> Safety Counts |
| <input type="checkbox"/> SISTA Project | <input type="checkbox"/> VOICES/VOCES |
| <input type="checkbox"/> Street Smart | <input type="checkbox"/> Teens Linked to Care |
| <input type="checkbox"/> Healthy Relationships | <input type="checkbox"/> Holistic Harm Reduction Program |
| <input type="checkbox"/> D-Up Defend Yourself ! | <input type="checkbox"/> Focus on Youth + Impact |
| <input type="checkbox"/> MIP | <input type="checkbox"/> Partnership for Health |
| <input type="checkbox"/> Respect | <input type="checkbox"/> Safe in the City |
| <input type="checkbox"/> Together learning choices | <input type="checkbox"/> Cuídate |
| <input type="checkbox"/> Light: Living in Good Health Together | <input type="checkbox"/> Other _____ |

2. In the table below, please identify the target population, subgroups, risk factors and influencing factors for the intervention your agency is planning to implement:

Intervention	
Target Population	
Target Population Subgroups	
Risk Factors	
Influencing Factors	

3. Did your staff attend AED training on the specific intervention your agency is planning to implement?

Yes (Go to question # 4)

No (Go to question # 5)

4. Please answer the following questions:

a. How many of your staff attended the training? ***Please specify the training they attended.***

b. Who are they and what are their roles?

5. Who will attend the training and when?

6. Is your staff familiar with the Procedural Guidance for Selected Strategies and Intervention for CBOs?

Yes

No

Comments:

7. Can your staff identify and understand the following components of the intervention:

Yes

No

Core Elements

Yes

No

Key Characteristics

Yes

No

Procedures

Yes

No

Resource Requirements

Yes

No

Recruitment

Yes

No

Physical Setting Characteristics

Yes

No

Necessary Policies and Standards

Yes

No

Quality Assurance

Yes

No

Monitoring and Evaluation

Comments:

8. Does your staff understand the science/theory behind the intervention you want to implement?

Yes

No

Comments:

9. Does your staff know the material needed for the intervention (included in each boxed intervention) such as training manual, participant manual, agenda, video, posters, etc?

Yes

No

Comments:

10. Does your agency recognize the staff patterns needed for the effective implementation of the intervention? For example: program manager, implementation staff, volunteers, consultants, FTEs/hours, job description, etc.

- Yes No

Comments:

11. Does your agency recognize the skill sets needed for the effective implementation of the intervention? For example: group facilitation, peer-based education, recruitment, retention, adequate training for intervention implementation and target population, etc.

- Yes No

Comments:

12. Does your agency recognize the different material/equipment needed for the effective implementation of the intervention? For example: TV/VCR, incentives, transportation, posters, condoms, etc.

- Yes No

Comments:

13. Does your agency have the financial resources required for the implementation of the intervention?

- Yes (Go to question # 14)
 No (Go to question # 15)

14. Please indicate your agency funding source for the implementation of this intervention:

- CDC PA 04064
- Other Federal Government funds: _____
- State Health Department funds: _____
- Private funds: _____
- Others: _____

15. How will your agency find and secure the necessary funds for this intervention?

16. What types of participants or community members will be recruited for this intervention?

17. What are the criteria your agency will use for participant recruitment?

- | | |
|---|--|
| <input type="checkbox"/> Race/ethnicity | <input type="checkbox"/> Tribal membership |
| <input type="checkbox"/> Gender | <input type="checkbox"/> Age |
| <input type="checkbox"/> HIV/STD risk behaviors | <input type="checkbox"/> HIV status |
| <input type="checkbox"/> Language spoken | <input type="checkbox"/> Others _____ |

18. How will your agency recruit participants for this intervention?

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Outreach | <input type="checkbox"/> Referrals |
| <input type="checkbox"/> Use of media | <input type="checkbox"/> Age |
| <input type="checkbox"/> HIV/STD risk Behaviors | <input type="checkbox"/> HIV status |
| <input type="checkbox"/> Others _____ | |

19. Who in your organization is responsible for participant recruitment for this intervention?

20. Does your agency have the recommended sites/space for this intervention?

Yes No

Comments:

21. How accessible is your proposed space to target population/intervention participants? For example: transportation, accessibility for people with disabilities, etc.

22. Does your agency have the necessary policies and standards in place for the implementation of this intervention?

Informed Consent	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Legal/Ethical Policies	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Confidentiality Policy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Data Security	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cultural Competence	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Referral Services	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Volunteers Policy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Comments:

Key informants act as links to the community and are incredible resources that can provide a wide variety of information about the populations you work with. The first tool in this section will help you identify key informants in your community.

Once you have successfully identified key informants, the protocol for interviewing them can assist the process of gathering information about the status of various Latino populations. This interview protocol asks questions spanning geographic location, religious affiliation and participation, location of HIV epidemic, risk factors, program opportunities, political involvement, and demographics of the population. This information can be useful in programmatic and strategic planning.

