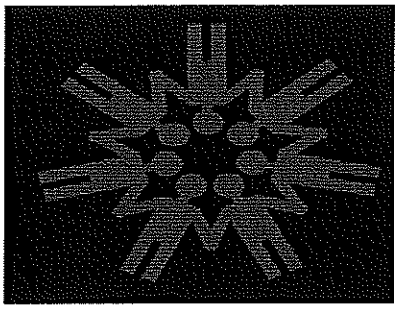
Appendix C
Training

1. Recruitment and Screener Training Manual
2. Intervention Facilitators Training Manual

1. Recruitment and Screener Training Manual



Eban II Project

African American Couples Study

Recruitment & Screener Training Manual

Edited for the Eban II Project

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Recruitment & Screening Training

The focus of this training manual is to prepare staff to maintain agency relationships and to recruit and screen participants. It is assumed that recruitment/screening training and interviewer training will be sequential and involve the same personnel. However, only the training plans for recruitment and screening are presented in this manual. See the ACASI training manual for the interviewer training plans.

Training Goal:

To prepare recruiter/screeners to identify the full range of community resources that serve HIV+ African American adults and to identify, screen and recruit prospective couples to participate in the Eban II Project.

Behavioral Objectives – Recruitment, Screening and Tracking:

At the end of the recruitment training, recruiters/screeners will be able to:

A. Describe the study objectives and procedures to community agencies and other sources of prospective participants.
B. Establish and maintain relationships with these community recruitment resources.
C. Know the study inclusion/exclusion criteria and conduct sensitive screening interviews that will identify appropriate couple participants.
D. Maintain appropriate records that will allow us to track all contacts and their disposition.

Training Materials Needed:

A. Recruitment Protocol & Manual
B. Consent forms for each site
C. Screener manual
D. Screener form(s)
E. Local recruitment site lists
F. Local service referral sources
G. Flip chart & markers
H. Tracking manual & procedures

Training Activities:

1. Review of study objectives & procedures
2. Recruitment strategies & principles

3. Recruitment script & role play
4. Screening procedures & role play
5. Tracking procedures & forms

I. Overview of the Eban 11 Project

The purpose of the Eban I1 Project is to prevent health risks in serodiscordant (i.e. where one partner is HIV positive) African American couples. We plan to screen and enroll 180 African American couples at sites in Southern and Northern California. Participants and will be recruited from a variety of different community sources, including HIVISTD clinics, CBOs, health departments, as well as through published ads, flyers, etc. Each participant will undergo comprehensive assessments, including ACASI administered psychosocial measures and biological samples collected at baseline, immediately post-treatment and at 3-month follow-ups. *Couples will be randomly assigned to an 8-week intervention - the Eban I1 HIVISTD risk reduction intervention or a waitlist group that will receive the intervention after a waiting period. Couples in the Eban I1 intervention will be taught how to strengthen their relationship, reduce their risk of sexually transmitted infections (STI), and to avoid infecting their HIV-negative partner. The primary outcome for the Eban I1 intervention will be increased self reported condom-protected sexual intercourse. All information provided by the couples will
be completely confidential and those who complete the program wilt receive reimbursement up to $- each for their time and effort.

II. Overview of the Recruiter/Screener/Tracker Role

A. Importance of role to the success of the study

The success of the study rests heavily on the skill and dedication of the recruiter. Helshe must identify the community sources of prospective participants, develop and maintain relationships with these sources, establish contact with and stimulate the interest of prospective participants in the study, conduct sensitive screening intel-views of couples, and track & maintain contact with enrolled couples over the life of the study.

B. Ethical/Professional issues

The goal of recruitment is to get the prospective participant interested enough in the project that she will commit to the screening interview. Courtesy, professionalism and respect for the confidentiality of the participants should guide all recruitment activities.

III. Introduction to Recruitment Strategies

A. Overview

While each year, two agencies will offer the Eban II intervention and their 6 staff will be trained to do so, this study will also use multiple recruitment strategies to make the LA and Oakland communities aware that the study is ongoing and that they can refer couples that they identify. We will use broad-based recruitment strategies, but recommend a geographic cluster approach for logistical reasons, so that sero discordant couples can be referred to agencies nearby. This approach will continue through the life of the study. Initial contact with new agencies and negotiations should be conducted first by site PIS or Co-Investigators or the Project Coordinator so that we can expand our recruitment resources for testing and services for couples.

B. Recruitment sources

Within each geographic cluster, multiple sources of recruitment will be used, and may include, but are not limited to:

1. HIV care clinics
2. HIV testing and counseling centers
3. Primary care clinics
4. AIDS Service organizations
5. Substance Abuse Treatment programs
6. Churches with HIVIAIDS ministries
7. Collaboration with other research organizations (i.e. setting up agreements to refer ineligible participants to one another)
8. HIV/AIDS Provider Networks, Coalitions, Advocacy Organizations
9. HIV/AIDS hotline services
10. Community-Based Organizations, particularly those that primarily serve African-American population
11. Ryan-White funded programs

C. Recruitment strategies - Thinking outside the box.

A number of recruitment strategies are described in detail in the Recruitment protocol (See Appendix xx). The primary strategies to be used include:

1. **Use of a dedicated recruiter**-At some recruitment sites that may have a high volume of potential participants (i.e. HIV care clinics) to be screened, it may be most efficient to have recruiters at the site at regular times during clinic hours to conduct screenings to determine eligibility.

2. **Recruitment phone coverage** during regular business hours- the broad distribution of flyers at many different sites and use of snowball sampling will generate calls from potential participants. Study Sites will need to arrange for phone coverage during regular business hours as many potential participants may be hesitant to leave messages. Study sites should also explore the feasibility of having a toll-free number installed as a number of participants may not have their own phone. Because of the simultaneous need for recruiters to receive phone calls and be out in the field, sites should consider the use of cell phones for some recruiters.

3. **Attending HIV care network meetings and other networking events** where the

Site Coordinator will have an opportunity to build on-going relationships with service providers, peer advocates, and members of our community advisory committees (CABS) who have extensive contact with mixed HIV serostatus couples.

4. Make informal and formal presentations about the Eban II Project to CBOs, faith-based organizations with HIVIAIDS services, and HIV care network meetings and distribute promotional flyers and posters with contact information about study.

5. **Advertising the study** in local papers and radio stations, which are popular with African-Americans, as well as in newsletters of organizations that address HIV/AIDS.

6. Snowball sampling -asking eligible as well as ineligible participants to give promotional flyers to their friends and family members who may qualify for the study. Sites may want to consider giving a small incentive for eligible, participating referrals if budgets allow. Thank you notes of appreciation should be sent to individuals making referrals.

D. Overview of Recruitment style & principles of effective recruitment.

Several principles should guide the recruitment of participants:

1. Recruitment is an ongoing process which will require time, patience, perseverance and open communication;

2. For participants to agree to the screening interview and terms of study participation, they must perceive that the advantages of participating outweigh the disadvantages;

3. As the first representative of the project, the recruiters should relate to potential participants in respectful, friendly, open and direct manner, and they must be fully informed about the study;

4. Recruiters must project a professional manner, including:

- Showing proper identification and supporting documentation
- Demonstrating a thorough knowledge of the purpose of the project and its materials, and delivering a courteous straightforward presentation.
- Demonstrating respect by listening carefully to participant's responses and addressing participants by Mr. or Ms. unless given permission to use first name.
- Demonstrating commitment to confidentiality by protecting all identifying information.

5. Avoid being pushy because this tactic is unethical, ineffective and could adversely affect the quality of the data collected, or being too passive because this conveys a lack of confidence or commitment. The most effective approach is an assertive approach in which the Recruiter "sells" the study by demonstrating with confidence and conviction the importance of participation to respondents.

IV. Recruiting participants.

A. Review of recruitment materials, brainstorm specific recruitment plans, and share ideas and costs estimates across sites.

1. Flyers
2. Brochures
3. Newspaper & radio ads
4. Recruitment sources & prior experiences

B. Logistics and role-play recruitment presentations at community agencies.

1. Setting the stage for recruitment:

- Identify agency contact person(s).
- Call ahead and set up appointment with agency contact person before visiting agency. Cold calls rarely work.
- Mail recruitment kit with information about the study (See 3 below).

2. Role-play recruitment presentation (20 minutes)

TRAINER: Have recruiters from each site take turns practicing the recruitment script below and have the trainer and the other recruiters give them feedback. Modify the script as needed to make the points more effectively.

Phone Script

Hi, my name is [enter name here] I'm calling to set up an appointment to talk with you about our exciting new NIMH-funded project. The project is called Eban II and it is designed specifically for African American couples affected by HIV. I would like to meet with you to discuss our study in more detail, as well as discuss the possibility of recruiting participants from your agency.

[If asked to provide more detail about the study, do so. Try to make the phone call brief, because you don't want to take up too much of their time. Once the appointment is made, inform the agency contact that you will mail or fax them an information kit of study materials so they can review it prior to your meeting. This will allow the agency contact to review the information at their convenience and to have any questions ready for you. This will make for a better and more productive meeting].

In Person

(Introduce yourself, thank the agency contact for taking the time to meet with you, begin script)

The goal of the study is to test the Eban II intervention, which provides couples with education to help them reduce their risky sexual behaviors and protect each other from contracting STDs and transmitting HIV to the uninfected partner.

In order to participate, at least one partner must be African American, they must be a real couple (i.e. identify each other as their primary sexual partner and have an ongoing sexual relationship) although they need not be married, and they must reside within a reasonable distance from your site. All participating couples will be screened to make sure they meet these study criteria and will be randomly assigned to the intervention group or a waitlist control group. Their HIV status will be confirmed, they will be interviewed at several points during the study and follow-up, and those who complete the program will be reimbursed up to $ ____ *each for their time and effort. They will also be provided with a light snack at each session.*

We are requesting your assistance in recruiting participants for our study. We would be happy to meet with your staff to inform them about our study and solicit their help in identifying couples that might be interested. We would also be willing to speak directly to your clients as they wait for services or to distribute our study brochure and flyers, whichever would be most convenient for your agency. If it is convenient, we would also like to screen couples that might be interested. This would require having a room where we would have some privacy since some of the screening questions are somewhat sensitive. Thank You. We appreciate your help with this very important study.

3. Recruitment kit for agencies

- Description of the purpose and design of the study
- List of eligibility criteria
- Copy of recruitment flyers and brochure
- Copy of the approved consent form
- Business card
- List of frequently asked questions (See IV. D below)

C. Frequently Asked Questions/Issues (FAQs)

For service providers/gatekeepers to become invested in the study, they must perceive that the benefits of involving their clients in the study will outweigh the disadvantages or risks. Study staff should anticipate and be able to address the following concerns of service providers/gate keepers:

1. Will participation in the study have any potential negative effects on your clients?

No, it will not. In fact, couples are likely to gain substantially from participating by reducing their health risks and enhancing their overall health.

2. **Has staff carefully considered the issue of confidentiality and are the procedures adequate to protect clients?**

   Yes, we have. All information provided by participants will be held in confidence, and the study is protected by a certificate of confidentiality from NIH that provides legal protection against subpoena. However, we do have a legal obligation to report new cases of STDs to the health department, as well as an ethical responsibility to reports incidents of child or elder abuse.

3. **Has there been any community input in the development and oversight of this study?**
   Yes, we have a community advisory board of community agency directors and staff, as well as HIV+ couples who have reviewed the study procedures and curricula and given us feedback. In addition, there is a national Data Safety & Monitoring Board of scientists that oversee the progress of the study and approve all study plans and procedures.

4. **What is the intent of the researchers in the study? – Are they going to collect the data from clients and leave?**

   The goal of this study is to develop effective interventions that will benefit couples that are impacted by HIV/AIDS. Once this intervention is shown to be effective, it is our goal to make these programs available to community agencies that serve this population.

5. **Does the study staff have a well thought out plan for disseminating data directly to service providers and consumers when the study is completed?**

   Yes, we will be developing plans to share our findings with the assistance of our community advisory boards and with the agencies that are helping us to identify and recruit our study participants. We plan to keep the collaborating agencies informed of the progress of the study on a regular basis and at the completion of the study.

6. **What impact will study have on the operations of their program? How much time will the study consume of program staff? Will recruitment operations require access to space on site? How long will the recruiting staff be at the agency?**

   It is our intent not to disrupt agency operations and have as little impact on staff time as possible. What role staff plays in assisting us in identifying prospective participants will be determined by each agency or clinic. Ideally, we would appreciate any assistance staff can provide us in helping to identify clients that would meet our study criteria, but we will be satisfied if we are able to make presentations about the study and hand out flyers and cards to clients while they are waiting for their appointments. Access to a private space for screening videos would also be very desirable in order to protect the privacy of prospective participants.

7. **What acknowledgement will agencies receive for participating in the study? Will there be opportunities for providers to be co-authors on articles?**

Agencies that assist us with recruitment and screening will be acknowledged by name in our reports to NIH. However, only investigators involved in the conduct of the study and in preparation of study results will be listed as co-authors on publications and presentations.

8. Can agencies receive any funds from the study?

Most agency sites have funds available to compensate other agencies for recruitment at their site. However, if agencies collaborate with the Eban II project by offering the interventions at their site, they will also receive a laptop computer for their use.

V. Screening Interview Procedures

A. Importance of role to the success of the study.

The Visit 1 Eligibility Screening is the first point of contact with all participants, so it is extremely important that you make a good first impression. The success of the study also rests heavily on the ability of the recruiter to effectively screen prospective couples to ensure that they meet study eligibility criteria. Participants who are later determined to have been ineligible constitute a violation of study protocol and are to be recorded as such.

Recruiters must be clear that:

1. Their role on the project is to find & screen prospects, and not to become an "advocate" for prospective participants if they do not meet criteria;

2. They need to be sensitive and respectful, but focused on obtaining the information necessary to determine whether each prospect meets study inclusion criteria;

3. They must make sure prospects that meet criteria understand what will be required of them and are able to meet study expectations (i.e. active participation as a couple in all assessment sessions and in all intervention sessions);

4. They must keep complete records of all screens conducted and their disposition.

B. Introducing the study to prospective participants.

The recruiter should first spend a few minutes individually or on the phone describing the project to potential participants. The project should be described as a unique opportunity to learn about issues related to health and wellness for mixed HIV serostatus African American couples. From previous experience, it is recommended that whenever possible, recruiters should be gender matched to participants as prospects are more likely to trust someone of their own sex recommending a couple study.

<u>Visit 1 Eligibility Screener Script</u>

Read the exact italicized script on the form:

*Hello, my name is _____. I am _____**[your title]** at **[your site.]** I'd like to talk with you about the Eban II Project, which is an important health risk reduction program for African American couples. This is a brochure that describes the program. **[Hand them a brochure.]** The program is for couples that are affected by HIV. The program will include 8 educational sessions about preventing health risks through education about medication, diet, exercise, heart disease, cancer, and sexually transmitted diseases, especially HIV. In addition to these 8 sessions, there is also a follow-up meeting after 3 months. .*

*To participate, you and your partner must both attend all sessions of the program **ON TIME**. There will be a total of 3-5 couples in your group, and you will meet for approximately 2.5 hours per overall session. Everything you and other people say in the group will be confidential, as this is an important ground rule of the group sessions. If you and your partner are a good match for the study and agree to participate, we will provide a light snack at each of the sessions.*

*Do you have any questions at this point? **[Recruiter answers all questions]** Do you think this would be something you would like to attend?*

1. **Interviewing Techniques**

It is essential that recruiters read the script and questions exactly as they appear, as each word has been carefully chosen to broadcast the purpose of the study and gather important data while taking into consideration the needs and interest of potential participants. Often times, participants will have questions concerning the study, or questions about what the recruiter said. It is important that recruiters answer each question to the best of his/her ability. If a recruiter does not know the answer to a question, he/she should be honest with the participant and/or ask someone else to get the answer.

2. **Handling Refusals**

If the participant refuses, say "*Okay, I am sorry to hear that. Do you mind telling me why? Your reason may help us plan future groups".*

Recruiters should respect the decision of the participant who refuses to participate, but always leave the door open for a reversal. They should provide individuals who refuse with a study brochure, and other contact information, encouraging them to call with questions about the study or if they change their minds and decide to participate. Recruiters should leave participants feeling that they just had an informative exchange with a pleasant, respectful person.

What may appear to be a refusal to cooperate may be only an expression of concern or a need for more information about the study. The following points will be helpful in reducing or eliminating "refusals" when making contacts.

- Do not invite refusals. An air of apology or defeat can sometimes trigger a refusal. Ask if you can call back in a week to check on them.

- A friendly, confident and positive manner, assertive but not aggressive, usually will have positive effects

- Listen carefully to the respondent's comments and try to determine the basis for his/her objections. Then, target your responses to those objections or concerns.

- More details about the study, the procedures, confidentiality, or time involved may answer the "unasked" question. Sometimes the best technique is to simply ask: "Is there something I can explain to you about your participation in this project that is bothering you?"

- Be prepared to explain the study and answer questions. It is critical that we listen to the respondent's comments and tailor our response to his or her need for information. Do not allow refusals to affect your positive approach to recruitment. Even the best recruiters experience an occasional refusal, which is not a reflection of the ability of the recruiter. It can be discouraging, but recruiters must learn to "roll with the punches" and quickly get back into stride. Here are some common refusals recruiters can expect to encounter and suggested ways of responding to such refusals:

Possible Refusal	Recruiter Response
"no time – ever"	At a minimum, attempt to determine if the client may be willing to participate in the future. Try to figure out why the s/he is so opposed to participation in the project. Also stress that s/he may ask any questions s/he may have about the interview in order to allay any fears .
"I have no time – I work every day from 9 to 5."	Inform the client that we are very flexible and are willing to work with his/her schedule by conducting interviews in the evenings and on weekends at our office or CBOs.
"I Don't like studies – they are a waste of time and money"	Stress the importance of conducting studies that help us to develop more effective interventions for populations in need. The government needs to learn the impact of these efforts so that funds can be allocated more effectively. Explain the importance of participation by every selected respondent since each represents other individuals like themselves.
Concerns about confidentiality	Acknowledge the legitimacy of their concern about confidentiality. Indicate the Eban II Project team understands the importance of this issue and has developed an extensive protocol about how to maintain confidentiality of their

	participation in the intervention program and their responses to the questionnaire. Before participants enroll in the program, they will sign a consent form which will detail how confidentiality will be maintained. Reassure respondent about confidentiality by explaining the design of the privacy of the survey, confidentiality and the manner of administration. Stress that our interest is only in the aggregate of all responses - not individual answers. No individual will be connected to any of the responses.
"My partner will not want to come to the sessions."	Explore the concern. If safety is not a concern, then normalize concern, indicating that a number of people have told us initially that they didn't think their partners would want to participate in a previous couple study. However, reassure participants that many of these same people have been pleasantly surprised that their partners were willing to participate after the couples program was carefully explained to their partners. Indicate that there are different options for presenting the study to the partners and that members of the recruitment staff will be on call to carefully explain the study to their partners and answer any of his or her questions or concerns about the study.
Transportation	If participants let us know in advance, the agency can arrange for public transportation.
Babysitting concerns	We can provide babysitting at all sessions,

3**. Handling Yeses.**

Script:

If an interviewee agrees to participate in the interview, say, "*Great! I will need to ask you a series of questions to make sure that you are eligible to participate. These questions are organized as a series of 5 questions that are grouped together. Please wait until I have asked all 5 questions before answering. Please answer Yes if any of the 5 questions are true of you. I will also ask you a set of 3 questions, and I would like you to answer No if any of the 3 questions are not true of you. Do you understand? If you are eligible, I will take your information, so that we can contact you about the program sessions. I will also need to talk to your partner and ask him/her the same questions before you can both participate.*

The participant must give verbal consent before the visit 1 eligibility screener can be completed. (See Section C Below regarding consent).

NOTE: Only the pre-screener is administered first at visit 1 which could be on the telephone. The more detailed screener is administered at visit 2 and written consent is required before administering this measure.

3. **Emphasize the benefits of participation**

In addition to addressing negative concerns of the potential participant, recruiters should highlight the following advantages:

- The health related interventions of Eban II Project are specifically designed for African American couples by African-Americans who are some of the leading Health Intervention experts in this country;

- Participating in Eban II Project will contribute to advancing knowledge about how to promote healthy behaviors among HIV-infected African American couples, which will help other couples.

- The intervention is an enjoyable way to spend time with their partner;

- This is a service that community agencies, clinics and churches will offer free of charge.

- The Eban II Project team recognizes the importance of maintaining confidentiality of their participation and the information they provide during sessions and interviews will be kept confidential. A detailed protocol about how to protect the confidentiality of all data has been developed, which the recruiter must review with each prospective participant before he or she decides to enroll in the study. This protocol has been reviewed and approved by the National Institute of Health and the IRB at the four participating universities.

4. **Screening Refusal Documentation**

Recruiters should complete a Screening Refusal Form when a potential participant declines participation in the screening interview (See Appendix) so that we can monitor the reasons for refusals.

C. Informed consent protocol & procedures for the screen.

NOTE: All of the issues addressed below apply to all sites.

1. Each participant must agree, either in person or by phone, to be screened or pre-screened before any screener questions can be asked. At some sites, consent to be screened must be

given in person and a signed consent must be obtained, while at other sites, a verbal consent is sufficient. Recruiters must follow the IRB guidelines of their respective institutions.