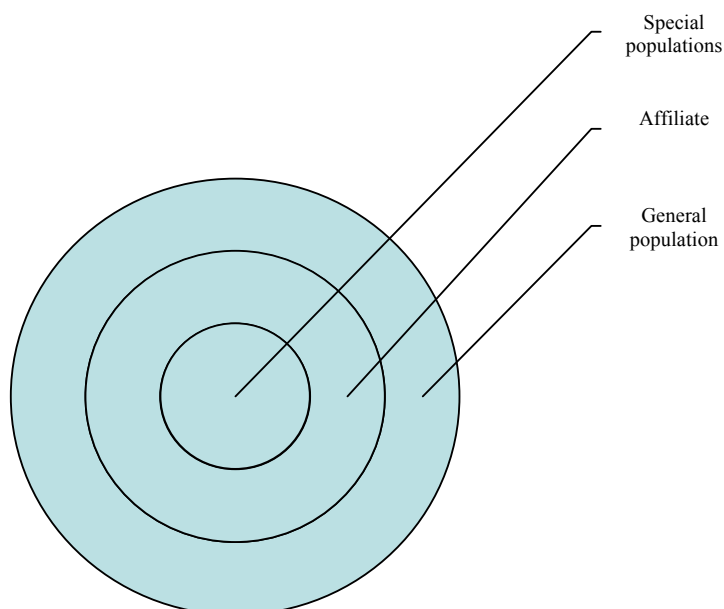


If you have any questions about how to appropriately use this tool, please contact us at proyectoideas@jsi.com or your capacity building assistance provider.

BRIEFING ON THE IDENTIFICATION AND USE OF KEY STAKEHOLDERS TO GATHER INFORMATION RELATED TO HIV RISK BEHAVIOR OR HIV PREVENTION NEEDS

Often, service providers or policymakers need to collect information related to HIV/AIDS risk behavior or HIV prevention needs in order to make decisions about current or new programs. That type of information is not always available due to a number of reasons. For example, information might be difficult to obtain because it is related illicit behavior (e.g., injection drug use, commercial sex work) or hidden within layers of language or culture of a particular group (e.g., MSM, access to care needs among recently arrived Hispanics). Thus, service providers or policymakers need to devote extra effort to gain that information. A commonly used method to gather that type of information is identifying individuals that have the knowledge or have access to persons that have this knowledge. These individuals are known as key informants and are people who possess knowledge or can facilitate access to those that know about a setting, community, or group of interest. In this briefing we share how to locate, identify, and utilize key informants. In this section we describe an approach to selecting key informants in the Hispanic community.

A key informant should not be selected at random but rather based on the amount of information he/she has or access to knowledge he/she is willing to facilitate or share with the person collecting the information. The selection of a key informant, however, should be guided by a theory or rationale. Proyecto IDEAS's approach to the delivery of capacity building interventions is ecosystemic, that is, HIV risk behavior occurs in a context such as a club, sauna, or shooting gallery, etc. Those contexts are organized around a number of concentric circles with the innermost circle representing the most specialized population or those most at risk. The diagram below illustrates this approach:



General population. In our view, key informants in the outer circle, the general population, are the easiest to identify. Key informants in the general population are those whose names first appear in a Google search. They are often spokespersons for media outlets and often serve as key people in local government and organizations. These types of key informants are more likely to have general but not really specific knowledge of the population of interest, particularly of LGBT populations or drug users. They can however, facilitate access to other resources or important leaders.

Affiliate population. Key stakeholders in the affiliate population consist of those leaders of community-based organizations that serve Latinos, or directors of civic and social organizations focusing on Latinos (e.g., Chicano Students Association). Key stakeholders in the affiliate population might include business owners such as Latinos that own grocery stores, hair salons or car repair shops. Due to the nature of their businesses, they can provide targeted and specific information in certain areas.

Special populations. Finally, key informants belonging to special populations are the most difficult to identify and recruit because they are either sexual minorities or often are involved in non mainstream activities. However, they are the ones that can provide the most useful and specific information. These individuals are leaders in the LGBT community, an injection drug user, a commercial sex worker, users of online sex services, etc.

RECRUITMENT OF KEY INFORMANTS

As noted earlier, key informants in the General Population or the Affiliate Population are rather easy to find, either through internet searches or resource directories. What is difficult to find are those in the inner circle, key informants that can provide inside information of those at risk.

An approach that has been used with difficult-to-find population is called respondent-driven sampling (RDS). RDS relies upon the idea of 'six degrees of separation, and upon the fact that peers trust each other. It also differs from traditional chain referral sampling, such as 'snowball' recruiting, in the following ways: 1) it allows inferences about the characteristics of the population from which the sample is drawn; 2) peers may recruit peers; and 3) peers can only recruit 3 other peers.