2. Obtaining permission from one member of the couple to contact their partner is not appropriate. Recruiters can ask the person they are talking with to contact their partner on the spot by cell phone to see if they are interested and willing to talk to the recruiter. If that is not possible, then they should give the person their card and project flyer to give to their partner and have them call the recruiter. A follow-up call to the contact member of the couple should be made to check on their partner's willingness to be screened.

3. The study purpose and procedures should be described to each member of the couple before their consent to the screening interview is obtained.

4. Once they consent to be screened, every effort should be made to conduct the screening interview in private. Ideally, this should be done in a private office at the agency site. If that is not possible, then other alternatives should be considered (e.g. take them to a public park, in the car, at a close by restaurant/diner, etc.). If this alternative is to be used, care must be taken to protect your safety and that of the prospective participant. **That is, make sure that there is enough privacy, yet that the area is safe and public, and, if at all possible, the genders should be matched.**

5. In obtaining informed consent, the following issues must be addressed:

   - **Confidentiality** – all information given will be kept in confidence and not disclosed to anyone, including to their partner, without their knowledge or consent. Because of ethical concerns, assistance will be provided to them to disclose incidents of child or elder abuse to the appropriate people so that appropriate action can be taken.

   - **Protection of their identity** – the information they provide will not be identified by their name or by any other personally identifying information. Instead, their information will be identified only with a discrete research ID number. In addition, personally identifying information will be kept separate from the data in a locked file and only project personnel will have access to this information. However, because the study involves discussion of personal information in the presence of their partner and other couples, we cannot guarantee that either they or their partner or other couples will not divulge personal information outside of the sessions. However, special attention will be given to this issue and all participants will be informed of the rule that everything discussed in the sessions is to remain in the sessions.

HIV & STI testing & reporting of results – all biological samples are to be collected by an HIV/STI testing site in private and identified by a research ID number only. In some cases, HIV/STI Pre and post-test counseling will be provided, and the test results will be provided to each participant privately. In other instances where home testing kits are used, counseling may be provided. A form will be given to participants to verify HIV status. This form will be given to agencies with the participant ID to record the HIV status. In the case of unexpected positive results, participants will be provided with assistance in dealing with the results (e.g. treatment for STIs, assistance in informing their partner, etc). Every precaution is to be taken to ensure that their

confidentiality is not violated. However, there is no way to stop them or their partner from disclosing this information to others.

- **Right to refuse to answer questions** – participants have the right to refuse to answer any questions that they feel are too personal or that they are too uncomfortable answering.

- **Right to terminate their participation at anytime** – all participants have a right to terminate their participation in the study at any time without any loss of rights to services at their agency. However, reimbursement will be given only for those sessions attended by the couple.

NOTE: These principles apply to all phases of the intervention, not just to the administration of assessment measures.

Trainer: Have screeners form two-person teams and role-play administering the screening interview.

VI. Administration of the screening interview to partner 1 & 2.

1. Review screening interview protocol. Discuss the purpose for each question, paying special attention to the inclusion and exclusion questions. Answer questions that come up.

2. Demonstrate administering the interview to the group.

3. Review interviewing principles about asking questions, reading each response or using response cards, and probing and clarifying participants responses.

4. Review how to assess for drug-related, cognitive or psychiatric impairment – role play different scenarios for handling impaired participants.

5. Have screeners form two-person teams and role-play administering the screening interview to each other. Evaluate the performance of each screener and give feedback. If a screener is having difficulties give him/her additional practice with you serving as the "interviewee".

6. Although this may not happen often, it is still important to review how to handle distress during the screen, make referral to the appropriate person at the agency or clinic, and report the incident to your supervisor immediately. Obtain consultation if needed.

7. In the event that a prospective participant reports that they are currently experiencing physical or sexual violence from their intimate partner, inform the participant that this will have to be reported, refer for services to the agency or to the appropriate referral source in the community.

<u>NOTE</u>: Each team must develop a comprehensive referral list for their community and all staff must have a copy when working with participants

CONTACT/VISIT 1 PARTICIPANT ELIGIBILITY SCREENER

PARTICIPANT 1 SCREENER INTRODUCTION:

1. **Introduction** (name, title, site)
2. **Purpose**:
   * I'd like to talk with you about an exciting new project called Eban II.
   * **Hand them a study brochure** and describe.
3. **Eban II Project**:
   * an important health risk reduction program for heterosexual African American couples where either one member is HIV positive and one member is HIV negative, or both members are HIV positive.
   * includes 8 educational sessions about preventing health risks through education about medication, diet, exercise, heart disease, cancer, and sexually transmitted diseases, especially HIV.
   * also includes follow-up meetings after 6 months, and 12 months.
4. **Study Participation**
   * to participate, you and your partner must both attend all couple and group sessions of the program together.
   * there will be a total of 3-5 couples in your group, and you will meet for approximately 2 ½ hours per overall session.
   * confidentiality (everything you and other people say in the group stays in the group) is strictly upheld.
   * you and your partner will receive a light snack at each meeting.
   * to participate in this study, you and your partner will both have to have taken a test for HIV. If you do not know your HIV status or do not have written confirmation of your HIV status, then you will be asked to give permission for your health care provider to allow us to receive this information.
   * As part of this study, you and your partner will also be asked get tested for common STDs (chlamydia, gonorrhea, and trichomoniasis). It is important that as a part of this study you know if you have an STD and if you are positive for an STD, you should receive treatment for it.

<u>Participation Script *(read word for word)*</u>

Where did you hear about this study?
Do you think this would be something you would like to attend?
***If No,** Okay, I am sorry to hear that. Do you mind telling me why? Your reason may help us plan future groups. **[Write down Reason for Refusal Below. After writing clown their reason, say:]**Thank you for your time today. If you change your mind, please call us at the number provided in your invitation letter. Also, if you know other couples who might like to participate, feel free to give them the brochure with our contact infomration.*

Reason for Refusal?

If Yes, *Great! I will need to ask you some personal questions to make sure that you are eligible to participate. Some questions may seem silly and obvious, but I still need to ask them. Thank you for taking the time to answer these questions. If you are eligible, I will take your information, so that we can contact you about the program sessions. I will also need to talk to your partner and ask him/her the same questions before you can both participate.*
Is it ok to ask you the questions on this interview?
VERBAL CONSENT FOR INTERVIEWEE OBTAINED? ❑ Yes ❑ No
If No, *Okay, I am sorry to hear that. Do you mind telling me why? Your reason may help us plan future groups.* ***[Write Down Reason for Refusal Below. After writing down their reason, say:]***
Thank you for your time today. You may keep the brochure, and if you change your mind, please call us at the number provided on the back. Also, if you know other couples who might like to participate, feel free to give them the brochure with our contact information.
Reason for Refusal?

_____

After writing down their reason, say: *Thank you for your time today.*
If Yes, "Everyone would like to live a healthy life. We know what we should do about eating healthy foods, not smoking, not drinking too much or driving too fast, and avoiding things that are risky to do. However, at times, we all do things that we know are not good for us to do but we do them anyway. An important part of this study is finding out what risky things people do and how often so that we can develop a prevention program that will help our African American community to live a healthier life. It is therefore very important that you try to be as honest as possible about behavior that you know is not what you should be doing to maintain good health. Please take a few minutes to think about your answers to the following questions."

1. Were you born a male or female?

   ❑ Male ❑ Female

2. How old are you?

   ❑ < than 18 years old ❑ ≥ 18 years old: _____years

3. Do you speak English well?

   ❑ Yes ❑ No

4. Do you have an address where you can receive mail?

   ❑ Yes ❑ No

5. Do you consider yourself Black or African American?

   ❑ Yes ❑ No

6. Do you have someone (spouse, girlfriend/boyfriend, or lover) that you consider a main sexual partner?

   ❑ Yes what are partner's initials? _____

   ❑ No ***SKIP to Instructions to Recruiter for Ineligible Participant(s) on page 7***

7. Was **[partner's name]** born a male or female?

❑ Male ❑ Female

8. How old is **[partner's name]**?

❑ < than 18 years old ❑ ≥ 18 years old: _____years

9. Does **[partner's name]** speak English well?

❑ Yes ❑ No

10. Does **[partner's name]** have an address to receive mail?

❑ Yes ❑ No

11. Does **[partner's name]** consider him/herself Black or African American?

❑ Yes ❑ No

12. How long have you been in a relationship with **[partner's name]**?

❑ < 3 months ❑ ≥ 3 months: how long _____

13. Do you plan to stay with **[partner's name]** for at least another year, or more?
READ response choices aloud

❑ Definitely yes ❑ Probably no
❑ Probably yes ❑ Definitely no

14. Sometimes couples experience conflict in their relationship. People may do things when experiencing conflict. I am about to ask you if you have had certain experiences in your relationship with **[partner's name]**. Please tell me if each of the following things happened in your relationship with **[partner's name]** during the past year:

a. Has **[partner's name]** punched or kicked you, beat you up, slammed you against a wall, hit you with something that could hurt or scalded or burned you on purpose?

❑ Yes ❑ No

b. Has **[partner's name]** choked you or used a knife, gun, or other weapon on you, or threatened to do so?

❑ Yes ❑ No

c. Has **[partner's name]** used any force to make you have sex?

❑ Yes ❑ No

15. Now I am going to ask you some sensitive questions about your sexual behavior and HIV status. Many people are uncomfortable answering these questions or think that there are right

and wrong answers. There are no right or wrong answers, so please answer each question as honestly as you can. Please remember that everything you say is confidential.

There are lots of ways that people use condoms. However, when you start having sex before putting on a condom or they slip off or break during sex, this does not protect against infection, and therefore is not considered proper condom use. I'd like to ask you about your condom use:

For female participants only

15a. In the past 90 days (3months), did your study partner put his penis in your vagina at least one time?

❑ Yes ❑ No (skip to 16a)

15b. In the past 90 days (3months), did your study partner put his penis in your vagina at least one time without wearing a condom?

❑ Yes ❑ No

16a. In the past 90 days (3 months), did your study partner put his penis in your bottom or anus at least one time?

❑ Yes ❑ No (skip to 18)

16b. In the past 90 days (3 months), did your study partner put his penis in your bottom or anus at least one time without wearing a condom?

❑ Yes ❑ No

17. In the past 90 days (3 months) when you had sex and used a condom, did the condom ever break or slip off?

❑ Yes ❑ No

For male participants only

15a. In the past 90 days (3months), did you put your penis in your study partner's vagina at least one time?

❑ Yes ❑ No (skip to 16a)

15b. In the past 90 days (3months), did you put your penis in your study partner's vagina at least one time without wearing a condom?

❑ Yes ❑ No

16a. In the past 90 days (3 months), did you put your penis in your study partner's bottom or anus at least one time?

❑ Yes ❑ No (skip to 18)

16b. In the past 90 days (3 months), did you put your penis in your study partner's bottom or anus at least one time without wearing a condom?

❑ Yes ❑ No

17. In the past 90 days (3 months) when you had sex and used a condom, did the condom ever break or slip off?

❑ Yes ❑ No

18. What is your HIV status?

❑ HIV Negative (skip to #20)
❑ HIV Positive
❑ Do not know (skip to #20)

19. How long have you known your HIV status?

❑ < 3 months ❑ ≥ 3 months: how long _____

20. Does **[partner's name]** know your HIV status?

❑ Yes ❑ No

If No, say, "If you are interested in disclosing your status to your partner, you can receive professional help to aid you in this process. I will give you this useful referral information." **[Recruiter gives respondent the referral information]**

21. *What is **[partner's name's]** HIV status?*

❑ HIV Negative (skip to #22)
❑ HIV Positive
❑ *Do not know (skip to #22)*

22. *How long has **[partner's name]** known [his/her] HIV status?*

❑ < 3 months ❑ ≥ 3 months: how long _____

23. Do you and **[partner's name]** plan to live in this area (within a 2-hour commute of site) for the next year?

❑ Yes ❑ No

24. Are you or **[partner's name]** currently pregnant?

❑ Yes ❑ No
If yes, when is your due date: _____

25. Do you and **[partner's name]** plan to get pregnant during the next 18 months?

❑ Yes ❑ No

We want to ask you one question on whether you and your partner have attended sessions on HIV and STDs and if you were paid for attending these sessions. The first question focuses on the past 12 months and the second whether you are currently attending. We also would like to know the name of the program you attended, the number of sessions you attended, and the sponsor of the program.

26. In the past 12 months, have you and your partner attended **together** any paid research studies to learn how to reduce HIV risks and STDs or how to negotiate safer sex?

❑ Yes ❑ No
Specify name of the program _____
Specify number of sessions you attended _____
Sponsor of the program _____

Recruiter: Participant is <u>ELIGIBLE</u> if:

- ☐ **At least one partner identifies as Black, African American or of African descent.** ***(Items 5 and 11)***
- ☐ **They have been together for at least 3 months.** ***(Items 12 and 8)***
- ☐ **They are a heterosexual couple and identify each other as their primary sexual partner, although they do not have to be married or living together.** ***(Items 1 and 7)***
- ☐ **Must be currently sexually active and engage in unprotected sex. (Items 15b, 16b, 17)**
- ☐ **Must live within a reasonable distance and have no plans to move within the next year. (Item 23)**
- ☐ **Are not currently expecting a child and are not planning on having children anytime within the next year. (Items 24 and 25)**
- ☐ **Are willing and able to participate fully in the study for at least 8 months. (Item 27)**

If respondent and partner are eligible for the study, continue to the next question.

27. Do you think that you and **[partner's name]** might be interested in participating in the *EBAN II* Program?

❑ Yes ❑ No

If eligible, get their contact information.
NEXT: Complete Tracking Information Sheet, and ask all shaded questions and screen partner.

If No, say, *Okay, I am sorry to hear that. Do you mind telling me why? Your reason may help us plan future groups.* ***[Writer Down Reason for Refusal Below. After writing down their reason, say:]*** *You may keep this brochure* ***[hand them brochure]****, and if you change your mind, please call us at the number provided on the back. Also, if you know other couples who might like to participate, feel free to give them the brochure with our contact information.*
Reason for Refusal?
❑ Transportation ❑ Dependent Children ❑ Confidentiality ❑ Participant Resistance
❑ No time ❑ Other *(list below)*

_____

_____

STOP the interview and say, *Thank you for your time today.*

NEXT: Complete Tracking Information Sheet, and ask all shaded questions.
Also Say, It is important in this study that you and your partner know your HIV status. Please go and get tested (or have your partner get tested) and then contact us again for enrollment. – **give out Treatment Notification & Authorization Letter, testing referral information, business card, and brochure that contain the relevant contact information.**

Recruiter: Participant is <u>INELIGIBLE</u> if:
None of the above criteria is met. Check if respondent answered any shaded response boxes.
Neither partner is agree they have been together for at least 3 months
Neither identified as Black or African American
Not a heterosexual couple

Not sexually active or use condoms properly all of the time
Live outside area and not accessible by transportation
Expecting a child within 2 months
Intentionally plan to have a child within a year
Cannot commit to program for 8 months

OR
Recruiter deems the participant as not mentally coherent enough to participate (confirmed by the MMSE)or their relationship has been abusive in the past year. STOP. Say, Thank you for your interest and your time. I am sorry, but you and your partner are not a good fit for the Eban II Couples Program. Would you like to be contacted for other programs in the future? **-give out business card and brochure that contains referral and relevant contact information.**

(Item 12 and item 8): If respondent or partner does agree they have been together for at least 3 months, STOP. Say, it is important that you and your partner are togher for at least 3 months.

(Item 20): If respondent has not yet disclosed their HIV positive status to their partner. STOP. Say, A major requirement to be eligible for this study is that your partner knows your HIV status. Please use the referral information I gave you which will help you disclose your status to your partner. Once he/she knows your status, please contact us again for enrollment. **– give out business card and brochure that contains the relevant contact information.**

STOP the interview and say, *Thank you for your time today.*

NEXT: Complete Tracking Information Sheet, and ask all shaded questions.

PARTNER SCREENER INTRODUCTION:

1. **Introduction** (name, title, site)
2. **Purpose**:
   * **[Indicate referring participant's name]** referred you to me to determine your interest and eligibility for an exciting new study called the Eban II Project.
   * **Hand them a study brochure (if in-person)** and describe.
3. **Eban II Project**:
   * an important health risk reduction program for heterosexual African American couples where either one member is HIV positive and one member is HIV negative, or both members are HIV positive.
   * includes 8 educational sessions about preventing health risks through education about medication, diet, exercise, heart disease, cancer, and sexually transmitted diseases, especially HIV.
   * also includes follow-up meetings right after the sessions are over, and after 3 months.
4. **Study Participation**
   * to participate, you and your partner must both attend all couple and group sessions of the program together.
   * there will be a total of 3-5 couples in your group, and you will meet for approximately 2 ½ hours per overall session.
   * confidentiality (everything you and other people say in the group stays in the group) is strictly upheld.
   * you and your partner can participate at no cost to you and have a light snack at each meeting
   * to participate in this study, you and your partner will both have to have taken a test for HIV. If you do not know your HIV status or do not have written confirmation of your HIV status, then you will be asked to give permission for your health care provider to allow us to receive this information.
   * As part of this study, you and your partner will also be asked get tested for common STDs (chlamydia, gonorrhea, and trichomoniasis). It is important that as a part of this study you know if you have an STD and if you are positive for an STD, you should receive treatment for it.

Participation Script *(read word for word)*

Where did you hear about this study?

Do you think this would be something you would like to attend?

If No, *Okay, I am sorry to hear that. Do you mind telling me why? Your reason may help us plan future groups.* ***[Write down Reason for Refusal Below. After writing clown their reason, say:]****Thank you for your time today. If you change your mind, please call us at the number provided in your invitation letter. Also, if you know other couples who might like to participate, feel free to refer them to this project.*

Reason for Refusal?

If Yes, *Great! I will need to ask you some personal questions to make sure that you are eligible to participate. Some questions may seem silly and obvious, but I still need to ask them. You will be paid $5 for taking the time to answer these questions. If you are eligible, I will take your information, so that we can contact you about the program sessions.*

Is it ok to ask you the questions on this interview?

VERBAL CONSENT FOR INTERVIEWEE OBTAINED? ____ YES ____ NO

If No, *Okay, I am sorry to hear that. Do you mind telling me why? Your reason may help us plan future groups.* ***[Write down Reason for Refusal Below. After writing clown their reason, say:]****Thank you for your time today. If you change your mind, please call us at the number provided in your invitation letter. Also, if you know other couples who might like to participate, feel free to refer them to this project.*

Reason for Refusal?

If Yes, "Everyone would like to live a healthy life. We know what we should do about eating healthy foods, not smoking, not drinking too much or driving too fast, and avoiding things that are risky to do. However, at times, we all do things that we know are not good for us to do but we do them anyway. An important part of this study is finding out what risky things people do and how often so that we can develop a prevention program that will help our African American community to live a healthier life. It is therefore very important that you try to be as honest as possible about behavior that you know is not what you should be doing to maintain good health. Please take a few minutes to think about your answers to the following questions."

1. Were you born a male or female?

   ❑ Male ❑ Female

2. How old are you?

   ❑ < than 18 years old ❑ ≥ 18 years old: _____years

3. Do you speak English well?

   ❑ Yes ❑ No

4. Do you have an address where you can receive mail?

   ❑ Yes ❑ No

5. Do you consider yourself Black or African American?

   ❑ Yes ❑ No

6. Do you have someone (spouse, girlfriend/boyfriend, or lover) that you consider a main sexual partner?

   ❑ Yes
   ❑ No ***SKIP to Instructions to Recruiter for Ineligible Participant(s) on page 13***

7. *What is the name of your main sexual partner?* **Write partner's initials**: _____

*** If the name does not match the referring individual, the recruiter should ask if their main sexual partner would like to participate in this study.**

8. How long have you been in a relationship with **[partner's name]**?

   ❑ < 3 months ❑ ≥ 3 months: how long _____

9. Do you plan to stay with **[partner's name]** for at least another year, or more?
   READ response choices aloud

   ❑ Definitely yes ❑ Probably no
   ❑ Probably yes ❑ Definitely no

10. Sometimes couples experience conflict in their relationship. People may do things when experiencing conflict. I am about to ask you if you have had certain experiences in your relationship with **[partner's name]**. Please tell me if each of the following things happened in your relationship with **[partner's name]** during the past year:

a. Has **[partner's name]** punched or kicked you, beat you up, slammed you against a wall, hit you with something that could hurt or scalded or burned you on purpose?

❑ Yes ❑ No

c. Has **[partner's name]** choked you or used a knife, gun, or other weapon on you, or threatened to do so?

❑ Yes ❑ No

d. Has **[partner's name]** used any force to make you have sex?

❑ Yes ❑ No

11. *Now I am going to ask you some sensitive questions about your sexual behavior and HIV status. Many people are uncomfortable answering these questions or think that there are right and wrong answers. There are no right or wrong answers, so please answer each question as honestly as you can. Please remember that everything you say is confidential.*

There are lots of ways that people use condoms. However, when you start having sex before putting on a condom or they slip off or break during sex, this does not protect against infection, and therefore is not considered proper condom use. I'd like to ask you about your condom use:

For female participants only

11a. In the past 90 days (3months), did your study partner put his penis in your vagina at least one time?