When recruiting key informants, the most difficult thing to do is recruiting the first person or “seed.” That is the person that can refer others that can also provide information. Community-based organizations, particularly case managers, usually have contacts in the community that can refer you to that one person. A referral consists of providing the name and phone number of a person with the same defining characteristics as the original seed and who has agreed to participate in an interview. A stipend is usually offered.

The third step is to develop a survey or set of guideline questions to ask key informants. We suggest that a thematic map should be drawn to guide question development. A sample thematic map showing questions about risk behavior is shown below.

	What	When	Where	How
IDU				
MSM				
Commercial Sex Workers				
Partners Injection Drug Users				

The above map can yield questions such as:

- What’s the specific risk behavior affecting this population?
- When is the behavior more likely to occur?
- Where does it occur?
- How does it occur?

Although at first glance the definition, recruitment, and use of key informants are commonsensical, this may not be necessarily the case. Researchers and policymakers often rely on the easiest person to find or the individual they already know to obtain information thus precluding other views and perspectives on the dynamics of the community from being taken into account. You can avoid this pitfall by using a systematic search strategy such as the one described in this section.

Questionnaire for Latino / HIV/AIDS key informants

Please provide the best answers to the questions below. We understand that you cannot respond to issues on behalf of all Latinos, however, you are a key leader in the community and your opinions and perceptions are important to help us understand the situation of the Latinos living with HIV/AIDS in your state, and propose strategies accordingly.

Thank you for your time!

Demographics

1. In what locations are Hispanic communities in your state primarily concentrated?

2. For the most part, what is their country of origin? If they are from Mexico, which Mexican state? _____

3. Some Latino immigrants belong to native groups that do not speak Spanish as a first language. Do you know of Latino groups in your state that speak a language/dialect other than Spanish or English? _____

4. For the most part, what is their religious affiliation? _____

5. How involved is the church with the Latino community?

Not Involved

1

2

3

4

Very Involved

5

6. How involved is the church on issues related to HIV-AIDS?

Not Involved

1

2

3

4

Very Involved

5

The questions below refer to Latinos in your state that are at high-risk for HIV/AIDS or are living with HIV/AIDS.

7. Do they reside in mostly rural or urban areas? Rural Urban

8. Do they reside in a particular county or city? _____

9. How would you characterize their risk behaviors? (Assign numbers 1-5 to indicate priority)
 MSM Intravenous drug use (IDU) Sex w/ IDU Commercial Sex Work Sex w/ bisexual

10. What substance is predominantly used? _____

11. Where do they go for HIV testing? _____

12. In your opinion, do AIDS service providers have the linguistic capacity to deliver services to Latinos?

No A little bit Yes Very much so Extremely

13. In your opinion, do AIDS service providers have the cultural competency to deliver services to Latinos?

No A little bit Yes Very much so Extremely

14. Are there programs designed for HIV/AIDS prevention and treatment for Latino MSM, IDU, sex workers, etc.?

Yes No

15. Is there a support group for Hispanic PLWHA? Yes No

16. Can you name 3 Latino leaders in your state? By leaders we mean people that are highly visible in the community or media and are often the “go to person” in issues related to Hispanics. _____

17. In your opinion, what are the 3 main social or political issues affecting Latinos in your state?

18. In your opinion, what are the 3 main health issues affecting Latinos in your state?

Occupation

19. What is the main industry employing Latinos in your state? _____

20. Can you name some specific businesses where a large number of Latinos are employed?

21. Are these businesses located in rural or urban areas? Rural Urban

Social Life

21. Where do Latinos socialize? _____

22. What do they do for entertainment? Where do they go?

23. What TV and radio stations do they listen to the most? _____

Policies in regards to Latinos

24. Do Latinos have access to technology such as the internet? Yes No

25. Does the state health department allocate specific funds for Hispanics? Yes No

26. What are the main Community Planning Group (CPG) target populations?

27. Are Latinos represented in the CPG? Yes No

28. What efforts are there to change/improve policy at the state and national levels to address Hispanic issues?



WHAT IS CULTURAL COMPETENCE?

It is essential for staff of organizations working with the community to be culturally competent - aware of the diversity among individuals (age, level of education, lifestyles, etc) and sensitive to cultural issues and needs so they are able to interact accordingly. This ability will allow staff to be more effective in implementing interventions and other programs that they provide. Furthermore, it is important for staff and management to practice cultural competence within the workplace and between agencies, since this will create a culturally competent network for individuals from the community to access and allow for a richer interaction. If your organization's staff has not received training on cultural competence, we recommend they do so, and even if they have, they might need a refresher. Below are some important aspects of cultural competence and awareness, though this is not a substitute for a formal training.



DIVERSITY

- Diversity is the mosaic of people who bring a variety of backgrounds, styles, perspectives, values, abilities, and beliefs as assets to the groups and organizations to which they belong. Understanding diversity is being aware of the differences in the community you serve.
- There are various dimensions of diversity and these vary per individual and affect how that person perceives the world and everything in it. There are certain dimensions, such as age, gender and race that one is born with, and others, such as language, education and religion that one acquires. Every individual will present different dimensions of diversity to be considered. For example, a 52 year old Latino male might think very differently of your intervention than a 24 year old Latino female, and it is your responsibility to be aware of these differences and ask your target population what works best for them.
- Culture plays an extremely important role in the decisions that individuals make. Culture is cumulative and learned throughout one's life. Culture implies certain unwritten norms and rules to live by, and it affects individuals' expectations and perspectives of the world and relationships.

CULTURAL AWARENESS AND COMPETENCE

- To become culturally competent, we first have to become culturally aware. Cultural awareness

is the foundation of communication involving the ability to stand back from ourselves and become aware of our cultural values, beliefs and perceptions. There are four stages of cultural awareness, which are blindness, sensitivity, competence and proficiency.

- **Blindness** is being unconsciously unaware; a person in this stage is not aware of the diversity between individuals and displays characteristics such as ethnocentrism and discrimination.
 - **Sensitivity** is being aware that one doesn't know or understand our differences.
 - **Competence** is being consciously aware of your diversity and striving to understand the differences with others.
 - **Proficiency**, which is extremely hard to achieve, is living and breathing diversity, being unconsciously aware. It means naturally understanding diversity, reacting respectfully and appropriately to those differences, without being conscious of it.
- When individuals are at either the Blindness or Sensitivity stage of awareness they tend to display certain behaviors that are called barriers that prevent agencies and other individuals from developing a cross-cultural relationship. Examples of barriers are:
 - **Ethnocentrism**: the inability to accept another culture's world view.
 - **Stereotyping**: generalizing about a person, while ignoring the presence of individual differences.
 - **Prejudice**: an irrational attitude of hostility formed without just grounds or before sufficient knowledge, and directed against an individual, a group, a race, or their supposed characteristics.
 - **Discrimination**: the practice of making a difference in treatment or favor on a basis other than individual merit.
 - **Oppression**: unjust or cruel exercise of authority or power.
 - **Imposition**: belief that everyone should conform to the majority.
 - Individuals in the community usually do not realize completely the aspects that define their culture; they live and breathe it every day. Their culture is innate to them. When staff at an agency become culturally aware, they realize the differences among individuals and adapt their interventions appropriately to better reach their target population. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures.
 - In order to become culturally competent, a system must value internal and external diversity, have the ability to internally assess its cultural competence, be aware of different dynamics that take place when two or more cultures interact, institutionalize cultural knowledge, and adapt the services delivered reflecting the understanding of diversity between and within cultures.

CULTURAL HUMILITY

- Cultural humility is a long process that individuals consciously enter into with clients, colleagues, friends and themselves. It involves an honest realization of what we lack and finding ways to gain that knowledge and/or experience with respect and humility.

When interacting with clients, one must consider the following:

- To what extent do I understand what the client is going through?
- What are the priorities for my client and for the time we have together?
- Have I worked with individuals in similar situations? How did I respond?
- What steps can be taken to address the concerns and needs of all parties involved?
- What are some of the personal and/or professional challenges I might face in helping this individual?



The information above is to be used as a guide of things to consider when working with others. Again, this is not a substitute for a formal training.

If you would like to receive more information or a formal training, please contact us at proyectoideas@jsi.com or contact your CBA provider.

Many community-based organizations implementing interventions could find the following information about the basics of teaching and facilitating group discussions beneficial. Should your organization request additional information, we are available to provide a training to increase the skills and techniques of facilitators including the following aspects:

ATTRIBUTES OF A FACILITATOR

One of the responsibilities of every facilitator involves motivating participants to make positive changes in their life by helping them understand the benefits of those changes. It is important that facilitators learn and apply these concepts to their life in order to comprehend the ability of these skills in creating positive change in both their life and the lives of others. Teaching techniques and facilitation skills are essential when working with individuals and groups to help them learn and understand new concepts, change behavior, and sustain those changes.

It is important for people to feel comfortable, ready, and motivated to make positive changes in their life. When a participant feels ready and understands the benefits of the change help them feel comfortable and motivated for change, provide easy access to the tools they need to actually make the change, and guide them on how to accomplish it in a positive way.

Strive to develop attributes to encourage and inspire participants to make a positive behavioral change and keep in mind that despite your best effort to catalyze this change, participants are free to choose to accept or reject any invitations you make.