❑ Yes ❑ No (skip to 12a)

11b. In the past 90 days (3months), did your study partner put his penis in your vagina at least one time without wearing a condom?

❑ Yes ❑ No

12a. In the past 90 days (3 months), did your study partner put his penis in your bottom or anus at least one time?

❑ Yes ❑ No (skip to 13)

12b. In the past 90 days (3 months), did your study partner put his penis in your bottom or anus at least one time without wearing a condom?

❑ Yes ❑ No

13. In the past 90 days (3 months) when you had sex and used a condom, did the condom ever break or slip off?

❑ Yes ❑ No

For male participants only

11a. In the past 90 days (3months), did you put your penis in your study partner's vagina at least one time?

❑ Yes ❑ No (skip to 12a)

11b. In the past 90 days (3months), did you put your penis in your study partner's vagina at least one time without wearing a condom?

❑ Yes ❑ No

12a. In the past 90 days (3 months), did you put your penis in your study partner's bottom or anus at least one time?

❑ Yes ❑ No (skip to 13)

12b. In the past 90 days (3 months), did you put your penis in your study partner's bottom or anus at least one time without wearing a condom?

❑ Yes ❑ No

13. In the past 90 days (3 months) when you had sex and used a condom, did the condom ever break or slip off?

❑ Yes ❑ No

14. What is your HIV status?

❑ HIV Negative (skip to #15)
❑ HIV Positive
❑ Do not know (skip to #15)

15. How long have you known your HIV status?

❑ < 3 months ❑ ≥ 3 months: how long _____

16. Do you and **[partner's name]** plan to live in this area (within a 2-hour commute of site) for the next year?

❑ Yes ❑ No

17. Are you or **[partner's name]** currently pregnant?

❑ Yes ❑ No
If yes, when is your due date: _____

18. Do you and **[partner's name]** plan to get pregnant during the next 18 months?

❑ Yes ❑ No

We want to ask you one question on whether you and your partner have attended sessions on HIV and STDs and if you were paid for attending these sessions. The first question focuses on the past 12 months and the second whether you are currently attending. We also would like to know the name of the program you attended, the number of sessions you attended, and the sponsor of the program.

19. In the past 12 months, have you and your partner attended **together** any paid research studies to learn how to reduce HIV risks and STDs or how to negotiate safer sex?

❑ Yes ❑ No
Specify name of the program _____
Specify number of sessions you attended _____
Sponsor of the program _____

Recruiter: Couple is <u>ELIGIBLE</u> if:

- ☐ **At least one partner identifies as Black, African American or of African descent.** ***(Item 5 on each interview)***
- ☐ **At least one partner is HIV-positive.** ***(Item 18 on first and 14 on second interview)***
- ☐ **They are a heterosexual couple and identify each other as their primary sexual partner, although they do not have to be married or living together.** ***((Item 1 on each interview)***
- ☐ **Must be currently sexually active and engage in unprotected sex. (*Items 11b, 12b, 13*). If one partner answers yes, then qualify.**
- ☐ **Must live within a reasonable distance and have no plans to move within the next year. (*Item 23 on other interview*)**
- ☐ **Are not currently expecting a child and are not planning on having children anytime within the next year. (*Items 17 and 18*)**
- ☐ **Are willing and able to participate fully in the study for at least 6 months. (*Item 20*)**

If respondent and partner are eligible for the study, continue to the next question.

20. Do you think that you and [partner's name] might be interested in participating in the Eban II program? ❑ Yes ❑ No

If YES and eligible, proceed to set <u>baseline appointment</u>.

If No, say, Okay, I am sorry to hear that. Do you mind telling me why? Your reason may help us plan future groups. [Write Down Reason for Refusal Below. After writing down their reason, say:] You may keep this brochure [hand them brochure], and if you change your mind, please call us at the number provided on the back. Also, if you know other couples who might like to participate, feel free to give them the brochure with our contact information.

❑ Transportation ❑Dependent Children ❑Confidentiality ❑Participant Resistance
❑ No time ❑ Other (list below)

STOP the interview and say, "Thank you for your time today."

NEXT: Complete Tracking Information Sheet, and ask all partner questions.

<u>Setting Baseline Appointment</u>

If BOTH individuals are screened eligible, then schedule their baseline interview. Give couple some specific blocks of times the SC will be available to see them.

Say, "Will any of these days and times work for you?" **If yes**, schedule the appointment: "OK, your appointment is scheduled for _____." **If no**, ask for better dates.

(Item 14): If respondent does not know his/her HIV status, say, "It is important in this study that you and your partner know your HIV status. Please go and get tested [or have your partner get tested], and then contact us again for enrollment." Give out Treatment Notification and Authorization Letter, testing referral information, business card, and brochure that contain the relevant contact information.

NEXT: Complete Tracking Information Sheet and ask all partner questions.

SC: Couple is **INELIGIBLE** if:

None of the above criteria is met. Check if respondent answered any shaded response boxes.
Neither partner is HIV-Positive
Neither identified as Black or African American
Not a heterosexual couple
Not sexually active or use condoms properly all of the time
Live outside area and not accessible by transportation
Expecting a child within 2 months
Intentionally plan to have a child within a year
Cannot commit to program for 8 months

OR

Recruiter deems the participant as not mentally coherent enough to participate (confirmed by the MMSE) or their relationship has been abusive in the past year. STOP. Say, Thank you for your interest and your time. I am sorry, but you and your partner are not a good fit for the Eban II Couples Program. Would you like to be contacted for other programs in the future? **-give out business card and brochure that contains referral and relevant contact information.**

NEXT: Complete Tracking Information Sheet, and ask all partner questions.

DETACH THIS PAGE FROM SCREENER!!

Tracking Information Sheet

Tracking Information Sheet

AL: THIS FORM IS USED TO KEEP TRACK OF INDIVIDUALS AND THEIR PARTNERS WHO ARE SCREENED FOR THE EBAN II PROJECT. THE INFORMATION ON THIS FORM IS ENTERED INTO THE EBAN II PROJECT DATABASE.

Participant Information (#1)		**Partner Information (#2)**	
Date:		**Date:**	
Name #1:		**Name #2:**	
Date of Birth #1:		**Date of Birth #2:**	
Address #1:		**Address #2:**	
Phone #1:	Home:	**Phone #2:**	Home:
	Work:		Work:
	Cell:		Cell:
E-Mail:		**E-Mail:**	
*When would you and **[partner's name]** be able to participate in the program?* ρ Weekdays ρ. Weekends ρ Either		*When would you and **[partner's name]** be able to participate in the program?* ρ Weekdays ρ. Weekends ρ Either	
*What time could you and **[partner's name]** participate?* ρ Mornings ρ Afternoons ρ Evenings		*What time could you and **[partner's name]** participate?* ρ Mornings ρ Afternoons ρ Evenings	
What is the best way to reach you to remind you of all future meetings? ρ Phone Call ρ Mailed Letter ρ Email		*What is the best way to reach you to remind you of all future meetings?* ρ Phone Call ρ Mailed Letter ρ Email	

*Would it be ok for me to call **[partner's name]** for a phone screening?*

Verbal Consent for contacting partner obtained: ρ No ρ Yes

If Yes ask:

How would you like us to introduce ourselves when we call? _____

What's the best day and time to call? _____

*What is **[partner's name's]** phone number?* _____

If individual does not have their HIV/STD test ask," Where will you go to get your HIV/STD testing?" Name of agency/provider. _____

Give respondent letter to partner, program brochure, and business card with contact information and say, *I have a letter here and other information for you to give to **[partner's name]** so that he/she can contact us about the program. We will attempt to call him/her within the next week, however, please let him/her know that they can call us with the number on the business card to speed things up. Thank you for your time today.*

NEXT: Input information into database

If No, ask, *Would you be willing to have **[partner's name]** contact me?*
ρ No ρ Yes

If NO, say, Okay, I am sorry to hear that. Do you mind telling me why? Your reason may help us plan future groups. **[Write down Reason for Refusal Below. After writing down their reason, say:]** Thank you for your time today. You may keep the brochure **[hand them brochure],** and if you change your mind, please call us at the number provided on the back. Also, if you know other couples who might like to participate, feel free to give them the brochure with out contact information. **Then give $_____ reimbursement.**

Reason for Refusal:
ρ Transportation ρ Dependent Children ρ Confidentiality ρ No time ρ Participant Resistance ρ Other (list below)

_____

If Yes, Give respondent letter to partner, program brochure, and business card with contact information and say, *I have a letter here and other information for you to give to **[partner's name]**. Please let him/her know to call us with the number on the business card for a phone screening. Thank you for your time today.*

If BOTH individuals are screened eligible then schedule their baseline interview. Give couple some specific blocks of times the . SC will be available to see them.
Say, *"Will any of these days and times work for you?"*
***If Yes,** schedule the appointment. "OK, your appointment is scheduled for*: _____"

Notify . .SC of appointment.

If No, *then ask for better dates and times then let them know the ASC will be calling them immediately.*

NEXT: If eligible couple is in person, ask them to complete consent form and couple verification, otherwise input information into database

Participant Name:		**Partner Name:**	
Contact Tracking:	DATE:	**Contact Tracking:**	DATE:
	ρ Busy		ρ Busy
	ρ No answer		ρ No answer
	ρ Left Message		ρ Left Message
	ρ Will be there		ρ Will be there
	ρ Will not be there		ρ Will not be there
	Reason:		Reason:
Contact Tracking:	DATE:	**Contact Tracking:**	DATE:
	ρ Busy		ρ Busy
	ρ No answer		ρ No answer
	ρ Left Message		ρ Left Message
	ρ Person called back		ρ Person called back
	ρ Will be there		ρ Will be there
	ρ Will not be there		ρ Will not be there
	Reason:		Reason:
Contact Tracking:	DATE:	**Contact Tracking:**	DATE:
	ρ Busy		ρ Busy
	ρ No answer		ρ No answer
	ρ Left Message		ρ Left Message
	ρ Person called back		ρ Person called back
	ρ Will be there		ρ Will be there
	ρ Will not be there		ρ Will not be there
	Reason:		Reason:
Contact Tracking:	DATE:	**Contact Tracking:**	DATE:
	ρ Busy		ρ Busy
	ρ No answer		ρ No answer
	ρ Left Message		ρ Left Message
	ρ Person called back		ρ Person called back
	ρ Will be there		ρ Will be there
	ρ Will not be there		ρ Will not be there
	Reason:		Reason:

C. Assessing for Impairment

Sometimes potential participants may be under the influence of alcohol and/or drugs, and will not be coherent enough to participate in the screening interview. Other times, potential participants may have intense psychiatric symptoms that make them incoherent. If the recruiter encounters a participant that is impaired in some way, he/she will administer two tests to determine whether the participant is eligible for the study. The Mini-Mental State Examination (MMSE; Folstein et al., 1975) (MMSE) is a screening instrument that provides an index of cognitive impairment. Participants who score below 27 (out of 30) will be seen by one of the study investigators for further clinical appraisal.

The second test is The Quick Test for Intellectual Functioning (Ammons & Ammons 1962). The Quick Test is a brief pictorial vocabulary test of intelligence, which provides an estimated IQ score that is highly

correlated with the WAIS-R Full Scale and Verbal IQ scores (Traub & Spruill, 1982). The measure will be used to screen for patients with cognitive intellectual impairment in the borderline range of mental retardation (i.e. score <.80). The Quick Test will be used in conjunction with the recruiter's assessment of the study participant's ability to comprehend major aspects of the study (i.e. random assignment, requirements of participation, risks and benefits) during the informed consent process in determining whether or not the participant has a cognitive impairment that will interfere with his or her ability to participate in the study. If a participant is ineligible for the study based on one of these tests, the recruiter will let the participant know. The recruiter will specifically tell the ineligible participant that he/she did not score high enough on the tests to participate in the study so they are ineligible.

D. Determining Eligibility/Ineligibility

Eligibility criteria

In order to participate, the following criteria must be met:

1. At least one partner must be Black, African American or of African descent.
2. At least one partner must be HIV-positive.
3. They are a heterosexual couple and identify each other as their primary sexual partner, although they need not be married or living together.
4. Must be currently sexually active and engage in unprotected sex.
5. Must live within a reasonable distance and have no plans to move within the next year.
6. Are not currently expecting a child and are not planning on having children anytime within the next year.
7. Are willing and able to participate fully in the study for 6 months.

The eligibility screener is included in the screener interview and is constructed in a user-friendly manner to determine eligibility very easily. All responses that deem a potential participant ineligible are shaded. During the interview, if the potential participant gives a shaded response, the recruiter should note it in his/her head and remember that the person is ineligible. In addition, at the end of the eligibility questions on the screener, the recruiter should review all of the responses to make sure that none of them are shaded. At the end of the interview, the following provides the recruiter detailed instructions for handling ineligibility: ***Recruiter: Couple is ELIGIBLE if:***

☐ **At least one partner identifies as Black, African American or of African descent.** ***(Item 5 on each interview)***

☐ **At least one partner is HIV-positive.** ***(Item 18 on first and 14 on second interview)***

☐ **They are a heterosexual couple and identify each other as their primary sexual partner, although they do not have to be married or living together. (*Item 1 on each interview)***

☐ **Must be currently sexually active and engaged in unprotected sex (*Items 11b, 12b, 13*) If one partner answers yes, then qualify.**

☐ **Must live within a reasonable distance and have no plans to move within the next year (*Item 23 on other interview*)**

☐ **Are not currently expecting a child and are not planning on having children anytime within the next year. (*Items 17 and 18*)**

☐ **Are willing and able to participate fully in the study for at least 8 months. (*Item 20*)**

If respondent and partner are eligible for the study, continue to the next question.

21. Do you think that you and **[partner's name]** might be interested in participating in the *EBAN II* Program?

❑ Yes ❑ No

If eligible, proceed to set baseline appointment.

If No, say, *Okay, I am sorry to hear that. Do you mind telling me why? Your reason may help us plan future groups.* ***[Write Down Reason for Refusal Below. After writing down their reason, say:]*** *You may keep this brochure* ***[hand them brochure]****, and if you change your mind, please call us at the number provided on the back. Also, if you know other couples who might like to participate, feel free to give them the brochure with our contact information.*

Reason for Refusal?

❑ Transportation ❑ Dependent Children ❑ Confidentiality ❑ Participant Resistance
❑ No time ❑ Other *(list below)*

_____

_____

STOP the interview and say, *Thank you for your time today.*
NEXT: Complete Tracking Information Sheet, and ask all partner questions.

Setting Baseline Appointment

If BOTH individuals are screened eligible then schedule their baseline interview. Give couple some specific blocks of times the SC will be available to see them. Say, *"Will any of these days and times work for you?"*
If Yes, *then schedule the appointment. OK, your appointment is scheduled for*:

_____
Inform ASC of appointment.

If No, then ask for better dates and times then let them know the SC will be calling them immediately.
NEXT: Complete Tracking Information Sheet, and ask all partner questions.

E. Determining Couple Status

If the couple is not living together, extra care should be taken to ensure that the couple is indeed a true couple. The recruiter must make sure that the name matches up to the partner. In addition, the recruiter should check that both partners answer the length of time they have been together in a similar fashion (Question #12 on participant interview and #8 on partner interview). If both potential participants answer discordantly, and/or the recruiter questions their status as a couple, he/she should contact the Coordinator who will make the final call on this matter. Another way of ensuring the couple is an actual couple is to verify their relationship by asking them the Couple Verification Questions that are below.

Couple Verification Questions and Procedures

Questions

1. When did you first meet your partner?

2. Where did you first meet your partner?

3. How did you first meet your partner?

4. When you and your partner are together, on what side of the bed do you each sleep?

Procedures (option 1)

1. After completing V1 screener (including the above questions), the recruiters will meet privately and review responses to screener in order to 1) confirm that the couple is eligible and 2) to verify the authenticity of the couple relationship.

   1.1. Couple eligibility is determined as specified in the Study protocol.

   1.2. Couple authenticity:

      1.2.1. If the responses to all four couple verification questions are different, then the Agency Liaison will consult with the Eban Coordinator to determine authenticity. The Agency Liaison may talk with each partner privately to facilitate determination of authenticity. If the Agency Liaison determines that the couple is not authentic then the couple is not eligible to participate in the study. Follow protocol for ineligible couples are identified.

      1.2.2. If there is partial concordance across all four responses, then the couple is deemed genuine. The couple is eligible; proceed with visit 2 according to protocol.

F. Visit 2 Full Screener Script

Read the exact italicized script on the form:

***PLEASE READ**: Hello and welcome, my name is _____. I want to thank you for agreeing to participate in our exciting project. Before we get started, I need to make sure that you are eligible to participate by asking you a few questions. Some of these questions were asked at your screening interview, but need to be asked again for confirmation of eligibility. I will also be asking you a few more personal questions. Please remember that all of your answers will be held in the strictest of confidence.*

Is it ok to ask you the questions on this interview?

Have you given verbal consent to participate in the study? ❑ Yes ❑ No
***If "No" say:** Okay, I am sorry to hear that. Do you mind telling me why? **Write down the answer.** Your reason may help us plan future groups.*
Reason for Refusal?
_____

The recruiter needs to get written consent from each partner. Both partners must consent in order for the couple to participate. Take special care to insure that each is consenting voluntarily and not being coerced by the other partner.

Recruiter checks off appropriate box.

VERBAL OR WRITTEN CONSENT FOR INTERVIEWEE OBTAINED? __ YES __ NO

VISIT 2 FULL SCREENER

After recording their reason, say: *Thank you for your time today.*
We want to ask you two questions on whether you and your partner have attended sessions on HIV and STDs and if you were paid for attending these sessions. The first question focuses on the past 12 months and the second whether you are currently attending. We also would like to know the name of the program you attended, the number of sessions you attended, and the sponsor of the program.

15. In the past 12 months, have you and your partner attended **together** any paid research studies to learn how to reduce HIV risks and STDs or how to negotiate safer sex?

    ❑$_1$ Yes ❑$_0$ No (skip to #3)
    Specify name of the program _____
    Specify number of sessions you attended _____
    Sponsor of the program _____

16. Do you and your partner currently attend **together** any paid research studies to learn about how to reduce HIV risks and STDs or how to negotiate safer sex?

    ❑$_1$ Yes ❑$_0$ No
    Specify name of the program _____
    Specify number of sessions you attended _____
    Sponsor of the program _____

17. Were you born a male or female?

    ❑$_1$ Male ❑$_2$ Female

18. How old are you?

    ❑$_0$ < 18 years old
    ❑$_1$ ≥ 18 years old: _____years

19. What is the highest grade of school you have completed?
    READ response choices aloud

    ❑$_1$ 1st grade ❑$_6$ 6th grade ❑$_{11}$ 11th grade
    ❑$_2$ 2nd grade ❑$_7$ 7th grade ❑$_{12}$ 12th grade
    ❑$_3$ 3rd grade ❑$_8$ 8th grade ❑$_{13}$ College
    ❑$_4$ 4th grade ❑$_9$ 9th grade ❑$_{14}$ Post College/Graduate
    ❑$_5$ 5th grade ❑$_{10}$ 10th grade

20. What is your employment status?
    READ response choices aloud

    ❑$_1$ Unemployed ❑$_3$ Part-time
    ❑$_2$ Student ❑$_4$ Full-time

21. Do you speak English well?

    ❑$_1$ Yes ❑$_0$ No

22. Do you have an address where you can receive mail?

❑$_1$ Yes ❑$_0$ No

23. Which groups best describe your racial/ethnic background?
READ response choices aloud and check all that apply

- ❑ Black or African American (go to question #10)
- ❑ Hispanic/Latino (skip to question #11)
- ❑ White/Caucasian (skip to question #12)
- ❑ Caribbean/West Indian (skip to question #12)
- ❑ American Indian/Alaskan Native (skip to question #12)
- ❑ Asian or Pacific Islander (skip to question #12)
- ❑ Other _____ (skip to question #12)

24. If Black or African American, what do you consider to be your place of origin?
READ response choices aloud and check all that apply

- ❑ United States
- ❑ Africa (specify country) _____
- ❑ Haiti
- ❑ Jamaica
- ❑ Cuba
- ❑ Dominican Republic
- ❑ Other Caribbean Island
- ❑ Central/South America
- ❑ Other _____

25. If Hispanic or Latino, do you consider yourself to be:
READ response choices aloud and check all that apply

- ❑ Mexican American or Mexican
- ❑ Central American
- ❑ South American
- ❑ Puerto Rican
- ❑ Cuban
- ❑ Puerto Rico
- ❑ Dominican
- ❑ Spaniard or Portuguese
- ❑ Other _____

26. Do you speak any other language other than English at home?

❑$_1$ Yes what language? _____
❑$_0$ No

27. Do you have someone (spouse, girlfriend/boyfriend, or lover) that you consider a main sexual partner?

❑$_1$ Yes what are partner's initials? _____
❑$_0$ No ***SKIP to Instructions to Recruiter for Ineligible Participant(s) on Answer Key***

28. How long have you been in a relationship with **[partner's name]**?

❑$_1$ < 3 months
❑$_2$ ≥ 3 months: how long _____

29. Do you plan to stay with **[partner's name]** for at least another year, or more?
READ response choices aloud

❑$_1$ Definitely yes
❑$_2$ Probably yes
❑$_3$ Probably no
❑$_4$ Definitely no

30. Sometimes couples experience conflict in their relationship. People may do things when experiencing conflict. I am about to ask you if you have had certain experiences in your relationship with **[partner's name]**. Please tell me if each of the following things happened in your relationship with **[partner's name]** during the past year:

d. Has **[partner's name]** punched or kicked you, beat you up, slammed you against a wall, hit you with something that could hurt or scalded or burned you on purpose?

❑$_1$ Yes ❑$_0$ No

e. Has **[partner's name]** choked you or used a knife, gun, or other weapon on you, or threatened to do so?

❑$_1$ Yes ❑$_0$ No

f. Has **[partner's name]** used any force to make you have sex?

❑$_1$ Yes ❑$_0$ No

Now I am going to ask you some sensitive questions about your sexual behavior, drug use, and HIV status. Please remember that everything you say is confidential.

For female participants only

a. In the past 90 days (3months), did your study partner put his penis in your vagina at least one time?
❑ Yes ❑ No **(skip to c)**

b. In the past 90 days (3months), did your study partner put his penis in your vagina at least one time without wearing a condom?
❑ Yes ❑ No

c. In the past 90 days (3 months), did your study partner put his penis in your bottom or anus at least one time?
❑ Yes ❑ No **(skip to coding instructions)**

d. In the past 90 days (3 months), did your study partner put his penis in your bottom or anus at least one time without wearing a condom?
❑ Yes ❑ No

e. In the past 90 days (3 months) when you had sex and used a condom, did the condom ever break or slip off?
❑ Yes ❑ No

For male participants only

a. In the past 90 days (3months), did you put your penis in your study partner's vagina at least one time?
❑ Yes ❑ No **(skip to c)**

b. In the past 90 days (3months), did you put your penis in your study partner's vagina at least one time without wearing a condom?
❑ Yes ❑ No

c. In the past 90 days (3 months), did you put your penis in your study partner's bottom or anus at least one time?
❑ Yes ❑ No **(skip to coding instructions)**

d. In the past 90 days (3 months), did you put your penis in your study partner's bottom or anus at least one time without wearing a condom?

❑ Yes ❑ No

e. In the past 90 days (3 months) when you had sex and used a condom, did the condom ever break or slip off?

❑ Yes ❑ No

Coding Instructions:

For Female/Male Questions: **If BOTH a and c = "No", then 17 = "No"; otherwise 17 = "Yes".**

For Questions 18: **If BOTH b, d, and e = "No" then 18 must = "Every single time (100%)"; otherwise check "More than half the time (51% - 99%)." If e = "Yes," then check "Less than half of the time (1% - 49%)."**

31. Have you had vaginal or anal sex with **[partner's name]** in the past 90 days (3 months)?

❑$_1$ Yes ❑$_0$ No (skip to #19)

32. In the past 90 days (3 months) when you had sex, how often did you use either a male condom or a female condom with **[partner's name]**?
READ response choices aloud

Was it?

❑$_1$ Every single time (100%) **(If b and d = "No")** (note: couple is ineligible if both partners answer this way)
❑$_2$ More than half the time (51% - 99%) **(If b or d = "Yes")**
❑$_3$ Half of the time (50%)
❑$_4$ Less than half of the time (1% - 49%) **(If e = "Yes")**
❑$_5$ Never (0%)

33. Have you ever injected drugs such as heroin, cocaine/crack, or speed?

❑$_1$ Yes ❑$_0$ No

34. Have you ever used drugs such as heroin, cocaine/crack, speed/crystal meth, or ecstasy?

❑$_1$ Yes ❑$_0$ No

35. What is your HIV status?

❑$_1$ HIV Negative (skip to #24) (Note: at lease one member of the couple has to be HIV positive)
❑$_2$ HIV Positive
❑$_{88}$ Do not know (skip to #24)

36. How long have you known your HIV status?

❑$_1$ < 3 months
❑$_2$ > 3 months: how long _____

37. Does **[partner's name]** know your HIV status?

❑$_1$ Yes ❑$_0$ No

If No, say, "If you are interested in disclosing your status to your partner, you can receive professional help to aid you in this process. I will give you this useful referral information." **[Recruiter gives respondent the referral information]**

38. *What is **[partner's name's]** HIV status?*

❑$_1$ HIV Negative (skip to #26) (Note: at least one member of the couple has to be HIV positive)
❑$_2$ HIV Positive
❑$_{88}$ *Do not know (skip to #26)*

39. *How long has **[partner's name]** known [his/her] HIV status?*

❑$_1$ < 3 months
❑$_2$ > 3 months: how long _____

40. Do you and **[partner's name]** plan to live in this area (within a 2-hour commute of site) for the next year?

❑$_1$ Yes ❑$_0$ No

41. Are you or **[partner's name]** currently pregnant?

❑$_1$ Yes ❑$_0$ No

g. If yes, when is your due date: _____

Note: the couple is only eligible for the next cohort if the female participant is due within 1 month after Session 8.

42. Do you and **[partner's name]** plan to get pregnant during the next 18 months?

❑$_1$ Yes ❑$_0$ No

43. Are you committed to attending all of the sessions in this program?

❑$_1$ Yes ❑$_0$ No

Note: Participants are ineligible if any of the highlighted responses are checked.

VISIT 2 ANSWER KEY

Instructions to Recruiter for Ineligible Participant(s):

If respondent answered any shaded response box from the answer key, is not in a heterosexual relationship, is not, or partner is not Black or African American, is not in a serodiscordant OR seroconcordant relationship, OR recruiter deems the participant as not mentally coherent enough to participate (confirmed by the MMSE) STOP. Say, Thank you for your interest and your time. I am sorry, but you and your partner are not a good fit for the Eban II Couples Program. Would you like to be contacted for other programs in the future?

If respondent or partner does not know his or her HIV status (item 21 and item 24), STOP. Say, It is important in this study that you and your partner know your HIV status. Please go and get tested (or have your partner get tested) and then contact us again for enrollment. – **give out Treatment Notification & Authorization Letter, testing referral information, business card, and brochure that contain the relevant contact information.**

If respondent has not yet disclosed their status to their partner (item 23). STOP. Say, A major requirement to be eligible for this study is that your partner knows your HIV status. Please use the referral information I gave you which will help you disclose your status to your partner. Once he/she knows your status, please contact us again for enrollment. – **give out business card and brochure that contains the relevant contact information.**

If respondent and partner are ELIGIBLE for the program, continue with the procedure for Visit 2.

G. Handling Refusals

Recruiter follows same procedure above for handling refusals.

J. Handling & Reporting Adverse Events.

Although it is likely to be an infrequent occurrence, some respondents may get very upset or angry and act out when asked some of the screener questions. If this occurs, first try to calm them down and give them time to regain their composure before proceeding. Try to determine the reason they are upset, answer any questions and address any concerns they have. If the situation deteriorates to the point where you don't feel you can complete the interview or you don't feel safe, then terminate the interview, and get assistance from another staff member if you feel you need it. Do not overreact, but don't take unnecessary chances or allow the situation to get out of control. The participant is not eligible and should be informed of this as calmly as possible and a referral for additional mental health services should be provided as needed.

Document the incident in writing and bring it to the attention of your supervisor.

VII. Overview of Follow-up & Retention Procedures

Please see Attachment C for an overview of the recruitment, randomization, and follow up process depicted through flow charts.

The Database. To assist in follow-up, each agency will utilize our computerized participant information system called "*Participant File*". This program is used to manage follow-up procedures by providing

immediate access to a variety of useful follow-up information on each subject. All contact information is included in this database including: names, phone numbers, and addresses of contact people, mother's maiden name, aliases, street names, hangouts, other study subjects known, treatment programs used, and people who would be contacted in case of incarceration. Access to this encrypted data is strictly controlled through a database security system. The database is stored on a removable disk that is locked in a safe each night. All attempts to locate subjects will be recorded in *"Participant File"*. This allows all staff to know the status of any missed subject so others can assist in follow-up work. It also allows us to monitor workloads, schedule calls, personalize letters, etc. Leads will continue to be recorded and discussed at follow-up meetings.

Below are the **abbreviations** used to indicate the specific staff titles.
PM-Program Manager
SC-Site Coordinator

Screening:
When an interested couple or individual calls in or is referred, the SC will screen them using the V1 screener (V1SCREEN). If the couple is eligible, then the SC will proceed to conduct the couple verification questions (V1COUPVER). Should the couple continue to be eligible, the SC will then complete the tracking form (TRACKINFO).

Ineligible
For those couples who were ineligible, their reason for ineligibility and information will be entered into the database as such. Those who are ineligible only because the length of their relationship was less than three months, their information will be entered and they will be asked to call back once their relationship has reached the three month window.

Eligible
Once a couple is screened eligible, their information is entered into the database or *"Participant File"* The SC will schedule a baseline interview (V2). Participants will be asked to bring confirmation of their HIV status and STD test records if they have them. The SC should send a letter of eligibility confirming they have agreed to participate in the Eban II Project and what to expect. Couples who do not have their HIV status confirmation and/or STD results will be given a letter called the "Provider Notification, HIV/STD Treatment Verification and Authorization Letter" (PROVNOTIF) that will be given to their health care provider, authoring them to provide this information to the Eban II Project staff.

Once the SC has baseline interviewed at least three couples, a group can begin (randomization). If less than six couples have had their baseline interview at one time, then all five couples can be in the same group. Six or more couples require two groups.

Scheduling Baseline Interviews:

Able to schedule Baseline
The couple's information is given to the SC to schedule a baseline interview, which is before groups sessions begin. If the SC is successful at scheduling the couple and completing the ACASI interview as well as obtaining the necessary HIV status verification, then the couple is asked for possible dates they can attend group sessions. The couple will also be informed that other couples are also being interviewed and when at least three have been interviewed they will be called to set up a group meeting.

Unable to schedule baseline

If the SC was unsuccessful at scheduling a baseline interview, then the couple is called repeatedly until the interview can be scheduled. However if the couple's contact information was incorrect (i.e., the phone is now disconnected), the SC will send a letter to the couple's address. The SC will engage in using all of the contact information provided by the individual to contact him or her. Should the reason for not scheduling a baseline be due to other factors (i.e., work schedule, hospitalization, illness, etc.), the SC will call often to check on individual or couple status.

The following are the ACASI interview documents completed at the baseline interview:

- V2 Full Screener (SCREEN2) at baseline
- Answer key 2 (ANSKEY2)
- ACASI script baseline (V2)
- Male Physical and Sexual Abuse Form (MABUSE)
- Female Physical and Sexual Abuse Form (FABUSE)
- Relationship Assessment Scale (RASSES)\
- ACASI Exit Survey (SURVEY)
- Social Desirability Scale (SOCDES)
- Addiction Severity Index (ASI)
- Female ACASI Report Summary (FREPORT)
- Male ACASI Report Summary (MREPORT)
- Couple Verification Questions and Procedures (COUPVER)
- Locator Form – Full (LOCATOR) at baseline

Randomization: The assignment to groups:

As couples come in, they will be asked to sign in on the randomization attendance sheet (SIGNIN). After the assignment of couples, the SC will complete the randomization form (RAND), randomization processing coversheet (COVERCT), and recruitment tracking report (RECRUIT) to log the completion of the randomization process for that or those groups.

Three couples

Once at least three or more couples have completed their baseline interviews, then they will be provided with possible dates for group sessions to being. Couples will be given a time and date that is agreeable to all couples, and facilitators. It will be at that time that they will know if they are being randomized as a Risk Reduction group or a waitlist group. After each session, the facilitator will turn the following documents to the SC: Session Sign in sheets (SESSATTEND), Process measures (SESS), Couple session evaluations (COUPLEVAL), and Receipts from facilitators (RECEIPT).

More than three couples

If there are six or more couples who have completed their baseline interviews, then all couples can called in a two groups will be begin at the same time. Couple will then be randomly selected to be in either the Risk Reduction. Once assigned, the process will be similar as described. Each co-facilitator team will take their couples to their rooms to being group sessions and schedule their following sessions accordingly.

Not randomized couples

If the couple could not come to randomization any some reason, then they will be asked to join the next group. However, if it takes longer than 3 months to get another group of three couples, the couple on hold will have to be re-assessed for eligibility.

Randomization Procedure:

In order to achieve the 2:1 ratio of intervention groups to waitlist controls, the Eban Site Coordinator will monitor the enrollment of 15 couples at a time. The site coordinators will communicate with the Project Manager when couples meet criteria for enrollment. These couples will be enrolled at a variety of agencies, but 10 couples will be immediately assigned to the Intervention, while 5 couples will be waitlisted and enrolled when those groups are completed. The ten couples can form groups or 3 or 4 at the same agency or at two different ones.

The Site Coordinators will also alert the Eban Project Manager as to when groups are almost ready to finish so that the waitlisted couples can be invited to attend groups after the 3 month follow up.

Forming Intervention Groups:

After allowing an appropriate amount of time for all invited couples to arrive, determine the number of intervention sessions that will be run today using the following algorithm:

- If the number of couples that has arrived today is **less than 3**, then ***no sessions*** will run today. Please reschedule these couples to return for another randomization visit (V3);
- If the number of couples that has arrived today is between **3-5**, then ***one session*** will run today containing all the couples who have arrived for this randomization visit.
- If the number of couples that has arrived today is between **6-10**, then ***two sessions*** will run today.
- If the number of couples that has arrived today is between **11-15**, then ***three sessions*** will run today.
    a. Alternate recording couple IDs between groups 1, 2 and 3 in the appropriate spaces below, *first* for couple IDs where the male partner is HIV+ and *second* for couple IDs where the male partner is HIV-. Alternating in this way will ensure a roughly even distribution of HIV+ (and HIV-) males in each group.
    b. Open the envelope labeled ***'2 groups'*** to determine which group (either Group 1 or Group 2) will receive the HIV Risk Reduction intervention and which will be assigned to the waitlist control.
    c. Open the envelope labeled ***'1/3 groups'*** to determine whether the couples assigned to Group 3 will receive the HIV Risk Reduction or be assigned to waitlist control.

- Check the appropriate intervention assignment for each group.

In the field labeled 'Cohort Number,' please record the 3 digit cohort number to this cohort of couples that have been randomized during this visit. The cohort number can be found on the page containing random group assignments, inside the appropriate randomization envelope.

Follow ups (Post and 3-month Interviews):

In completing the Post and 3-month assessments, procedures will be implement that have proven instrumental in obtaining high retention rates among participants in our studies of IDUs over the past 12 years. Ideally, facilitators who conducted the group sessions will be assigned to follow-up with a designated group of enrolled subjects for whom they will be responsible. The SC, will ultimately be responsible to calling couples who are hard to locate. The SC and PM will meet weekly by phone to discuss follow-up activities and strategies for locating difficult to find subjects. At the time of enrollment, the follow-up schedule for that subject will be automatically produced. A series of structured activities will be used to maximize completion of follow-up. Most importantly, maintaining accurate and timely follow-up contact information is essential for successful program completion. Appointment letters will be mailed once month before the scheduled follow-up appointment and reminder calls made one day before the scheduled visit. Missed appointments will be dealt with immediately by a phone call the same day and a reminder letter if attempts to make phone contact fail. Street outreach should also be used for follow-up. If unable to make contact after 5 days, staff members should implement outreach procedures, including visiting the subject's home, designated contacts, known copping corners, shelters, and common hangouts reported by the subject at the time of their prior visit. We will also search for known aliases. Local and state correctional facilities will be searched as needed. Participants who are incarcerated will be contacted by mail and telephone and asked to call immediately upon release.

Final session (session 8) and Post Interviews

The facilitators should remind couples during their final session (session 8) that the SC will be interviewing them immediately after the groups sessions have ended. The facilitator will ask the couple to review their locator forms and update them with new contact information or addresses. The facilitators will inform the SC immediately when the couple is scheduled for their session 8 so the SC can call them to schedule the couples' post interview. At the end of session 8, facilitators will turn in the following in addition to their weekly documents:

- Certificate of Completion
- Facilitator Evaluation Form for Couples in Eban Risk Reduction Intervention (COUPEVALRR)
- Updated locator form (LOCATE)

Post scheduled

Upon successful scheduling of the post interview, the SC will give the couple an approximate month they will be calling for their 3-month interview. The SC will send out a letter a month before 3-month interview to remind them of their upcoming interview. The facilitators should be calling couples on a monthly basis to check in.

The following are the ACASI interview documents completed at Post interview:

- ACASI script IPT
- Male Physical and Sexual Abuse Follow up (MABUSEPT)
- Female Physical and Sexual Abuse Follow up (FABUSEPT)
- Relationship Assessment Scale (RASSES)\
- ACASI Exit Survey (SURVEY)
- Social Desirability Scale (SOCDES)
- Non-Sexuality Active Couples (NO SEX)
- Female ACASI Report Summary (FREPORT)
- Male ACASI Report Summary (MREPORT)
- Locator Form – Mini (MINILOCATE)
- Participant Evaluation Form – Risk Reduction (PEVALRR)

Post Interview not scheduled

If the SC is unsuccessful at scheduling a post interview, then he or she will continue to calling until they are contacted. The SC can ask the facilitator to call the couple, since at that time a bond should been formed between them. If the facilitator or SC is unsuccessful the first week after groups sessions have ended, then the SC should send a letter to their addresses reminding them of their agreement to participate in the post interview. If contact information has changed, then all alternate information on the locator form should be utilized to contact them.

3-month interviews

The same process should be followed to schedule couple for their 3-month interviews. Couples should be called on a monthly basis by facilitators or the SC, depending on availability.

The following are the ACASI interview documents completed at the 3-month interview:

- ACASI script V10
- Male Physical and Sexual Abuse Follow up (MABUSEPT)
- Female Physical and Sexual Abuse Follow up (FABUSEPT)
- Relationship Assessment Scale (RASSES)\
- ACASI Exit Survey (SURVEY)
- Social Desirability Scale (SOCDES)
- Addiction Severity Index (ASI)
- Non-Sexuality Active Couples (NO SEX)
- Female ACASI Report Summary (FREPORT)
- Male ACASI Report Summary (MREPORT)

- Diffusion Questions (DIFFUSE) V10 only
- Locator Form – Mini (MINILOCATE)

Once a participant has been screened and found ineligible, they should not knowingly be screened again for at least 90 days. Once a participant has attended any intervention sessions, they cannot be screened again.

TIMELINE FOR RECRUITMENT AND ASSESSMENTS

Participants will be scheduled to have their baseline visit within 80 days of the screening in anticipation of being randomized within 90 days of the screening. In the event that a couple exceeds the 80-day window period from V1 to V2, that couple will need to be re-screened.
Participants should be scheduled for randomization within 21 days of their V2. HIV and STD results must be received prior to randomization.

Baseline data, including the ACASI, remains valid for up to 60 days before randomization.
Post-tests can start after the first day following intervention session #6, and should best be scheduled within 10 days. However, if we are unable to schedule them within 10 days, we should continue attempting to schedule them. The window for post-test closed 30 days after Session #8.

Intervention sessions may be conducted up to 30 days following completion by the rest of the group (This is in emergencies such as illness, absence, not as part of general scheduling protocol).

3-month follow-ups are administered 3 months after Session #8. Study personnel will actively recruit participants for the 3-month follow-up assessment for a window of 60 days: 30 days prior to the 3-month interval and 30 days after the 3-month interval. Data obtained outside of the specified interval/window will be flagged and analyzed as such.

Case Report Forms (CRFs) should be mailed to UCLA within 1 week of collection.
To maximize the probability that eligible participants will attend, the SC will attempt to maintain contact with the participants via phone calls and reminder letters during the 80-day window period between Contact/Visit 1 and Visit 2. Specifically, a letter will be mailed to participants ten days before and call a day before the scheduled Visit 2 within the 80-day window period to confirm the meeting.

VIII. Ensuring safety in the field.

A. When at a site, make sure to check in and out with the agency contact.
B. Notify agency contact in advance, if possible, of your schedule. For instance, if you have arranged to be at a site every Mon. afternoon, make sure your agency contact is aware of it. Many sites have a monthly calendar. If they know your schedule, maybe they can add you to their calendar. Clients get this calendar, so if they are interested in seeing you, they know to show up on the days that you are there.
C. When at a site, become familiar with the site (how to make an outside call, staff, etc) and security procedures (what to do in case of an adverse event and who to report it to). In case of an adverse event, report it to the appropriate person at the site, then immediately call your supervisor.
D. If at a site and things are slow, offer to help out. Don't just hang out. If you offer to help at a site, you tend to build a good rapport with the staff and in return they tend to be more helpful with recruitment, and locating participants.

E. Ideally, interviewers should be gender matched. However, in the event that you are interviewing a participant of the opposite sex make sure to be in a private yet visible area, in order to ensure your safety and avoid any claims of inappropriate behavior (e.g. flirtation, sexual harassment).

F. When conducting an interview, for your safety and the safety of the interviewee, make sure that both you and the interviewee have easy access to the door.

G. Because of safety concerns, home visits should be avoided. However, if these become necessary for recruitment or retention, then visits should never be made by one staff member alone. In addition, the home visit team should have cell phones in the event of an emergency, and information about the name and address of the participants and the time of the interview should be left with the office staff. The team should also check in to the office when they reach the site and when they leave the site.