BEHAVIORAL CHANGE FACILITATION PROCESS

The Behavioral Change Facilitation Process is a tool to help you prepare participants to feel motivated, invite them to make commitments, and follow up to help them keep their commitments. During this process, participants may have concerns that keep them from progressing towards positive behavioral change. Facilitators can help to resolve those concerns. In the Behavioral Change Facilitation Process there are four phases that will help you smooth the process of positive behavioral change for participants.

1. **Preparation Phase:** Help participants understand clearly the concepts you are teaching. When they understand your teachings, they will want to apply that knowledge to their life and it will be more likely that they will make and keep a commitment to improve their behavior.
 - A. **Build trust:** As soon as participants trust in you, they will be prepared to feel motivated.
 - *Become acquainted with the participants:* Get to know them better by sharing your experiences and opening a safe space for participants to share theirs.

- *Build on common ground:* You can increase trust among participants and yourself by building upon beliefs or knowledge that you share. Build upon what your participants already believe. Point out the concepts you have in common. People will feel your respect for their beliefs, and they will be more willing to listen to you as you fortify their self-confidence.
- *Show understanding:* Develop an ability to put yourself in another's situation and understand their thoughts and feelings. It also means seeing things from that person's point-of-view. As you listen, try to understand how participants might feel.

B. Help participants feel motivated: As the participants become motivated, they are better able to make a positive behavioral change in their life.

- *Share experiences:* If you feel comfortable, share positive experiences that will help your participants understand the topic and inspire them in some way,
- *Identify motivation:* As participants feel motivated, encourage them to express what they think of the discussion and how it makes them feel. When they feel motivated, it is easier for them to create a change in their behavior. Validate their thoughts and feelings and let them know that the motivation they have is the first step before any achievement.

C. Present the message: Present the message of the intervention clearly and directly.

- *Know the content of discussion:* Know the content of the intervention, its objectives, your audience, your strengths, and your limits. It is important to understand and remember the objectives of the intervention in every session. By remembering the objectives you will be able to lead the session with a specific goal in mind.
- *Believe the message you present:* Have confidence that the teachings you present are correct and accurate. This also means feeling certain that the knowledge you provide to the participants is for their benefit. Believe in their potential and that the education you provide will be received with interest. Finally, believe that those you help will accept commitments to improve behavioral change.
- *Present the message with clarity:* A facilitator might have extensive knowledge of the topic being discussed, but keep in mind that some people may not have the same knowledge as you do and may not be familiar with all the vocabulary you use. Keep the conversation simple at all times.

- D. **Personalize the message:** Cultural competence is very important when working with people from different backgrounds. Even if all the participants of the intervention are from the same culture, you should personalize your message so that people of different ages, lifestyles, and educational levels will understand it.
- *Find out:* Show those you interact with that you are genuinely concerned about them and it will be more likely that they will open up to you and feel motivated to change a behavior for the better.
 - *Listen:* Paying attention when others speak will help you identify their concerns, feelings, and beliefs. Listening includes hearing what another person says, looking for nonverbal messages, restating the person's message, and pausing to let the person think. Hear what the other person says and be well prepared before the discussion so you can concentrate on what is being said to you.
 - *Ask Open-ended Questions:* When prompted to do so, when concepts are not clear, after a lesson has been taught, when participants seem pensive, and in many other situations you should ask questions to learn what others are thinking and feeling. As you use these skills, others will be more willing to share their feelings and beliefs with you.
 - *Ask Additional Questions:* Ask a question and then listen. If necessary to understand the participant's position, continue to ask additional questions. Whenever you feel that the participant has a question or concern, stop the intervention and ask to find out what he/she is thinking. As you ask these questions, try to identify their feelings and concerns and show that you are interested in their needs.

2. **Invitation Phase:** When people are motivated to make a change help them make specific commitments. When they are ready and willing, they must act on that motivation. By fulfilling these commitments, participants will acquire an increased trust in themselves.

- A. **Extend the Invitation:** People must make and maintain their commitments in order to create a change in their behavior. Be confident, direct, specific, and clear when you invite people to make commitments.
- B. **Confirm the Commitment:** Take the time to confirm the commitment with them and make sure they know exactly what they are to do, that they are willing to do it, and express your confidence that they will fulfill the commitment.

3. **Follow-up Phase:** Help the participants fulfill their commitments so they continue to feel motivated. You can always encourage them and help them meet challenges successfully.
 - A. **Arrange to Follow Up:** Begin following up immediately after people have accepted an invitation. Tell them that you are going to follow up with their commitment; this will help them know that you sincerely want them to fulfill it.
 - B. **Make Regular Contact:** Make contact as often as needed; share your availability (dates, times) to help participants feel motivated to keep their commitments.