Appendix A

CONTACT/VISIT 1 SCREENER PARTNER ANSWER KEYS

Recruiter: Couple is <u>ELIGIBLE</u> if:

- ☐ **At least one partner identifies as Black, African American or of African descent.** ***(Item 5 on each interview)***
- ☐ **At least one partner is HIV-positive or both partners are HIV-positive.** ***(Item 18 on first and 14 on second interview)***
- ☐ **They are a heterosexual couple and identify each other as their primary sexual partner, although they do not have to be married or living together.** ***((Item 1 on each interview)***
- ☐ **Must be currently sexually active and engage in unprotected sex. (Items 11b, 12b, 13) If one partner answers yes, then qualify.**
- ☐ **Must live within a reasonable distance and have no plans to move within the next year. (Item 23 on other interview)**
- ☐ **Are not currently expecting a child and are not planning on having children anytime within the next year. (Items 17 and 18)**
- ☐ **Are willing and able to participate fully in the study for at least 8 months. (Item 20)**

If respondent and partner are eligible for the study, continue to the next question.

22. Do you think that you and **[partner's name]** might be interested in participating in the *EBAN II* Program?

❑ Yes ❑ No

If eligible, proceed to set <u>baseline appointment</u>.

If No, say, *Okay, I am sorry to hear that. Do you mind telling me why? Your reason may help us plan future groups.* ***[Write Down Reason for Refusal Below. After writing down their reason, say:]*** *You may keep this brochure* ***[hand them brochure],*** *and if you change your mind, please call us at the number provided on the back. Also, if you know other couples who might like to participate, feel free to give them the brochure with our contact information.*

Reason for Refusal?

❑ Transportation ❑ Dependent Children ❑ Confidentiality ❑ Participant Resistance
❑ No time ❑ Other *(list below)*

_____

_____

STOP the interview and say, *Thank you for your time today.*
NEXT: Complete Tracking Information Sheet, and ask all partner questions.

<u>Setting Baseline Appointment</u>
RECRUITER: If BOTH individuals are screened <u>eligible</u> then schedule their baseline interview. Give couple some specific blocks of times the ASC will be available to see them.
Say, *"Will any of these days and times work for you?"*
If Yes, *then schedule the appointment. OK, your appointment is scheduled for*: _____
Inform ASC of appointment.

If No, then ask for better dates and times then let them know the ASC will be calling them immediately.

NEXT: Complete Tracking Information Sheet, and ask all partner questions.

Recruiter: Couples is <u>INELIGIBLE</u> if:
None of the above criteria is met. Check if respondent answered any shaded response boxes.
Neither partner is HIV-Positive
Neither identified as Black or African American
Not a heterosexual couple
Not sexually active or use condoms properly all of the time
Live outside area and not accessible by transportation
Expecting a child within 2 months
Intentionally plan to have a child within a year
Cannot commit to program for 8 months

OR
Recruiter deems the participant as not mentally coherent enough to participate (confirmed by the MMSE) or their relationship has been abusive in the past year. STOP. Say, Thank you for your interest and your time. I am sorry, but you and your partner are not a good fit for the Eban II Couples Program. Would you like to be contacted for other programs in the future? **-give out business card and brochure that contains referral and relevant contact information.**

(Item 14): If respondent does not know his/her HIV status), STOP. Say, It is important in this study that you and your partner know your HIV status. Please go and get tested (or have your partner get tested) then contact us again for enrollment. – **give out Treatment Notification and Authorization Letter, testing referral information, business card, and brochure that contain the relevant contact information.**

NEXT: Complete Tracking Information Sheet, and ask all partner questions.

Appendix B

VISIT 2 FULL SCREENER ANSWER KEY

***PLEASE READ**: Hello and welcome, my name is _____. I want to thank you for agreeing to participate in our exciting project. Before we get started, I need to make sure that you are eligible to participate by asking you a few questions. Some of these questions were asked at your screening interview, but need to be asked again for confirmation of eligibility. I will also be asking you a few more personal questions. Please remember that all of your answers will be held in the strictest of confidence.*

Is it ok to ask you the questions on this interview?

Have you given verbal consent to participate in the study? ❑ Yes ❑ No

***If "No" say:** Okay, I am sorry to hear that. Do you mind telling me why? **Write down the answer.** Your reason may help us plan future groups.*

Reason for Refusal?

_____

***After recording their reason, say:** Thank you for your time today.*

We want to ask you two questions on whether you and your partner have attended sessions on HIV and STDs and if you were paid for attending these sessions. The first question focuses on the past 12 months and the second whether you are currently attending. We also would like to know the name of the program you attended, the number of sessions you attended, and the sponsor of the program.

1. In the past 12 months, have you and your partner attended **together** any paid research studies to learn how to reduce HIV risks and STDs or how to negotiate safer sex?

   ❑$_1$ Yes ❑$_0$ No (skip to #3)
   Specify name of the program _____
   Specify number of sessions you attended _____
   Sponsor of the program _____

2. Do you and your partner currently attend **together** any paid research studies to learn about how to reduce HIV risks and STDs or how to negotiate safer sex?

   ❑$_1$ Yes ❑$_0$ No
   Specify name of the program _____
   Specify number of sessions you attended _____
   Sponsor of the program _____

3. Were you born a male or female?

   ❑$_1$ Male ❑$_2$ Female

4. How old are you?

   ❑$_0$ < 18 years old
   ❑$_1$ ≥ 18 years old: _____years

5. What is the highest grade of school you have completed?
   READ response choices aloud

   ❑$_1$ 1st grade ❑$_6$ 6th grade ❑$_{11}$ 11th grade
   ❑$_2$ 2nd grade ❑$_7$ 7th grade ❑$_{12}$ 12th grade

❑3 3rd grade	❑8 8th grade	❑13 College
❑4 4th grade	❑9 9th grade	❑14 Post College/Graduate
❑5 5th grade	❑10 10th grade	

6. What is your employment status?
READ response choices aloud

❑1 Unemployed	❑3 Part-time
❑2 Student	❑4 Full-time

7. Do you speak English well?

❑1 Yes ❑0 No

8. Do you have an address where you can receive mail?

❑1 Yes ❑0 No

9. Which groups best describe your racial/ethnic background?
READ response choices aloud and check all that apply

- ❑ Black or African American (go to question #10)
- ❑ Hispanic/Latino (skip to question #11)
- ❑ White/Caucasian (skip to question #12)
- ❑ Caribbean/West Indian (skip to question #12)
- ❑ American Indian/Alaskan Native (skip to question #12)
- ❑ Asian or Pacific Islander (skip to question #12)
- ❑ Other _____ (skip to question #12)

10. If Black or African American, what do you consider to be your place of origin?
READ response choices aloud and check all that apply

- ❑ United States
- ❑ Africa (specify country) _____
- ❑ Haiti
- ❑ Jamaica
- ❑ Cuba
- ❑ Dominican Republic
- ❑ Other Caribbean Island
- ❑ Central/South America
- ❑ Other _____

11. If Hispanic or Latino, do you consider yourself to be:
READ response choices aloud and check all that apply

- ❑ Mexican American or Mexican
- ❑ Central American
- ❑ South American
- ❑ Puerto Rican
- ❑ Cuban
- ❑ Puerto Rico
- ❑ Dominican
- ❑ Spaniard or Portuguese
- ❑ Other _____

12. Do you speak any other language other than English at home?

❑$_1$ Yes what language? _____
❑$_0$ No

13. Do you have someone (spouse, girlfriend/boyfriend, or lover) that you consider a main sexual partner?

❑$_1$ Yes what are partner's initials? _____
❑$_0$ No ***SKIP to Instructions to Recruiter for Ineligible Participant(s) on Answer Key***

14. How long have you been in a relationship with **[partner's name]**?

❑$_1$ <3 months
❑$_2$ ≥3 months: how long _____

15. Do you plan to stay with **[partner's name]** for at least another year, or more?
READ response choices aloud

❑$_1$ Definitely yes
❑$_2$ Probably yes
❑$_3$ Probably no
❑$_4$ Definitely no

16. Sometimes couples experience conflict in their relationship. People may do things when experiencing conflict. I am about to ask you if you have had certain experiences in your relationship with **[partner's name]**. Please tell me if each of the following things happened in your relationship with **[partner's name]** during the past year:

h. Has **[partner's name]** punched or kicked you, beat you up, slammed you against a wall, hit you with something that could hurt or scalded or burned you on purpose?

❑$_1$ Yes ❑$_0$ No

i. Has **[partner's name]** choked you or used a knife, gun, or other weapon on you, or threatened to do so?

❑$_1$ Yes ❑$_0$ No

j. Has **[partner's name]** used any force to make you have sex?

❑$_1$ Yes ❑$_0$ No

Now I am going to ask you some sensitive questions about your sexual behavior, drug use, and HIV status. Please remember that everything you say is confidential.

For female participants only

a. In the past 90 days (3months), did your study partner put his penis in your vagina at least one time?
❑ Yes ❑ No **(skip to c)**

b. In the past 90 days (3months), did your study partner put his penis in your vagina at least one time without wearing a condom?
❑ Yes ❑ No

c. In the past 90 days (3 months), did your study partner put his penis in your bottom or anus at least one time?
❑ Yes ❑ No **(skip to coding instructions)**

d. In the past 90 days (3 months), did your study partner put his penis in your bottom or anus at least one time without wearing a condom?
❑ Yes ❑ No

e. In the past 90 days (3 months) when you had sex and used a condom, did the condom ever break or slip off?
❑ Yes ❑ No

For male participants only

a. In the past 90 days (3months), did you put your penis in your study partner's vagina at least one time?
❑ Yes ❑ No **(skip to c)**

b. In the past 90 days (3months), did you put your penis in your study partner's vagina at least one time without wearing a condom?
❑ Yes ❑ No

c. In the past 90 days (3 months), did you put your penis in your study partner's bottom or anus at least one time?
❑ Yes ❑ No **(skip to coding instructions)**

d. In the past 90 days (3 months), did you put your penis in your study partner's bottom or anus at least one time without wearing a condom?
❑ Yes ❑ No

e. In the past 90 days (3 months) when you had sex and used a condom, did the condom ever break or slip off?
❑ Yes ❑ No

Coding Instructions:

For Female/Male Questions: **If BOTH a and c = "No", then 17 = "No"; otherwise 17 = "Yes".**

For Questions 18: **If BOTH b, d, and e = "No" then 18 must = "Every single time (100%)"; otherwise check "More than half the time (51% - 99%)." If e = "Yes," then check "Less than half of the time (1% - 49%)."**

17. Have you had vaginal or anal sex with **[partner's name]** in the past 90 days (3 months)?
❑$_1$ Yes ❑$_0$ No (skip to #19)

18. In the past 90 days (3 months) when you had sex, how often did you use either a male condom or a female condom with **[partner's name]**?
READ response choices aloud
Was it?
❑$_1$ Every single time (100%) **(If b and d = "No")** (note: couple is ineligible if both partners answer this way)
❑$_2$ More than half the time (51% - 99%) **(If b or d = "Yes")**
❑$_3$ Half of the time (50%)
❑$_4$ Less than half of the time (1% - 49%) **(If e = "Yes")**
❑$_5$ Never (0%)

19. Have you ever injected drugs such as heroin, cocaine/crack, or speed?
❑$_1$ Yes ❑$_0$ No

20. Have you ever used drugs such as heroin, cocaine/crack, speed/crystal meth, or ecstasy?
❑$_1$ Yes ❑$_0$ No

21. What is your HIV status?
❑$_1$ HIV Negative (skip to #24) (Note: at lease one member of the couple has to be HIV positive)
❑$_2$ HIV Positive

❑88 Do not know (skip to #24)

22. How long have you known your HIV status?

❑1 < 3 months
❑2 > 3 months: how long _____

23. Does **[partner's name]** know your HIV status?

❑1 Yes ❑0 No

If No, say, "If you are interested in disclosing your status to your partner, you can receive professional help to aid you in this process. I will give you this useful referral information." **[Recruiter gives respondent the referral information]**

24. *What is **[partner's name's]** HIV status?*

❑1 HIV Negative (skip to #26) (Note: at least one member of the couple has to be HIV positive)
❑2 HIV Positive
❑88 *Do not know (skip to #26)*

25. *How long has **[partner's name]** known [his/her] HIV status?*

❑1 < 3 months
❑2 > 3 months: how long _____

26. Do you and **[partner's name]** plan to live in this area (within a 2-hour commute of site) for the next year?

❑1 Yes ❑0 No

27. Are you or **[partner's name]** currently pregnant?

❑1 Yes ❑0 No

k. If yes, when is your due date: _____

Note: the couple is only eligible for the next cohort if the female participant is due within 1 month after Session 6.

28. Do you and **[partner's name]** plan to get pregnant during the next 18 months?

❑1 Yes ❑0 No

29. Are you committed to attending all of the sessions in this program?

❑1 Yes ❑0 No

Note: Participants are ineligible if any of the highlighted responses are checked.

Instructions to Recruiter for Ineligible Participant(s):

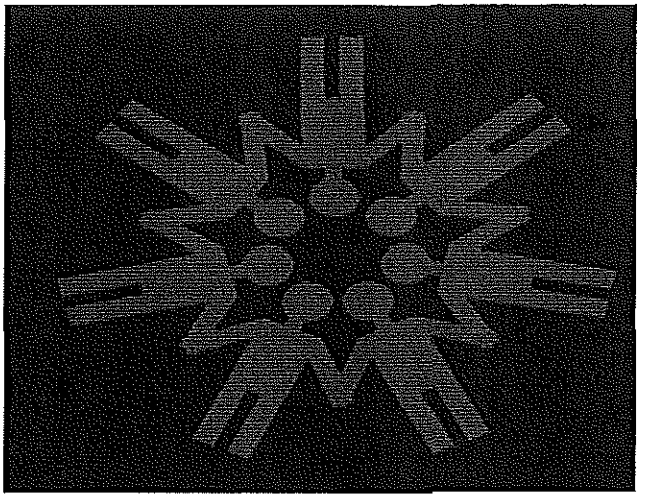
If respondent answered any shaded response box from the answer key, is not in a heterosexual relationship, is not, or partner is not Black or African American, is not in a serodiscordant OR seroconcordant relationship, OR recruiter deems the participant as not mentally coherent enough to participate (confirmed by the MMSE) STOP. Say, Thank you for your interest and your time. I am sorry, but you and your partner are not a good fit for the Eban II Couples Program. Would you like to be contacted for other programs in the future?

If respondent or partner does not know his or her HIV status (item 21 and item 24), STOP. Say, It is important in this study that you and your partner know your HIV status. Please go and get tested (or have your partner get tested) and then contact us again for enrollment. – **give out Treatment Notification & Authorization Letter, testing referral information, business card, and brochure that contain the relevant contact information.**

If respondent has not yet disclosed their status to their partner (item 23). STOP. Say, A major requirement to be eligible for this study is that your partner knows your HIV status. Please use the referral information I gave you which will help you disclose your status to your partner. Once he/she knows your status, please contact us again for enrollment. – **give out business card and brochure that contains the relevant contact information.**

If respondent and partner are ELIGIBLE for the program, continue with the procedure for Visit 2.

2. Intervention Facilitators Training Manual



Eban II Project

UCLA Collaborative HIV/STD Intervention for African American Couples

Training Manual for Intervention Facilitators

HIV/STD Risk Reduction Intervention

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MODULE ONE

INTRODUCTION TO THE TRIAL

MODULE TWO

YOUR ROLE AS A FACILITATOR

2.1 OVERVIEW OF THE EBAN HIV RISK REDUCTION TRAINING MANUAL

Transmission of the Human Immunodeficiency Virus (HIV) is one of the foremost public health problems in the United States. Even though the incidence of AIDS has declined due to the introduction of highly active antiretroviral therapies in the mid-1990s, HIV transmission continues to rise in specific sub-groups, such as racial and ethnic minorities. The African American community has been disproportionately affected by HIV/AIDS. While African American men and women represent 12 % of the general population, new statistics from the International AIDS Conference indicate that this ethnic group represents 50% of new HIV infections in the US. Seventy-five percent of new heterosexually transmitted infections in this country are among African American women. Many of these new infections could have been prevented, if people did not engage in risky behaviors. This clearly demands effective prevention efforts targeting women and their sex partners. Research consistently has shown that couples, especially those in long-term relationships, tend not to protect themselves. The longer they are together, the less likely they are to use condoms.

Motivating people to change their behavior is very difficult, but it is essential in order to stop the further spread of HIV/STDs. The U.S. Public Health Service (PHS) under the leadership of the National Institute of Mental Health (NIMH) has placed great emphasis and resources on conducting what is known as HIV prevention research. The focus of these efforts is to identify effective strategies to motivate individuals to curtail HIV-related risk behaviors and adopt safer behaviors.

There are three limitations of existing HIV/STD prevention programs: first they have focused primarily on individuals only; second, they have focused primarily on HIV- individuals; and third, they are generally not culturally-sensitive.

First, most HIV/STD prevention programs focus on individuals who are HIV negative (HIV-), with the aim to prevent HIV transmission. Increasing evidence indicates that there is a need to target HIV positive (HIV+) and HIV- individuals in HIV prevention, and to address within these programs other sexually transmitted diseases (STDs), which can compromise the health of both HIV+ and HIV- persons.

Second, most HIV/STD prevention programs also focus on women or men only. Individuals, and women especially, may have a difficult time successfully applying what they learn in such programs to their actual relationship, because it takes two partners together to agree to make change. Having both partners together allows male participants to develop knowledge, education, self-interest and empathy, which can lead to a mutual desire to reduce risky behaviors.

Third, most HIV/STD prevention programs are developed without attention to the contexts in which transmission behaviors take place. In addition to relationship, as noted above, the context of culture and community plays a key role in our ability to learn and practice behavior change. The African American community is one community that has been disproportionately affected by HIV infection and AIDS, as well as other STDs. There is a critical need for new prevention programs to develop and test HIV/STD prevention programs that are specific to the needs of members of the African American community.

In response to the current HIV/STD prevention program shortcomings of targeting only HIV- individuals, focusing on men or women only, and neglecting to address attention to cultural sensitivity, a group of investigators from across the US conceived and proposed the current study: Project EBAN, a study designed to test the efficacy of providing HIV/STD prevention intervention to African American heterosexual couples in mixed HIV status relationships.

Couples counseling differs from individual counseling in that the unit of focus is the "couple" or the "relationship." This approach takes the expectation for change off of one or the other partner, and rather, asks

the *couple* to choose to care for each other. Focusing on the safety and health of the relationship as a context for safer behavior can eliminate feelings of guilt, shame or stigma associated with safer sex behavior. Couples counseling allows us to empower couples as "experts" on their own relationship. By focusing on the importance of the relationship, facilitators can provide choices for reducing risk, encouraging the couple to act as a "team" in deciding how to protect each other.

The EBAN interventions use principles and concepts derived from Social Cognitive Theory (SCT) and employs a cognitive-behavioral approach to motivate the program participants to change their risk behaviors and adopt safer behaviors. It incorporates work with couples alone and couples in groups with clinically- trained facilitators delivering the intervention to each couple. The Ecological Perspective, which also guides the study interventions, will be used to address relational and contextual factors that SCT does not emphasize. The Ecological Perspective suggests that attitudes and behaviors arise from not only individual-level factors, but also interpersonal, social, and cultural factors and the interrelationship among all these factors.

As a facilitator, you play a pivotal role in this important project. In a very real sense, you can make or break this program. Our ability to determine the success of the EBAN HIV/STD risk reduction intervention depends upon your ability to deliver the information and conduct the exercises contained in this manual. You must always remember that this is, first and foremost, a research study. Everything in this manual was designed with a special purpose in mind. Take the time to read and understand the basic principles, the key elements, and each and every one of the sessions. Be attentive during the training and do not deviate from this manual when facilitating the sessions.

1. Review each session ahead of time.

2. The format consists of objectives, materials, and a detailed outline of what you say.

3. In the text of each session, the italicized sections are what you say to the participants.

4. As you become familiar with what you are to say and feel comfortable, use your own words rather than what is written for you to say.

5. Check to make sure you have the necessary equipment and materials by using the preparation section for each session.

6. Relax, be enthusiastic, and be creative.

You have been selected to act as Facilitator for the EBAN HIV Risk Reduction Intervention. You will be able to build upon your experience with couples and couple groups. We hope that your experience as a facilitator for the EBAN HIV/STD risk reduction intervention proves rewarding, and that the knowledge and experience that you acquire during the process of training/facilitating will be educational and enjoyable.

2.1.1. Information About The Programs You Will Be Facilitating

The EBAN Interventions

This study is testing the effectiveness of the EBAN HIV Risk Reduction Intervention, which focuses on reducing risk for HIV and STD transmission.

What will I be facilitating?

You have been selected to facilitate the EBAN HIV/STD risk reduction intervention. This is an 8-session intervention comprised of one split (group and then single gender) session, followed by 3 couple sessions, 3 couple group sessions and ending with a couple session, which is included in this manual. You will be facilitating sessions with couples who have been randomly assigned to attend these sessions.

Can I be trained in the other intervention?

No, it is important that you do not read the other intervention materials, nor talk with the facilitators of that condition. This is because we do not want to contaminate the interventions.

What will the sessions be like?

Sessions are designed so that there is as much interaction with the couple(s) as possible. Some of the time you will give participants information, but most of the content of the programs will be devoted to skills-building through modeling and practice, using real-life situations reported by the participants.

What happens if someone asks me a question that I do not know the answer to?

Answer all questions that participants ask you completely and factually. Make sure to check with the participant to be sure that you have answered his/her question. If you do not know the answer, ask the couple to wait until the next session, and ask the Project Manager or the Clinical Supervisor. It is important for you to show the participant that it is okay if you do not know the answer to a question and that you will find out for them. In addition, read the *Guide to Commonly Asked "Tough to Answer" Questions on HIV Transmission and Treatment* that follows this section.

If you have any questions or problems, please feel free to contact your Site Coordinator.

2.1.2 What Type of Information Is In This Manual?

Summary of Each Session

Following the first training manual sections on how to work with African American/Black, mixed HIV status couples in couple and group modalities, you will find each intervention session. A summary of each session is located at the beginning of each session. A more detailed explanation of each exercise can be found in the session description. Also, included with each session will be a list of objectives and materials that are needed for the session and a summary of difficult issues that arise, based on session content, and how to handle such issues.

Objectives of Each Session

The objectives identify each skill or new area of information we would like participants to gain from the session.

Materials

All materials to run the sessions will initially be provided by the Project Manager or the Site Coordinator at your site. Then, before each session, it becomes your responsibility to make sure that

you have all the materials that you will need for each particular session at each site (the materials vary from session to session).

If you run out of any materials/supplies, order replacements from the Project Manager or Site Coordinator at your site at least 1 week before that session begins, otherwise you may not get the *materials you will need for the session(s) on time.*

Your Project Manager will explain the procedures for payments for participants and other reimbursements to you. Generally, at the end of each session, participants are paid for their attendance.

Before Session

Co-facilitators will need to be at the location of the session site 30 minutes before each session to set up and review the progress of each participating couple using your goal records and to consider ways to suggest handling problems that participants are encountering in their efforts to protect themselves. Refreshments must also be obtained and set up for each session.

Session Outline

The outline is the actual content of the session. Make sure you understand all content outlined in each section of your manual before you run the intervention.

Each activity has a suggested time limit. Try to keep to the time limit as best you can to insure that you cover all the material in a given session. Also, if you go overtime, it may turn off some of the participants. Also, make sure to start on time. As part of the quality assurance process, adherence to these time limits will be assessed.

2.2 OBJECTIVES OF FACILITATOR TRAINING

Objectives of facilitator training are to ensure that the intervention is delivered in a standardized way across successive cohorts of participants and across sites; that intervention techniques and procedures are delivered in the manner intended; and that unforeseen problems or issues that arise in intervention sessions are handled consistently.

To accomplish these objectives, by the end of the training sessions, the facilitators will:

- understand the goals, objectives, context, and organizational environment of the study and the intervention,
- master the contents of the intervention protocol,
- understand and be able to implement intervention techniques (e.g., goal setting, addressing questions),
- use all intervention materials (e.g., the intervention manual, visual displays, videotapes, educational materials), all delivery methods, and all forms consistently in the proper manner,
- review special aspects of the population that might affect delivery of the intervention,
- be able to elicit cooperation from the participants when leading a session,
- review and understand how to handle potentially sensitive situations that might arise during the intervention sessions,
- review and understand how to manage participants who become emotionally distressed during the course of implementing the intervention,

- review and understand how to provide referrals as needed,
- discuss possible situations that might arise during the intervention and agree upon a way to handle each situation (for example, providing a referral) that would be faithful to the study protocol and consistent across facilitators, and
- have led specific sections of the intervention sessions assigned to them, gotten feedback for their performance, and performed at a satisfactory level.

2.2.1 Training Program

Training Components

Pre-Training Preparation (on site)

a. Site-specific trainers will emphasize the critical role facilitators play in the implementation of the study, and the importance of standardization and fidelity to study outcomes.
b. Facilitators will review their assigned intervention manual and commit intervention content to memory.
c. Facilitators will read and discuss recommended articles related to their intervention content and couples and group modality with Investigators and project staff.
d. Facilitators will review assigned intervention modeling videotapes and discuss with facilitation team and Clinical Supervisor.
e. Facilitators will lead mock sessions.

Centralized Training (UCLA or on-site)

a. Workshops on theoretical principles (2 days) for all facilitators.
b. Participation in an intensive, training program on facilitation of individual, couples and group sessions (3 days); mock sessions for treatment and comparison sessions will be held at separate locations to avoid contamination of the comparison condition.
c. Trainers will emphasize the critical role facilitators play in the implementation of the study and the importance of standardization and fidelity to study outcomes.

2.2.2 Centralized Training Sessions

The format of the five-day centralized training requires each facilitator to arrive with complete knowledge of the sessions' contents, having previewed the pre-training videotape and recommended readings, and having led some mock sessions on site with their site Clinical Supervisor. During the centralized training, two days of workshops by experts will be presented. Workshop topics include a theoretical overview and rationale of the study intervention, ethical principles, cognitive-behavioral and skills training procedures, cultural diversity issues, couple intervention techniques, couple group intervention techniques, strategies for handling participant, couple and group problems, and sensitivity training for effective work with HIV mixed status and African American populations.

During the final three days co-facilitation pairs will lead sessions in which the other facilitators play the parts of participants, allowing each facilitator to not only practice, but also observe the styles of the other facilitators. During training facilitators will be encouraged to raise questions and identify potentially problematic areas of the intervention, and, together with trainers, fashion common responses

to resolve them, which will be recorded in the standardized intervention manual. In addition to feedback provided to each facilitator concerning his or her performance in leading the mock training sessions, training personnel also assess whether the intervention was delivered according to the protocol. Trainers will emphasize the importance of standardizing intervention implementation and the role of quality assurance measures to maintain intervention fidelity.

2.3 ROLE OF THE INTERVENTION TEAM

The intervention team is comprised of:
- The Eban II Management Team, co-chaired by Drs. Gail Wyatt and Hector Myers
- Site-specific Eban Site Coordinator (1);
- Clinical Supervisor (1); and
- Co-facilitators (2 male/female dyads, one for each region)

2.3.1 Eban II Management Team

The Eban II Management Team is responsible for the development of the intervention curriculum, and refinement and monitoring of all intervention content, and participating in regular conference calls.

2.3.1.1 Management Team "Across Site" Communication

Several forms of communication will be used to assure that the EBAN interventions are implemented in a standardized way (see also Module Seven: Quality Assurance and Quality Control).

2.3.1.1.1 Weekly Facilitator Conference Calls

Facilitators from all sites will participate in a conference call weekly or as needed to discuss how implementation is going. Particular attention will be paid to issues or challenges faced during sessions. The group will work together to brainstorm standardized responses to such issues across sites.

2.3.1.1.2 UCLA Eban II Management Team website

The UCLA/Oakland Management Team will establish a website with a listserv that can be used by facilitators to post questions and concerns about such issues as they arise. This list will be used to develop the weekly Facilitator conference call agenda.

2.3.2 Site Coordinators

The Site Coordinators will provide support to the facilitators and will participate in weekly calls with the Project Manager. Project Managers will provide intervention delivery updates to the intervention team in the weekly conference calls.

2.3.3. Clinical Supervisors

The Clinical Supervisors are responsible for all aspects of supervision for the co-facilitation teams, including regular supervision, review of audiotaped sessions for site QC/QA, feedback to the Project Managers and Investigators regarding adverse events, documenting protocol violations or other concerns related to standardized intervention delivery. Supervisors are also responsible for participating in intervention conference calls scheduled on an as-needed basis where they may compare and contrast issues and concerns related to intervention delivery across sites.

2.3.4 Facilitators

Co-facilitators or co-facilitation teams at each site are responsible for conducting the EBAN risk reduction sessions according to the training protocol laid out in this manual. Co-facilitators are required to attend weekly Internet-based groups and/or individual supervision with the Clinical Supervisor and their fellow facilitators.

MODULE THREE

ETHICAL ISSUES

MODULE FOUR

INTERVENTION PROCESS

4.1 THEORETICAL MODEL FOR EBAN INTERVENTION: A MODEL FOR UNDERSTANDING, MOTIVATING, AND MAINTAINING BEHAVIOR CHANGE

People will continue to behave in a certain way if…

1. They expect something good to come out of it.
2. Something that they want does come out of it.
3. Something good comes out of it often.
4. Anything negative that comes out of it happens a long time after the good part.

People will behave effectively in their best interest if…

1. They know what is in their best interest.
2. They have the skills.
3. They have opportunities to learn skills in many ways: observing, imitating, and practicing.
4. They believe they can be effective and have effective tools.
5. They fit into the environment in which they live and the environment supports them.

4.1.1. Underlying Concepts

The EBAN HIV/STD risk reduction intervention seeks to change risk-associated behaviors. In order to this, the program combines theoretical principles from Social Cognitive Theory (SCT) and the Ecological Perspective, framed within the cultural principles known as the Nguzo Saba. The Social Cognitive Theory provides a framework for conceptualizing the factors underlying risky health behavior The Ecological Perspective provides a framework for conceptualizing the hierarchy of domains (and related factors within those domains) within which risky attitudes and behaviors take place, including individual, interpersonal, social, and cultural domains. The Nguzo Zaba (Swahili for "seven principles") are seven basic values of African culture which contribute to building and reinforcing family, community and culture among African American people as well as Africans throughout the world African community. The main principles in each of these theoretical and cultural frameworks are provided below so that you may apply them in your facilitation of the intervention.

4.1.2. Social Cognitive Theory (SCT)

This program is based on the Social Cognitive Theory (Bandura, 1982, 1986, 1989) as a theoretical framework for conceptualizing the factors underlying risky health behavior. The Social Cognitive Theory provides a comprehensive analysis of the determinants of behavior change. What makes the theory a particularly advantageous approach to health behavior is that it provides prescriptions for changing the presumed mechanisms that underlie health behavior. Three components of the theory are especially pertinent: intention, perceived self-efficacy and outcome expectancies. There was a consensus among behavioral theories (Theorist's workshop Washington NIMH October 3-5, 1991).

Intention to perform a given behavior is one of the immediate determinants of that behavior. The stronger one's intention to perform a given behavior, the greater the likelihood that the person will, in fact, perform that behavior. Intention is a continuous variable ranging from strong intention not to perform a behavior through uncertainty to strong intentions to perform the behavior.

The committee in the consensus conference indicated that that one will not form a strong intention to perform a behavior unless one first believes that behavioral performance will lead to more positive than negative outcomes or she or he has the skills and the abilities to perform that behavior (i.e. that she or he can perform the behavior) . This implies that outcome expectancies and /or self efficacy may influence the strengths of one's intention may influence the strengths at behavior. But also outcome expectancies or self –efficacy can have direct influence upon the behavior. For example, by influencing the efforts and persistence in dealing with the barriers, self-efficacy may also have direct impact upon the behavior. An individual may have a positive intention to perform a behavior, and may in fact perform a given behavior at least in partly because the person believes that performance of the behavior lead to a positively outcome But also when this person performs the behavior, however, the outcome may not occur, this information will influence the persons' outcome expectancies, which may in turn influence intentions and future behavioral performances.

For example, people's confidence that they can use a condom every time they have intercourse, or increase their condom use is related to the likelihood that they will actually do so. For example, negative outcome expectancies about condom use has been identified as being significant to high risk sexual behaviors in a variety of populations. The most obvious outcome expectancy in the domain of sexual risk is the belief that using condoms can reduce the risk for STDs, including HIV: we call these kinds of beliefs prevention beliefs. Another outcome expectancy is the belief that one's peers would approve of their risk-reduction behaviors, including condom use, and one's concern about their peers' reaction to their decision to use condoms during intercourse. We call these kinds of beliefs peer reaction beliefs.

Hence, within social cognitive theory, intention, skills and lack of environmental constraints are the key determinants of behavior change toward healthful practices. Strong perceptions of efficacy to stop practicing risky sexual behaviors (or behaviors in other domains, such as smoking or drinking alcohol or to change one's diet), greater expectations of positive outcomes of these behaviors, and lower expectations of negative outcomes of these behaviors might all contribute to practicing healthful behaviors.

SCT emphasizes that behavior changes related to prevention of HIV/STD infection require ALL of the following principles to be in place for each individual. SCT covers three classes of principles: expected outcomes of behavior (both safe and risky); skills and self-efficacy for using those skills; and personal goals. Each of these is addressed in the intervention, usually in more than one session.

4.1.2.1 Expected Outcomes

Personal Vulnerability to HIV/STDs (expected outcomes)

Before people will change their behavior, they must have a reason, or motivation, to do so. If people do not see how they can personally benefit by doing something differently (for example, using condoms every time they have sex), then no amount of skill development will be enough to produce change.

When it comes to safer sex, the behaviors themselves are not in-and-of-themselves appealing. Few

people truly prefer to wear a condom during sex. Therefore, another reason must operate. Probably the most likely reason a person will have for making their HIV-related behavior safer is to avoid contracting HIV or another STD. However, most people have a natural tendency to believe that bad things will not happen to them, and they underestimate their chances of experiencing negative consequences from their behavior.

Our goal in this program, then, is to increase participants' sense of personal risk. Personal risk refers to a person's belief that "HIV/AIDS and other STDs really could happen to me, or to my partner."

My partner will react positively to my efforts to be safer. Our relationship is worth it. (expected outcomes)

Sexual behavior that puts people at risk for becoming infected with HIV is always done with another person, and using safer practices requires cooperation from them. Thus, the intervention focuses on protecting not only the individual, but also the couple. Valuing the relationship, then developing skills to help partners talk more effectively together about condom use and other safer behaviors, will likely promote good feelings about using safer sex to protect their relationship.

Safer sex is "The Right Thing to Do" (Self- and Social-Approval)

Everybody has standards for behavior. When they behave in accordance with their standards, they feel good about themselves, and when they do not, they feel guilty, afraid, or depressed. Much of what we come to value in our own behavior is shared by community, friendship, and family networks, and people are often influenced in what they value by others in their networks. For example, changes in clothing fashions can sweep friendship networks very quickly. We want our intervention to begin to affect community standards, first, by creating the belief that safer behavior is "the right thing to do" among our participants, and secondly, by empowering our participants to affect the norms within their own networks and communities.

4.1.2.2. Skills and Self-efficacy

Skills are people's abilities to perform difficult behaviors, such as using condoms, negotiating with partners, developing strategies to overcome barriers, and solving difficult problems. Self-efficacy refers to people's confidence in their own abilities to engage successfully in a given behavior. People who do not feel confident are less likely to try out different behaviors, and will exert less effort and persistence when they have difficulty. The intervention builds people's skills and self-efficacy by providing people with the ability to learn and practice new skills, and then to try them out in their lives between sessions through setting goals. It is very important to remember to always use real-life situations, partner responses, etc. in all skill building activities.

Using condoms with my partner is easy: Condom Skills and Self-efficacy

Many people find it difficult to obtain condoms, and to use them correctly -- to put them on without embarrassment so that sex will not be interrupted, and correctly so that they will not break, and to take them off correctly so that they are effective in preventing HIV, other STDs, and pregnancy. We need to provide skills through modeling correct use of the condom (we put the condoms on artificial penis and pelvic models), and by providing the opportunity for our participants to practice for themselves.

Getting your partner to cooperate in safer sex is easy: Negotiation Skills and Self-efficacy

Practicing safer sex is not something that our participants can do by themselves. They need the cooperation of a partner. Sometimes attempts to use condoms may be seen as a signal of partner unfaithfulness, partner illness, or partner distrust. Many couples feel that safer sex conflicts with feelings of intimacy. Or condoms may be viewed as lessening the pleasure of the sexual experience, and be resisted on those grounds. One advantage of intervening with couples is that we can characterize the concept of protection as a loving expression towards ones partner, or between partners. By working with both partners, they can receive education and skills-building together and talk about the ways in which behavior change might challenge their feelings of intimacy. They may be better able to maintain a sense of intimacy by expressing to each other the importance of protection and good health so their relationship will be long-lasting and strong. As facilitators we must be sensitive to our participants' desires to keep their partners' interest and avoid conflict, and at the same time to enhance intimacy between partners. We also need to provide practice for responding to partner objections tactfully and effectively. This program will provide such opportunities by emphasizing communication and negotiation techniques that increase partner's self-efficacy to discuss safer sex.

Achieving safer sex despite "triggers" such as sexual arousal, moods, and drug use behavior is easy: Self-control Skills, Problem Solving Skills and Self-efficacy

We all know how critical the issue of drug use is in HIV prevention, both because sharing injected drug needles is an important mode of transmission, and also because when people are drunk or high, they are likely to be careless. People need to be able to control their urges to use drugs, as well as their urges to have unprotected sex (for example, when no condom is available), and despite being in moods that make them vulnerable to risky behavior. Participants will learn how to identify their own triggers as well as using problem-solving techniques for dealing with their triggers.

4.1.2.3. Personal Goals

Once a person, or couple, realizes that negative outcomes might occur as a result of unsafe sex, and that positive outcomes might occur as a result of safer sex, and once that person (or couple) believes that they have or can acquire the skills necessary to use safer sex practices, then that person (or couple) is likely to develop a personal standard for using safer sex.

My goal is to have safer sex.

Everyone has personal standards, or goals, for their behavior. In this intervention, our aim is for every couple to develop a couple goal for safer sex. In the intervention, this goal is stated in the form of a "contract of commitment" that participants sign together and then work at slowly by setting small, achievable goals at the end of each session..

4.1.3. Ecological Perspective

The Ecological Perspective is used to further buttress relational and contextual principles from SCT mentioned earlier. The Ecological Perspective suggests that attitudes and behaviors arise from not only individual-level factors, but also interpersonal, social, and cultural factors.

The Ecological Perspective was adapted from physical sciences by Bronfenbrenner (1979) to explain human behavior. This Perspective explains that human behavior is influenced by multiple influences on an individual. The Perspective was further adapted for application to HIV/STD prevention for the purposes of this study. Here, it explains that risk behavior is influenced by four different systems:

1) ontogenetic, which refers to the personal factors that are unique to an individual's developmental history, including self-efficacy, outcome expectancies, and personal factors that are unique to an individual's developmental history, including trauma history (e.g., childhood sexual abuse).

2) the micro-level, which refers to the interactional factors that are part of the immediate context in which the behavior takes place. In Eban, this level centers on interactional factors that are part of the immediate context in which sexual activity occurs, including couple condom negotiation self-efficacy, length of the relationship, and couple sexual communication skill. Recent research underscores the importance of these dyadic factors in understanding why couples engage in unprotected sex.

3) the exo-level, which refers to formal and informal social factors that impinge upon the immediate setting, including peer norms and social support. Several studies have tied peer norms about HIV risk reduction to sexual risk behavior. Low income, urban women who have adequate social support are more likely to use condoms than are other women.

4) the macro-cultural level, which refers to the broad cultural values and belief system that interact with all the other analytical levels. HIV sexual-risk behaviors are embedded in cultural factors acting on individuals, couples, and communities. We will address broad cultural norms, particularly gender-role norms that affect dyadic contexts and how women and men handle sexual situations.

4.1.4. Seven Principles of Nguzo Saba ("Seven Principles")

The EBAN HIV/STD risk reduction intervention was developed to be culturally grounded in concepts that reflect the history and concerns of African Americans, and to draw on the strengths of participating couples in order to empower them to achieve risk reduction. This is achieved by adapting messages of risk reduction interpreted through the Nguzo Saba into the principles of SCT and Ecological Perspective previously mentioned. The Nguzo Saba may be familiar to some of you and known to you as the seven principles celebrated during Kwanzaa. They are seven basic values of African culture which contribute to building and reinforcing family, community and culture among African American people as well as Africans throughout the world African community. These principles are introduced in the first session, and then referred to throughout the remaining seven sessions.

The **Nguzo Saba:** each principle is followed by a sentence framing it within the EBAN risk reduction goals.

1. **Unity – Umoja:** To strive for and maintain unity in the family, community, nation and race (*Our union is jointly committed to safer sex practices and to maintaining a healthy lifestyle).*

2. **Self-Determination – Kujichagulia:** To define ourselves, name ourselves, create for ourselves and speak for ourselves instead of being defined, named, created for and spoken for by others. *(We have the knowledge, power and skills to jointly determine how we will stay safer sexually).*

3. **Collective Work and Responsibility – Ujima:** To build and maintain our community together

and make our sisters' and brothers' problems our problems and to solve them together. *(We can get back on track and continue to practice safer sex by working together as a couple and sharing joint responsibility).*

4. **Cooperative Economics – Ujamma:** To build and maintain our own stores, shops and other businesses and to profit from them together. (*We can work together to support each other emotionally, socially and financially, in maintaining safer sex behavior).*

5. **Purpose – Nia:** To make our collective vocation the building and developing our community in order to restore our people to their traditional greatness. *(Our purpose is to keep each other safer, to protect each other and to maintain safer sex practices in our loving, intimate relationship).*

6. **Creativity – Kuumba:** To do always as much as we can, in the way we can, in order to leave our community more beautiful and beneficial than we inherited it. *(We can use our skills such as problem solving, Speaker Listener and the EBAN Café to regain and recreate safer sex practices).*

7. **Faith – Imani:** To believe with all our heart in our people, our parents, our teachers, our leaders and the righteousness and victory of our struggle. *(We have faith in our ability to practice safer sex and protect each other).*

You will notice these referred to throughout the sessions. Try to incorporate them whenever you can to emphasize their importance.