4. **Resolving Concerns Phase:** Help participants find the answers to their questions through study and group or individual discussion. You may also need to help resolve concerns at any point of the facilitation process---while preparing, inviting, or following up.
 - A. **Discover the Concern:** Find out what the participant's concerns are through out the session. Show that you care for others by listening to them and showing that you understand them.
 - B. **Discuss the Concern:** Once you find out what the participant's concern is, discuss it with him/her. This will help the participants know what they need to do and will let them know that the concern has not damaged your relationship.
 - C. **Help Resolve Concerns:** After you have discussed the concern with the participants, explain unfamiliar ideas to the participants to help them discover what they need to do to resolve their concerns.

ADDITIONAL ENHANCING TECHNIQUES

Aside from knowing how to teach and to facilitate groups more effectively, all facilitators benefit from using enhancing techniques to engage individuals effectively in the intervention. Below are some you might find useful:

Providing Feedback: After participants have had an opportunity to practice or to play a role, provide positive suggestions to them. The feedback you provide should focus on the goal of the role play or practice. Make sure your input will encourage the participants to improve the skill they are learning/developing.

Icebreakers and Energizers: Icebreakers and energizers can help maintain interest in the learning process. They give participants a break from the session and allow them to relax. Giving learners different options for engaging with the group and showing how they can contribute is a valuable way to help people gain the confidence they need to be able to continue learning.

Brainstorming: Brainstorming encourages active and imaginative input from participants and taps their knowledge and expertise. It is a technique that helps to generate ideas or a variety of solutions to a problem and can increase the range of factors taken into account in reaching a decision. Brainstorming is generally used to help introduce or direct a topic. The facilitator's role is to encourage safety among all participants to say the first thing that comes to their minds and to keep ideas flowing quickly ensuring that no one reacts to the ideas, just offers. When there are no more ideas to offer, the facilitator leads a discussion of the results of the brainstorm.

Utilizing Videos/DVDs: Moving pictures can be used to bring issues and people to life. The selection of an appropriate video/DVD can offer a low-key, entertaining way to share detailed information or issues. Preceded by focus questions and followed by a discussion of what participants saw, a video/DVD can introduce a lot of content in a short period of time.



Organizing Games: Learning games are contests among participants who play the game while following given rules. There is an outcome or a way to “win” that usually requires players to complete tasks while learning something of value to them. Types of games include paper-and-pencil games, board games, card games, quizzes, games that use props, computer games, and games involving physical movement.

Physical Continuum: Physical Continuum focuses attention on viewpoints to approach a situation and helps strengthen decision-making skills among participants in a large group setting. It poses a situation for the participants to promote thinking, self-reflection and decision making. The facilitator poses a situation and asks participants to place themselves in one corner of the room if they agree with statement or on the other corner if they don't. This is followed by asking the participants why they place themselves on that side of the room.

Case Studies: A very efficient activity that can help resolve concerns of the participants is the use of case studies. Case studies encourage participants to analyze situations they might encounter and determine how they would respond. A case study is basically a story that illustrates an event

and is followed by questions for the participants to discuss. Case studies are particularly effective when they illustrate problems that are similar to the ones that participants face. The case study activity should be structured to allow learners enough time to read, think, and discuss.

Demonstration: A demonstration brings information to life that could be presented in a lecture, discussion, or explanation and even when inviting a person to make a commitment. Demonstration requires the facilitator to be very familiar with the content and the process of the skill being illustrated, as it must clearly and accurately convey the process and acceptable standards. Depending on the objectives of the session, the demonstration can be conducted by the facilitator, by the participants, or both.

Role Play: Role play encourages participants to explore solutions to situations or problems under discussion. It is a short, often unrehearsed drama where the participants are given roles to act out. Participants receive a description of the situation, the positions they should take, what they might do or opinions they should express. While participants are acting out their role, all other participants should observe the situation. This is entertaining and educational. It improves skills of expression and observation. It is an excellent technique to stimulate discussion about a topic and for analyzing types of attitudes, skills, and knowledge.

Debriefing: Debriefing is very important in the learning process especially after the participants have gone through an activity such as a Demonstration or Role Play. When participants have engaged in a complex learning activity, they have gathered a lot of information and impressions and need a chance to clarify questions, differentiate between facts and impressions, and reflect on what the experience has meant for them. Debriefing should be carried out as soon as possible after the leading activity is complete.

Plenary Discussion: When resolving concerns or as an activity alone, a facilitator could create a plenary discussion. In this technique, all participants come together for a discussion. It can take place as a stand-alone activity or as part of debriefing for another activity. This technique is often called large group discussion.

Contact proyectoideas@jsi.com or your CBA provider if you are interested in receiving a complete training on teaching techniques and facilitation skills to better serve the population you work with.

As a state or federal grantee you might be required, through a contractual mandate, to conduct monitoring and evaluation (M&E) activities. M&E activities provide information and data to address at least two general questions regarding your program:

- Are we doing what we said we would do?
- Is what we are doing having its intended effect?