4.2. FACILITATOR RESPONSIBILITIES

4.2.1. Intervention Delivery

- Deliver the intervention as this manual and your trainer has defined it.
- Before the first session (and every so often) check to ensure that all materials are readily available for all of the sessions.
- Facilitators should pick up refreshments before each session. Make sure that all receipts for refreshments are saved for reimbursement.
- Facilitators should get petty cash and receipts for participant reimbursement before each session. Make sure that all receipts are saved for reimbursement.
- Of highest priority is to maintain the confidentiality of session proceedings and all participant communication. Audiotapes of sessions should be returned to the Project Manager for secure keeping as soon as possible following each session.
- You should be prepared to report back to the Project Manager or Clinical Supervisor about your session at facilitator meetings.

If You Will Miss a session

If there is an emergency and you cannot attend your session or the facilitator meeting, contact your Site Coordinator, Project Manager, or Clinical Supervisor as soon as possible. The participants will need to be contacted so that the session can be rescheduled.

4.2.2. Reminder Calls to Participants

The facilitators should arrange to call each participant the day before each session to remind them of the time and location of their session. It is essential that you talk to the participant personally rather than leave a message if possible. Be sure to follow the information in the locator form as to who can call and whether or not you can mention The EBAN HIV/STD risk reduction intervention to the person who answers the call. Some couples do not live together. Instead they have separate homes and/or contact phone numbers. If you are not certain that both participants live together, or if they have different contact phone numbers, then you should call each one personally to be sure they get the reminder message.

Calls to participants should be under 5 minutes in duration. They should be warm. Discuss attendance-related issues. Try to remove barriers preventing attendance (e.g., babysitting, transportation). You should not discuss substantive issues about the intervention.

4.2.3 If a Participant Misses a Session

If one or both partners miss a session, call each participant immediately (within 24 hours) after missed sessions. In order to attend any session, both partners must be present. If one or both partners miss a couple session, co-facilitators should make every effort to reschedule the couple session within a week's time. If this is not feasible, the session will be rescheduled within a window of no more than two weeks. If one or both partners miss a group session, the co-facilitators will request that both partners arrive 30 minutes prior to the next scheduled session in order to provide them with a summary of the content of the previous group session that they missed. If a couple misses more than one group session sequentially, the co-facilitators will request that both partners arrive 45 minutes prior to the next scheduled session in order to provide the content of the two missed sessions. If two or more couples miss a group session, the couples should reschedule together and meet in a smaller group.

If a couple completes a rescheduled session in full, they should receive full incentive payment. However, if a group session is missed and then subsequently made up prior to the next session, the couple will receive only half of the incentive payment for that session, as it is a significantly shorter period of time.

When completing the attendance sheet remember to indicate whether participants are completing a full or abbreviated session.

Facilitator note: One partner missing a session could be due to a concrete barrier, like transportation or working late on a job, or it can also be the result of anxiety about participating in the couple or group sessions or the feeling that the sessions cannot help. Probing for the reasons participants miss sessions can be helpful. Help participants brainstorm ways to address attendance barriers and make notation in your Participant Contact Log regarding these issues.

4.2.4. Participant Referrals

Each site will prepare a comprehensive facilitator resource and referral manual specific to their site and local communities. Your role on this project is to serve as a facilitator for this intervention, not to provide counseling or other services for participants, even if that is what you are trained to do outside the study. Therefore, the following guidelines should be followed when providing referrals to participants. In some instances, the need for a referral will arise due to a negative or unusual event (an event experienced by the participant due to their participation in the EBAN intervention). If this is the case, in addition to completing the Participant Referral Form, you should also complete a Negative or Unusual Event Form (Appendix 4B) and discuss the situation with your Clinical Supervisor, Management Team, or Project Manager.

Participants may need referral to other agencies or groups for a variety of reasons. Among these are the following:

- HIV/STD related treatment and care
- Mental health services
- Substance abuse and alcohol abuse treatment
- Partner violence
- Child abuse
- Suicide threats
- Counseling or services after receiving HIV seropositive test results

Some of these are discussed in the section on Handling Problems in the Sessions.

In general, you should spend no more than 10 minutes discussing a problem and providing a referral to a participant. You should talk with your Clinical Supervisor or Project Manager about the appropriate way to handle a problem requiring more time than this. All information should be logged in on the Participant Referral Form at your site for your Project Manager or Clinical Supervisor to review.

If the participant is extremely distraught or is in need of immediate services, you should attempt to deal with the situation by following the protocol for "upset, depressed or suicidal" participants (see Section 4.9.3). If you are unable to handle the situation, attempt to contact your Clinical Supervisor or Project Manager. If you cannot reach either, try to contact an Investigator from your site. If you are unable to reach any of these people, and the participant is still distraught or in distress, walk him or her to the nearest Emergency Room for assistance.

4.3. HOW TO TEACH BEHAVIOR CHANGE: INTERVENTION DELIVERY SKILLS

Teaching people to change behavior requires that you use several basic skills. Four of these basic skills are: (1) modeling; (2) role play; (3) reinforcement; and (4) goal setting. Below each are defined and their use in the program described using the example of the male condom use.

4.3.1. Modeling

Modeling refers to the process of teaching others a skill by showing them the skill in action. Skills are first described verbally, then demonstrated or "modeled" for participants either by you as facilitators,

and also sometimes by videotapes of others performing a skilled behavior. In this program, we teach participants how to use a male condom. You will show participants a variety of male condoms, describe how to put on a male condom, and model putting a male condom on a wooden penis, talking through each step of the skill.

4.3.2. Role Play (behavioral rehearsal)

Role-playing is the process whereby participants have the opportunity to practice the skills they acquire through the sessions. Facilitators should ask participants to identify risky behaviors and situations, choose one of the situations, and act it out. Remember, always use real-life situations, partner responses, etc. in role plays and other practice-with-feedback activities. Use examples that are not personal as a back up only. Here is an example of setting up a role-play:

1. The facilitator asks participants to describe a real-life risk situation in their relationship (e.g., "the last time you had unsafe sex; or the next time you are both triggered to have unsafe sex").

2. The couple is asked to imagine that they are in that situation presently. The facilitator describes the set up, asks the participants to imagine that they are in the situation, and to talk through the situation as if it were real.

3. The facilitator prompts the couple if they get stuck (remind them what the scene is), gives coaching if they get stuck (encourages participant to behave as if they were really in the situation), and keeps the role-play going.

4. The same gender facilitators can provide coaching. by standing behind the man or woman and whispering in his/her ear a statement that can be said to the partner

5. The facilitator stops the role-play when he or she feels that the couple has successfully finished the role-play, and debriefs with the couple by asking them how they felt during the role-play.

Be sure that each person understands his or her role. Ask the actors to play their roles realistically and without resolving the conflict at first. Encourage actors to think through all of the possible options. Be sure that these exercises do not stereotype individuals by sex, age, race, or HIV status. Reverse stereotype roles whenever possible. For example: "This time let us have the woman be the one who does not want to use a condom." Should participants be reluctant to engage in a role-play, one facilitator may play the role of that partner or can serve as a coach.

All role-plays should end with a successful, that is, a *safer* sex (or no sex) outcome.

4.3.3. Reinforcement

Reinforcement is used in our program in several ways. First, whenever an individual or a couple contributes, shares experiences, or attempts to achieve a goal (whether successfully or unsuccessfully), you should thank that person and emphasize the positive aspects of the contribution. People feel reinforced when they receive respect, positive regard and appreciation from others, and providing this will enhance their pleasure and participation in the program. Another source of reinforcement will come from successfully achieving changes in behavior, as reflected in the results of self-monitoring and goal setting, described below. Finally, participants are rewarded for coming -- by being paid money, by getting other incentives, and, perhaps most importantly, by you as a facilitator.

4.3.4. Goal-Setting

Goal setting at the couple level is introduced in Session two and goals are set each week as home work and reviewed in the subsequent session. The purpose of goal setting is to put our program to the test in the real world, permitting participants to practice skills in vivo and receive feedback while still in the program. It is often difficult to translate enthusiastic plans formed during educational sessions into behavior change in the outside world, because we cannot always predict what barriers we will encounter when we try. Through goal setting, participants will select, each week, a behavior change to achieve by the following session. Then, at the next session, they report and assess how well the plans went. If the goal was achieved, then the next one selected should be more difficult. If it was not, then the facilitator tries, with the participant, to identify barriers to achieving the goal, and the participants should brainstorm solutions to the problem. A slightly easier one, particularly one that addresses the problems encountered, should be selected for the next time. It is essential that unmet goals not be viewed as failures, but rather as learning opportunities. In this atmosphere, people will feel free to report problems encountered honestly and without embarrassment.

The goal selected should always be moderately difficult for that person. Goals that are too easy do not promote growth, and ones that are too challenging are unlikely to be achieved. Goals must also be specific and concrete, so that it is easy to know one week later whether they have been achieved. The ultimate purpose of the goal-setting procedure is to reduce the number of risky behaviors the person engages in (such as sharing drug needles or having unprotected sexual intercourse). Therefore, each goal that is selected should be directed toward that end, and by the end of the seventh session, each person should be as close as possible to being consistently safe with respect to HIV infection.

In Session two, the couple identifies big goals that they would like to achieve by the end of the program. During each session, goals that are smaller steps to reach the ultimate goal are set.

Guidelines for goal-setting

1. Allow participants to propose their own goals. In order to do this, you must convince them of the important role goal-setting plays in being able to achieve behavior change. It may take the participant some time to formulate a goal; facilitators should not rescue the participant prematurely in their attempt to come up with goals.

2. Make sure the participant sets specific, risk-related goals. Some tips for achieving this:

    - Get to know each of your participants well: who their partners are, and what they are like, so that you have information about how difficult their partners and environment are.

    - Have the participant rate their confidence in meeting the goal on a scale from 1-10. Good goals are ones where confidence is in a middle range, so they are not too easy or too hard.

    - Try setting sub-goals to realize larger, unrealistic goals.

    - Do not ask open questions; rather, make suggestions.

    - Be sure to take the individual's previous experiences into account in setting new goals.

- If a participant sets a goal that requires participation by another person, and there is any possibility that they may not reach the goal because they do not see the other person or the opportunity to have sex does not arise, a dual goal that they can accomplish alone also should be set. For example, a participant might have the goal of negotiating safer sex with my main partner before the next session. However, the opportunity to do this might not arise. In this case, a dual goal, such as role playing safer sex negotiation in front of a mirror for a total of thirty minutes between now and the next session, could be set. This goal would be used only if there was no opportunity to accomplish the original goal.

- Provide positive reinforcement to the participant when a good goal has been selected.

3. When setting goals, use the following strategies:

   - If the goal was achieved, then:

     ▶ reward!
     ▶ What now? (start to plan next goal; keep it brief as you will come back to it at the end.)

   - If the goal was not achieved, then:

     ▶ reward for trying and for any progress made. Emphasize that this is a learning experience.
     ▶ make sure the goal is still important to the person.
     ▶ identify the trigger/problem that prevented the goal from being reached.
     ▶ use problem-solving strategy to have participant identify a solution. This will likely become next session's goal.
     ▶ make the point that obstacles encountered during goal-setting may be relevant to relapse after participation in The EBAN Risk Reduction intervention has ended, and emphasize that long-term strategies for managing them will need to be developed.

Suggested Safer Sex-related Goals for Couples in Different Situations

1. If couple is not sexually active now, there are still ways for them to make themselves safer so that they are prepared when they do become sexually active:

   - locate and purchase condoms
   - carry condoms with you at all times
   - develop comfort with handling and identifying different types of condoms
   - practice putting condoms on at home alone (on self or banana).
   - use condoms while masturbating
   - practice introducing a condom to your partner
   - if you become sexually active, negotiate safer sex; in the meantime, role play what you would say and how you might introduce using a condom to your partner. How might the conversation go using assertive communication (speaker/listener) and negotiation skills?

2. Participant is currently sexually active, but has no experience with condom use:

   - locate and purchase condoms
   - carry condoms and keep them accessible at all times
   - develop comfort with handling and identifying different types of condoms
   - practice putting condoms on at home alone (on self or banana).
   - use condoms while masturbating.
   - negotiate using a condom with partner; use alternatives for safer sex or negotiation if unsuccessful

3. Participant is currently sexually active and has access to condoms:

   - keep condoms accessible (are you sure you will not run out?) and available in convenient locations (bedrooms, bathrooms, boyfriend or girlfriend's home)
   - practice using a condom
   - practice using a female condom
   - negotiate using a condom with partner or offer alternative for safer sex
   - negotiate using a condom with partner using alternative for safer sex or condom comebacks
   - negotiate using a condom with partner using assertive communication (speaker/listener) and/or negotiation
   - negotiate using a condom with partner, including eroticizing condom use

4. Participant reports consistent condom use with current partner:
   Confront the participant with the fact that we are all here because we have put ourselves at risk some time in the past, and that, although we sometimes use condoms, there are times that we may not. Ask what was going on for them the *last time* they remember having unprotected sex and ask them to set goals in anticipation of those moments.

   - keep condoms accessible (are you sure you will not run out?) and available in convenient locations (bedrooms, bathrooms, boyfriend or girlfriend's home)
   - practice using a condom
   - practice using a female condom
   - negotiate using a condom with partner using alternative for safer sex or condom comebacks
   - negotiate using a condom with partner using assertive communication (speaker/listener) and/or negotiation
   - negotiate using a condom with partner, including eroticizing condom use

5. Participant is currently an active drug user:
   Because substances become the most significant triggers to unsafe sex for many active drug users, goal setting may drift to steps toward the larger goal of recovery. Explain the focus of The EBAN HIV/STD risk reduction intervention to participant and stress that we would like to set smaller, short-term goals to keep them safe now, even if they are active. Try to explore goals that may be set within the context of drug use.

   - identify location and resources for free condom access
   - avoid triggers

- obtain condoms and keep them accessible; avoid triggers
- practice using male and female condoms; avoid triggers
- negotiate safer sex or alternatives to sex with partner before you get high; use assertive communication (speaker/listener) and negotiation skills

4.2.5 Problem Solving

Whenever possible, participants are encouraged to apply problem solving to a situation. The acronym we use in EBAN for problem solving is FENCE. The FENCE steps are:

F	Find out what is going on, and how you are feeling about it. Consider the context of the problem.	(Define the trigger(s) and the occurring problem)
E	Explore your partner's feelings about it, how your partner reacted	(Evaluate whether your partner feels positive or negative about what is going on)
N	Name and discuss your options, know your needs	(Brainstorm whatever options you may exercise to reach goal)
C	Choose the best option.	(Consider all options, but select one best-suited to you now)
E	Execute a plan - Execute the plan that achieves the best option, meets your needs, and ensures the safety of you and your partner. Be self-determined. Stay focused.	(Develop and discuss execution of an action plan to achieve your goal)

While the steps of problem solving appear quite logical, problem solving is often not successful because of a wide variety of human biases and limitations. Examples of biases include paying attention to things presented first or last rather than in the middle, falling into competition, and being trapped by superficial elements (being willing to pay more for the same product but from a "high class" establishment). Limitations refer to a lack of information, time pressures, inadequate resources, imperfect perceptions, short-term memories, and levels of complication we cannot handle. These biases and limitations must be considered and guarded against while practicing problem solving.

Application of FENCE

F	Find out what's going on.	While having sex with her partner, a woman unsuccessfully attempts to put a condom on her partner, and refuses to do so.
E	Explore your partner's feelings about it, how your partner reacted	When discussing this problem, she learns that he is upset and feels that she does not care for him. He learns that she is too turned on to focus on putting the condom on appropriately.
N	Name and discuss your options, know your needs	The couple identifies several options for dealing with this problem: she can practice on a banana, they can practice condom placement together so that the pressure is off of the woman.
C	Choose the best option.	The couple decides that the best option for them is to practice together.

E	Execute a plan - Execute the plan that achieves the best option, meets your needs, and ensures the safety of you and your partner. Be self-determined. Stay focused.	The couple makes a date specifying date, time, location to practice. Together they gather the supplies they will need. The couple is careful to choose a time when they can be alone without interruption. They execute their plan.

4.4. FACILITATOR ISSUES

4.4.1 Tips for the Facilitator

1. Reward frequently any observable positive behavior. "Catch the participant doing something good."
2. Be supportive.
3. Give specific compliments on progress made towards achieving goals.
4. Be nonjudgmental.
5. Create an energetic atmosphere by showing enthusiasm about the session content.
6. Encourage couple cohesion; focus on the relationship and not the individual.
7. Model appropriate assertive behavior.
8. Be firm.
9. Illustrate points through modeling.
10. Keep language simple & try to be the *observer* as often as possible.
11. Encourage couples to share their own experiences.
12. Build on strengths.
13. Listen.
14. Let the couple do the reacting, responding, thinking and analyzing.
15. Be flexible.
16. Keep trying. If one approach does not work, find another one.
    Draw on Nguzo Saba principles as often as possible.
17. Personalize the intervention by brining in couple's experiences as often as possible.
18. Provide male and female condoms at the end of every session.

4.4.2. The Co-Facilitation Process

The goal of facilitation is to teach the couple how to communicate and problem solve with each other so that they can achieve any mutually agreed upon goal in their life together. This is more likely to occur if the facilitators can elicit the couple content for the session from the couple rather than providing the content as a lecture. The facilitator should ask questions and coach the couple to provide the answers and reinforce whatever verbal contribution the couple makes during the session even if this requires reframing it.

Two major roles for facilitators can be labeled (1) lead and (2) process. The facilitator who is assuming the role of the lead should structure the sessions, provide the set up and transition between activities, provide the content and elicit content from couples and set up role plays. The facilitator who is assuming the role of process should time the sessions , be sure posters and other materials are available and watch the process of the session. If the man or woman look as if they would like to say something but are reluctant or do not know how to begin, the process facilitator should help by asking him or her to participate or serving as a coach.

The facilitator could assume the lead or process role for the entire session or alternate depending on what works best for them.

4.4.3 The Co-Facilitator Relationship

The EBAN HIV/STD risk reduction intervention will be co-led by two facilitators: one male and one female. The large number of people (10-12) usually participating in each group (4-6 couples) as well as the multiple levels (intra-family, inter-family, between participants, between HIV+ and HIV- participants) on which interactions (both verbal and non-verbal) occur are more effectively monitored and constructively utilized with two co-facilitators present.

Because the sessions entail multiple components, each of which will require instructions to couples, explicit content, and exercises to maximize within-couple and across-couple interaction, *it is imperative that the division of tasks between the two facilitators* (as described for each session) *be thoroughly discussed and delegated prior to the start of each session.* They can divide the roles or maintain the same roles during a session. Facilitators should meet approximately one half hour prior to the session, not only to prepare materials, but to also discuss session content and specific facilitator roles. Specific attention should be paid to potentially sensitive topic areas and facilitators should decide who is best suited to present the material. Likewise, facilitators should spend about one half hour after the session for debriefing, note taking, and preparing for the next session. It is also recommended that facilitators try to follow the time allocations for each component.

Also remember that because you are working as a team, co-facilitators are encouraged to check with each other periodically throughout the session to review if all content items have been covered. This style of working will have the additional advantage of modeling for the couples the type of collaborative, interactive approach to problem-solving that we want them to use as they share risk reduction experiences and coping strategies with each other.

The challenge for the co-facilitator team is to achieve a balance between (a) eliciting from participants a variety of (sometimes quite disparate) viewpoints and feelings, and (b) organizing those ideas, feelings, and concerns into a useful framework that remains within and consistent with the skill components that should be covered.

The Co-facilitator relationship is key:

- Co-facilitators must agree on content of sessions and determine who will cover what materials ahead of time.
- An environment of mutual respect and admiration must be created. Differences may arise but it is important that these issues are addressed in a manner such that the mutuality of the relationship is not undermined.
- Co-facilitators must model successful resolution of conflict. This may be achieved by engaging in either the Speaker/Listener technique or problem-solving, two skills taught within the curriculum.
- If there is a relationship between the co-facilitators outside of the group it must be maintained, as often participants will idolize their relationship.
- Any problems within the co-facilitator relationship may have significant impact on participants as they may feel the need to try to mend the relationship.
- Co-facilitators must also agree on the appropriate amount of self-disclosure. If each facilitator

discloses different amounts of information, the participants may view one as more caring and the other, that discloses less, as not invested in the participants' success. Pre-establishing self-disclosure procedures is especially important in cases where co-facilitators are in a relationship.

4.4.4. Facilitators' Division of Labor

Two facilitators will conduct each of the eight sessions. Facilitators must be very familiar with the protocol so their attention may be focused on the couple or on the group, their interaction, feedback and individualized needs. Facilitators may assign tasks prior to the session and alternate so one person is not always in charge of support tasks. Facilitators should monitor non-verbal cues from participants so that reluctant people are drawn into the discussion. In addition to the lead and the process roles, there are the following tasks:

- Write on flip chart as described in the manual.
- Show videos, posters or provide hand-outs as described in manual.
- Take care of any problems that occur in the session.
- Complete any and all paperwork related to the session.
- Make follow-up/reminder phone calls to couple before each session.