The answers to these two very broad questions provide information that can be used for program management and improvement, accountability to funders and other stakeholders, and for program marketing and advocacy purposes.

M&E activities are conducted throughout program implementation. Specifically, M&E activities help you determine the following:

- Did we reach our intended target population?
- Did we implement all the key elements of the intervention?
- How did our clients respond to this intervention?
- Are we making the most effective use of staff and community resources?
- Did we achieve our stated goals and objectives?
- Are we compliant with CDC funding requirements?

HOW TO IMPLEMENT M&E ACTIVITIES?

Usually, the federal funder recommends that a portion of the grant award (10-15%) is dedicated to carry out the M&E. Some program managers decide to implement these activities in house, that is, within the existing agency staff. Others opt to hire an outside evaluator. Regardless of your decision, the following section provides the basic M&E terminology and guiding principles. It also directs you to the excellent array of resources that the federal government has developed to assist you in these efforts. This basic knowledge will allow you to either 1) decide whether you have the internal capacity to conduct M&E or 2) decide to hire an outside evaluator. Regardless of your decision, by reviewing the resources provided in this section as well as the basic description of evaluation components you will be in a stronger position to discuss the scope of your M&E activities.

OVERALL APPROACH

Usually, M&E activities can be organized around six different steps.

Step 1: Engage stakeholders

Stakeholders are those with vested interests in the program and are potentially affected by the program and its evaluations. They include your staff, clients, and community leaders, among others. Identify who your stakeholders are and meet with them to identify what are the program expectations, what information they would like from the M&E activities, what would be the definition of success, etc. The answers to these questions will lay the foundation of all your M&E activities.

Step 2: Describe the program

Describe the program to your stakeholders. Discuss program features such as problem or challenge that it will address, the prospective clients, the expectations, etc. A flowchart, table or diagram of these features will help you to guide this discussion.

Step 3: Focus the evaluation design

By now, after completing steps 1 and step 2, you will have an idea as to what questions are important to you and your stakeholders. Make a list of these questions. Afterwards, with the information and resources provided in this section you should be able to design or at least, to discuss with a program evaluator, your evaluation design.

Step 4: Gather credible evidence

After determining the key questions to examine in the evaluation, the next step is to gather evidence. In this step you will be collecting data that best answers your stakeholders and program staff questions. Several sources are readily available to you: 1) notes from meeting, 2) focus groups, 3) interviews, 4) surveys, 5) observations, etc. The resources that we list below provide examples of how to collect data.

Step 5: Justify conclusion

After all the data have been collected, the next step is data analysis and interpretation. The interpretation part of this step is critical. In this phase you judge your findings against the established program benchmarks. It's important to involve stakeholders in this step and consider the context in which the program is operating so that your conclusions are sound, reasonable and objective. Once conclusions have been reached, recommendations can then be made if appropriate.

Step 6: Ensure use and share lessons learned

This step of the framework emphasizes the importance of using findings for program improvement once the evaluation has been completed. Dissemination of the evaluation findings and sharing lessons learned ensures that the evaluation efforts will be used.

Notice that many of the activities outlined in these steps can be done with minimal expertise in the field of evaluation. For example, you can meet with the program stakeholders and identify expectations (Step 1); you can describe the program to your stakeholders (Step 2); identify questions of interest (Step 3); identify sources of data (Step 4); and find ways to share lessons learned (Step 6). However, for some tasks, such as creating an evaluation design (Step 2) and conducting the data analysis (Step 5), you might need to consult with a program evaluator.

Again, regardless of your decision it is very useful to have a roadmap to guide your efforts. In the field of program evaluation such a road map is called a logic model which is a tool that describes the main elements of an intervention and how they work together to prevent HIV in a specific population and lists the specific desired outcomes.

USING LOGIC MODELS

The Centers for Disease Control published in 2002 an excellent guide to program evaluation. The following section was taken from that document and it explains the components of a logic model. A logic model can be illustrated in a variety of ways such as a table, flowchart, diagram etc. For the most part they contain the following categories:

Component	Definition	Example
Problem Statement	Factors that put a population at risk, such as knowledge, attitudes, beliefs, behaviors, skills and environmental conditions.	MSM youth do not perceive themselves to be at risk for HIV, lack condom use skills, and have low self efficacy for condom use.
Inputs	Resources used in an intervention, such as money, staff, curricula, and materials.	<ul style="list-style-type: none"> • \$50,000 grant • Two 1/4 FTE prevention educators • The Safe Skills Curriculum • 300 Condoms
Activities	Services the intervention provides to accomplish its objectives, such as outreach, materials distribution, counseling sessions, workshops, and trainings.	<ul style="list-style-type: none"> • Conduct 3, two-hour small group sessions with MSM youth at the Youth Center • Distribute condoms
Outputs	Direct products or deliverables of the intervention, such as intervention sessions completed, people reached, and materials distributed.	<ul style="list-style-type: none"> • 4 interventions conducted • 40 MSM youth completed all three sessions • 500 condoms distributed
Immediate Outcomes	Immediate results of the intervention, such as changes in knowledge, attitudes, beliefs, and skills.	<ul style="list-style-type: none"> • Perception of HIV risk increased • Condom use skills increased • Condom use self efficacy increased

Obtained from http://www.cdc.gov/hiv/topics/evaluation/health_depts/guidance/strat-handbook/pdf/guidance.pdf, page 33.

Intermediate Outcomes	Intervention results that occur some time after the intervention is completed, such as changes in behaviors and environmental conditions.	<ul style="list-style-type: none"> • Condom use increased
Impact	Long-term results of one or more interventions over time, such as changes in HIV infection, morbidity and mortality.	<ul style="list-style-type: none"> • HIV rates decreased

Obtained from http://www.cdc.gov/hiv/topics/evaluation/health_depts/guidance/strat-handbook/pdf/guidance.pdf, page 33.

So far, we have discussed what are M&E activities, how to conduct them, and the importance of having a roadmap or logic model to guide your M&E activities. Before you explore the resources that we will provide, you might want to be familiar with the different types of M&E activities.

Formative evaluation includes the activities for program improvement. It is designed to assess the strengths and weaknesses before and during implementation. Formative research tailors the program to the target audience. This type of evaluation permits ongoing program refinement. Its purpose is to maximize program success.

Process evaluation examines the procedures and tasks involved in implementing a program. This type of evaluation also can look at the administrative and organizational aspects of the program. Process evaluation monitors the program to ensure feedback during the course of the program **as well as tell a program’s story.**

Outcome evaluation is used to document outcome results. Task-focused results are those that describe the output of the activity (e.g., the number of public inquiries received as a result of a public service announcement). Information that can result from an outcome evaluation includes:

- Knowledge and attitude change
- Expressed intentions of the target audience
- Short-term or intermediate behavior shifts
- Policies initiated or other institutional changes made

Summative Evaluation: It refers to any combination of measurements and judgments that permits conclusions to be drawn about impact, outcome or benefits of a program or method.

RESOURCES

The CDC has assembled a comprehensive list of monitoring and evaluation resources. Go to the following link: <http://www.cdc.gov/eval/resources.htm> to view these resources.

The list of resources are grouped under the following categories:

- 1) Ethics, Principles, and Standards Organizations,
- 2) Societies, Foundations, Associations journals and On-line Publications,
- 3) Step-by-Step Manuals,
- 4) Logic Model Resources,
- 5) Planning and Performance Improvement Tools ,
- 6) General Reports and Publications.

You should start with Dr. Carter McNamara's guide, under the Step by Step section. His manual is the most comprehensive and user friendly guide to evaluation. The CDC framework for program evaluation is a valuable overview of the key components of public health program evaluation.

If you are a directly or indirectly funded CDC grantee you may want to be familiar with their evaluation framework. Framework for Program Evaluation in Public Health- Centers for Disease Control and Prevention. MMWR 1999; 48 (no.RR-11). 1-42. <http://www.cdc.gov/eval/framework%20summary.pdf>



USEFUL LINKS

Organizations & Agencies

CDC Capacity Building Branch - <http://www.cdc.gov/hiv/topics/cba/index.htm>

CDC HIV/AIDS Department - <http://www.cdc.gov/hiv/default.htm>

JSI Research & Training Institute - <http://www.jsi.com/JSIInternet/>

National Network of STD/HIV Prevention Training Centers - <http://www.depts.washington.edu/nnptc/>

National Association of People With AIDS (NAPWA) - <http://www.napwa.org/>

U.S. Government HIV/AIDS Information - <http://www.aids.gov>

Statistics & Education

Academy for Education Development (AED) HIV/AIDS Anti-stigma website - <http://www.hivaidsstigma.org/>

Avert HIV/AIDS Education - <http://www.avert.org/educate.htm>

The Body: A Complete HIV/AIDS Resource – <http://www.thebody.com>

CDC National Prevention Information Network - <http://www.cdcnpin.org/scripts/hiv/index.asp>

Effective Behavioral Interventions - <http://effectiveinterventions.org/>

Kaiser Foundation's Health Policy website - <http://www.kaiseredu.org/>

National Alliance of State and Territorial AIDS Directors (NASTAD) - <http://www.nastad.org/>

National Institute of Health AIDS Information - <http://www.aidsinfo.nih.gov/>

UCSF HIV InSite Gateway to HIV and AIDS Knowledge - <http://hivinsite.ucsf.edu/>