4.4.5. Building Cohesiveness in Couples and Groups

Connectedness between individuals as part of a couple and also as part of a group is an integral component of a successful group.

Leadership Skills that Enhance Cohesiveness When Working with Couples

1. Always remind the couple that by coming to these sessions, they are expressing their care and concern for one another and for the relationship. They are role models for other couples in their community.

2. Reinforce the idea that they are the experts on their own relationship; we are not here to tell them what to do, but rather to provide as much information about their choices, skills-building and skills practice as possible. They must decide for themselves how safe they want to be.

Six Building Blocks to Co-facilitation of Successful Couples Groups

1. The Safe Harbor of the Group - members must feel that they can self-disclose without being attacked by the group. Safe Harbor is established with a clear statement of group guidelines at the beginning of the group.
2. Acceptance - Members must feel that even if another group member disagrees with them they will still want them to be part of the group. Co-facilitators ensure that criticism is not the basic undertone of the group.
3. Assumption that the Power to Change is within the Couple or the Group - The fantasy that it will be the co-facilitators that change or alleviate the couple's problems must be avoided. The facilitators must communicate that the power to change lies in the couples.

4. Modeling of Honesty - Facilitators must be honest to group members and to each other. "Falseness" between the facilitators will be detected by group members.
5. Universality - Members must feel that they are not the only couple dealing with this kind of problem they are dealing with. Also, the idea of the "joint group struggle," where the group is dealing with a common problem.
6. Humor- Humor as part of group experiences of as parody should be introduced as relief but cannot be disrespectful.

Leadership Skills that Enhance Cohesiveness in Couples Groups

1. Facilitators Communicate Their Belief in the Group - Group importance is established through starting the group on time, consistently being there and helping members to work through their problems.
2. Prepositioning - Using language to connect people, by showing members that their issue relates to the entire group (e.g., pointing out similarities).
3. Employing Structured Exercises-
   - ▶ Promote Sharing - Early in the group members should be encouraged to share information about themselves through specific exercises.
   - ▶ Promote Enjoyment
   - ▶ Promote Common Moving Experiences - Sharing of feelings and experiences that involve profound feelings.
   - ▶ Enable Group Celebration - Celebrations within the group should be tasks of the group and not forced.
   - ▶ Distribute attention among all of the couples.
   - ▶ Encourage constructive self-disclosure.

Above points and discussion taken from:

Coche, J., & Coche, E. (1990). Building cohesiveness in couples and groups. In *Couples group psychotherapy: A clinical practice model* (pp. 61-71). New York, NY: Brunner/Mazel, Publishers.

Steinglass, P., Ostorff, J., Steinglass, A. (2002). The Ackerman/Memorial Sloan-Kettering Multiple Family Discussion Group for Cancer Patients and Their Families *One-Day Workshop Version* Treatment.

4.5 WORKING WITH AFRICAN AMERICAN COUPLES

In couple's therapy with African American clients, it is essential that facilitators recognize the significant and unique issues facing African American couples. When working with African American couples it is important that facilitators have knowledge of the many historical and current barriers that face the couple, as individuals, as part of a partnership, part of a family, and community. In recognizing these societal barriers the facilitators acknowledge the strengths of the couples as they have faced these forces in the past.

When appropriate, it is important to emphasize that the African American community, and African Americans individually have successfully challenged and fought to overcome oppression, and continue to fight against racism and other forms of discrimination. This tremendous strength and resiliency should be drawn upon in highlighting achievement of the risk reduction goals in EBAN, and to fighting HIV/AIDS and other STDS within the African American community.

In an effort to emphasize the importance and relevance of African American culture in risk reduction, and to attempt to have facilitators perceived as knowledgeable, not only about risk reduction, but also African American culture, all co-facilitators will be African American themselves. As such, it is important that they explore the following issues for themselves prior to conducting the sessions so they do not become reactive as a result of their own ties to racism and gender roles.

4.5.1 Issues Experienced by Men and Women of African Descent

Racism – The fear and frustration caused by facing racism daily causes significant strain on African American couples. This has sometimes been called the *"Rage over Racism" issue.* Often couples who face racism as a reality of their daily lives direct the rage over this racism at each other without realizing it. Facilitators should help the couples to reframe their conflicts to realize that sometimes rage may not be about just their partner, but perhaps also over this oppression. It is imperative that facilitators try to be aware of how both the individuals and the couple together experience racism.

Mistrust of Authority and "Conspiracy Theory" understanding of HIV/AIDS – The "conspiracy theory" understanding of HIV/AIDS suggests that HIV was introduced into African, African American, and other minority communities deliberately. While there is no formal evidence of this, the history of medicine and medical research in the U.S. includes examples of situations where African Americans were deliberately mistreated and used unethically for research purposes. Thus, the notion of a "conspiracy" is important to acknowledge, given U.S. history, but more importantly, the ability of the African American community to successfully identify unethical and inappropriate conduct on the part of authorities and to bring about justice and policy reform should be emphasized.

Importance of Spirituality – African American couples more frequently identify spirituality as being an important part of their lives than the general American population. Throughout history the church has played a supportive role of African Americans as they have faced hardships. The Black church has been a forum for community organization, spirituality, and counseling when African Americans has no place to call their own. Facilitators should be open to the strength drawn from spirituality among couples participating in EBAN, and to integrate strengths or social support drawn into couple efforts to achieve risk reduction.

Definition of Family – Facilitators must be sure not to attempt to treat a couple in a vacuum as African American couples frequently have strong, multi-generational family ties. In addition, facilitators need to recognize that in African American cultures the roles of family members are not reserved only for blood-relatives. Often close family friends are given the title of "Aunt" or "Grandma", reflecting the importance of this person in the life of the family. When exploring social support or disclosure issues, facilitators should recognize the importance of extended family and kinship ties.

Cherishing Diversity – Facilitators must recognize and acknowledge that the African American community is not homogeneous. It is comprised of individuals with varied ethnic and racial backgrounds from Africa, the Caribbean, and other countries of origin around the world. Political issues often drive groups to be "named" or "labeled" in order to define them for political or seemingly practical purposes. This has the effect of challenging the unique identities of all people who may be characterized as African American. While the EBAN Project targets "African American" mixed HIV status couples, we recognize that this is a very broad generalization requiring us to clarify what it means for each individual and couple participating. Additionally, many couples in Eban may be mixed ethnicity, where only one partner is African American. Individual and collective identity issues may arise in mixed ethnicity couples. Facilitators play a key role in reinforcing the importance of cherishing diversity and celebrating differences within and among Eban couples.

4.5.2 Experiences of African American Men

"Invisibility Syndrome" – describes how African American men have been treated as if they are invisible in American culture. This has resulted in many of these men feeling extreme frustration as they try to fulfill the expectation of being a good provider in a society where they are not seen (unless doing something wrong).

Favorable Treatment to Males – African American families often attempt to compensate for the intense racism faced by their sons by giving favorable treatment to the boy children of the family. This can result in hostility between men and women and can in turn affect relationships.

Contradictory Gender Roles – African American men are often presented with contradictory gender roles. They are expected and taught to be dominant and assertive as men while they are also given messages that they should always be composed and calm so that they do not fit into stereotypes of their race and gender.

4.5.3 Experiences of African American Women

Sexism – In addition to battling racism in society, African American women must also face sexism as it affects their views of their own intelligence, beauty, and worth.

Differences in Workplace Experiences – African American women have had traditionally more success in white male dominated workplaces then their male counterparts. This distinction can put significant stress on African American couples.

The "Shortage of Black Men" Issue – High rates of incarceration, high mortality rates and high unemployment rates are some of the issues affecting African American men in the U.S. At the same time, over the last quarter century, African American women are increasingly more successful in terms of education and employment, than their male counterparts. This phenomenon contributes to a perception that there is a "shortage" of qualified partners for African American women, which leads to some women feeling trapped in relationships that are destructive because they fear they may not be able to find another partner.

Lack of Popular Media Images of Black People – Dominant Western society's views of women and beauty has led to an invisibility of African American women that is similar to African American men. These women are often left to feel negatively about much of their physical self (including hair and skin color).

Contradictory Messages about Gender Roles – African American women are also sent mixed messages about their gender roles. They are expected to be independent and taught not to depend on men for support while they are also encouraged to "find a man" to take care of them.

Above points and discussion taken from:

Black, L.W. 2000. Therapy with African American couples. In Papp, Peggy (Ed.), Couples on the fault line: New directions for therapists (pp. 205-221). New York, NY: The Guilford Press.

Boyd-Franklin, N. & Franklin, A.J. (1998). African American couples in therapy. In McGoldrick, M. , Re-visioning family therapy: Race, culture, and gender in clinical practice (pp. 268-281). New York, NY: The

Guilford Press.

4.6 WORKING WITH MIXED HIV STATUS COUPLES

Stress and Challenges in Serodiscordant Relationships

Couples demonstrate a range of strategies to cope with the stress and distress of HIV infection in their relationship, some positive and some negative. When communication is impaired due to unexpressed fears about HIV transmission, potential illness and loss, future uncertainty and a desire to protect each other from these fears, many aspects of the relationship can be negatively affected. Confronting these issues and legitimizing the emotional needs of both members of a mixed status relationship is a challenge for couples and for mental health clinicians developing intervention strategies for these couples.

Couples of mixed HIV status are confronted with numerous, unique challenges and stressors that render them vulnerable to increased psychological distress. These include:

- fear of HIV transmission;
- fears about anticipated illness and death;
- difficulty maintaining intimacy and a safer yet satisfying sexual relationship;
- reproductive decision making (whether or not to have a child);
- issues around caregiving and changes in roles related to receiving and giving care;
- disclosure of individual and couple HIV status to friends and family;
- social stigma;
- feelings of isolation and a lack of support from the community; and
- uncertainty about the future.

Role of Support Within the Relationship

Primary relationships can be both a buffer from distress and a source of distress. Support in relationships can play an important role in alleviating distress in mixed HIV status couples. Increasing sexual satisfaction and increasing communication are two important areas that we can support in order to increase relationship satisfaction and lower levels of distress among these couples, which in turn will help them adapt sexual risk reduction behaviors.

Tendency to avoid communication

It is common for mixed status couples to avoid talking about HIV-related topics, including all of their fears and concerns about many issues. Anything that is related to the topic can feel emotionally charged. It is safe to assume that every person who is aware of their HIV+ serostatus and every person who is the partner of an HIV+ person entertains, in their own mind, a range of fantasies about the future possibility of severe illness, physical dependence, cognitive decline, and premature death. It can be difficult to verbalize these fears to oneself and to one's partner, thus individuals often endure these fantasies in isolation. Both members of the couple will typically express the need to "protect" their partner from these thoughts and feelings. The seronegative partner typically does not want to express his or her sadness and fear so as not to burden the partner with "something else to worry about" or make the partner "feel bad," since after all, the partner is infected and he or she is not, thereby thinking that his or her emotional needs are less valid. The seropositive partner, likewise, feels that he or she needs to protect the partner from worrying about him or her and may feel guilty for bringing HIV infection into

the relationship, whether he or she already knew their seropositive status before or after forming the relationship. Eventually they realize that both share similar concerns and that, to a large degree, they are attempting to protect each other from confronting the potential reality of what may lie ahead. With increased communication, they usually realize that both share similar concerns, and that talking about those concerns increases feelings of intimacy and couple satisfaction, and reduces isolation.

Sex in Mixed HIV Status Relationships

There are many reasons why mixed status couples may practice sexual risk behavior. Some reasons have to do with individuals' background variables such as age and ethnicity. Other factors have to do with couple level variables, such as length of relationship, already established behavior patterns, level of emotional and sexual intimacy, satisfaction with the relationship, and communication patterns. Other determinants of sexual risk behavior are situational, such as use of alcohol and drugs with sex, and the *passion of the moment.* Finally, some determinants are more intrapsychic which include feelings of depression and hopelessness, personal preferences in sexual behavior (e.g., a preference for anal sex), lack of feeling susceptible and lack of motivation for change.

These factors interact in numerous ways to determine sexual risk behavior in a couple. For example, a couple that has a history of engaging in unsafe sex in the past (perhaps before they were even aware of their mixed HIV status) is vulnerable to resuming that behavior. This risk will be heightened if one or both of them have a high preference for unprotected sex, they are feeling hopeless about their future, they find it difficult to talk to each other about intimate things, and they are using recreational drugs while engaging in sexual activities. Couples, just like individuals, have a strong resistance to change familiar behavior patterns. They find ways to rationalize behaviors that go against their beliefs about safe and unsafe sex behavior. Therefore, conflicts between beliefs, normative behavior, and the couple's risk behavior need to be addressed.

Consistent maintenance of protected sex is difficult to achieve in ongoing intimate relationships. Condoms are perceived to be a barrier to intimacy. They are a constant reminder of HIV infection and therefore can interfere with the spontaneity and pleasure of sexual expression. Many couples say that using the condom is like "bringing death into the bedroom" because of all of the cognitive and emotional associations attached to the necessity of its use. Not using condoms, or engaging in sex behavior that may be risky can be perceived as exciting, passionate, and a "true" expression of love and commitment.

How HIV impacts our relationship

An important issue to be addressed in the group sessions is "the impact of HIV on our relationship." If left unexamined and unaltered, it may threaten to take over the couple's identity and to interfere with (distort or inhibit) their ability to practice safer behaviors and live healthy lifestyles. In an effort to attend to the issues raised by having to live with HIV, other couple/family goals and needs are often neglected. By refocusing concern to the importance of communication, negotiation of risk reduction and healthy behaviors, the couple may be able to find an appropriate balance between responsible attention to illness demands, and engagement in non-illness family activities and issues.

Feeling Left Out

In addition to issues of communication and intimacy, there are concrete issues that raise barriers in the relationships of mixed HIV status couples. Because most HIV-related services target individuals who are HIV+, HIV- partners may have services needs that are unaddressed. The lack of attention to the service needs of HIV- partners can create an imbalance in mixed HIV status partnerships. Addressing the unique service

needs of HIV- partners can enhance the quality of life for the individual and the couple.

Remien, R.H.: Couples of mixed HIV status: Challenges and strategies for intervention with couples. In: L. Wicks (Ed.), Psychotherapy and AIDS. Washington, D.C.: Taylor and Francis, pp.165-177, 1997

Steinglass, P., Ostorff, J., Steinglass, A. (2002). The Ackerman/Memorial Sloan-Kettering Multiple Family Discussion Group for Cancer Patients and Their Families *One-Day Workshop Version* Treatment.

4.7 CONDUCTING COUPLES SESSIONS

Why Work with Couples?

Most HIV/STD prevention programs focus on women or men only. Individuals, and women especially, may have a difficult time successfully applying what they learn in such programs to their actual relationship, because it takes two partners together to agree to make change. Having both partners together allows male participants to develop knowledge, education, self-interest, and empathy, which can lead to a mutual desire to reduce risky behaviors.

Couples counseling differs from individual counseling because it takes the expectation for change is shifted from the individual to the couple. Focusing on the safety and health of the relationship as a context for safer behavior can eliminate feelings of guilt, shame or stigma associated with safer sex behavior. A couples counseling approach recognizes the couple as "experts" on their own relationship. By focusing on the importance of the relationship, facilitators can provide choices for reducing risk, encouraging the couple to act as a "team" in deciding how to protect each other.

Benefits of Intervening at the Couple Level

Intervention studies with couples have demonstrated reduced couple distress through communication and conflict-management training. In HIV and AIDS specifically, it is important to work clinically with the many challenges these couples face at the relationship level to strengthen the partnership, rather than only referring each partner to his or her separate support group or individual therapy. Having both partners engaged in the process allows the facilitator to address stumbling blocks or barriers in the relationship. Both partners are invited to share their perspective and encouraged to develop empathy and cohesion. It is important to validate the emotional concerns of both partners and help the members of the couple see that the concerns of both partners are legitimate and that there are unique concerns associated with being in a mixed status relationship. There is value in strengthening couple-level support, satisfaction, and cohesion to reduce distress and increase individual feelings of well-being. It is also important to help couples increase their sexual satisfaction within the relationship without incurring increased risk for transmission of HIV and other sexually transmitted diseases. Sex is an intimate behavior that can influence and be influenced by other modes of emotional intimacy within a relationship.

Remien, R.H.: Couples of mixed HIV status: Challenges and strategies for intervention with couples. In: L. Wicks (Ed.), Psychotherapy and AIDS. Washington, D.C.: Taylor and Francis, pp.165-177, 1997

4.8 CONDUCTING COUPLE GROUPS

Benefits of a Group Modality

Couple groups provide an opportunity to reduce feelings of isolation and to validate the challenges or living as a mixed serostatus couple. The group format can allow individuals to gain insight into how their partner is coping, and to engage in discussions of sexual behavior that the couple may not be able to initiate on their own and which may facilitate new sexual behaviors that are more pleasurable as well as safer. Risky couples may re-evaluate their behavior when, compared to others in the group, they see how risky it is, while those couples unable to express themselves comfortably may learn to increase their expressions of desire and need for intimacy. Peer norms influence thoughts about behavior, and there seems to be a tendency within groups of couples affected by HIV for movement towards safer sex practices.

Couples can have a powerful influence on each other. Exposure to other couples with which they can identify and share coping strategies as well as model safer and intimate behaviors should be the core ingredient of an *intervention for male couples confronted with HIV or the threat of HIV in their relationship.*

Providing an environment for mixed status couples to meet with other mixed status couples can be a powerful mode of intervention. It is an important first step in reducing the profound isolation experienced by these couples. The group experience allows for the emergence and exploration of emotionally charged issues that are difficult for these couples to address. Providing couples with the opportunity to discuss these issues can lead to improved satisfaction with their sexual and emotional relationship, a feeling of validation as a couple, and a reduction in sexual risk behavior without a reduction in feelings of intimacy.

What Makes Couples Groups Effective?

Two Most important aspects:

- Having couples participate together within the group gives the participants an opportunity to have first-hand observation of problems within relationships. This "normalizes" issues and concerns and also provides models for solving problems.

- Benefits of group work: learning from others, experiential learning, altruism, and feedback. The group becomes a microcosm of a community of couples.

Treatment Skills with Intimate Partners:

Specific Skills:

- **Empathy building** - Enhancing the ability to see a problem from another person's point of view can introduce new thinking about old problems in a relationship.

- **Benefits Generalize** - Couples work not only benefits the couple but also the individuals that are a part of the couple and the group as a whole. The benefits can also accrue to the family.

- **Enhancing intimacy** - To achieve greater intimacy one must overcome the individual obstacles created throughout their life course. This new personal freedom will then result in positive changes within the couple. Adult intimacy involves taking responsibility for one's actions. Partners must take responsibility for their behaviors, thoughts and feelings in relation to the other person. In order to do this, each person must gain an awareness of how they feel and why they act along with the ability to communicate these ideas.

  Living life fully and responsibly entails making life choices. People must take responsibility for their

choices and learn from their mistakes. In addition, individuals always have options in relation to how they respond to the actions of their partner.

- **Resistance** - Resistance is a natural part of the process of change and couples will inevitably use resistance to maintain stability in the relationship. Co-facilitators should support couples even when they express the opinion that change within the relationship is not possible, and help them to reframe an inability to change as an opportunity to try something new.

- **Incorporating Listening & Communication Skills** - Four steps to increase communication between couples.

  - ▶ Teach partners to recognize what they feel and how to name their feelings.
  - ▶ Teach couples to actively listen to their partner.
  - ▶ Teach partners to communicate clearly and carefully using exercises within the group.
  - ▶ Teach couples to respectively negotiate differences and learn specific negotiating skills.
  - ▶ Teach couples to learn negotiation skills and to apply them to negotiate differences in the relationship.

- **Gender Issues in Couples Development** - Authors from many fields have identified the importance of recognizing gender and gender roles within couples' groups. It is especially important to address the language used within the group in relation to gender (i.e. using the word "girl" instead of "woman") or making assumptions about the wishes of the partner based on stereotypes.

Dealing With Naturally Emerging Member Roles In the Group

1. **The Scapegoat** - The group scapegoat is usually the target of anger or frustration in the group. Typically the scapegoat role will change through the phases of group development. In the event that a group member seems to be "stuck" in this role, the co-facilitators should intervene and try to reframe the criticism and raise group awareness about the pattern that has developed.

2. **The Joker** - The joker will protect the group from difficult topics by using humor. The humor is usually not well received by the group and can interrupt group processes. Usually the group will ask the joker to settle down but in the event that the group cannot do this the facilitators will have to intervene and attempt to make the person recognize why they feel the need to behave in this manner.

3. **The Polite Socializer** - The polite socializer does not understand the difference between polite conversation and group work and often will not take part in the intimate conversation of the group. This person may attempt to keep the conversations superficial and non-threatening. Often the group will redirect this conversation back to the task at hand.

4. **The Monopolizer** - The monopolizer is a needy group member who takes most of the group time for his or her own discussion. This discussion could range from a lengthy narrative to a debate with the facilitators. The facilitators should carefully involve the group to intervene in this situation using caution not to make the monopolizer into the scapegoat.

5. **The Competitive Member** - The competitive member consistently gives criticizing feedback to other members (often in the form of "that happened to me..."). The competitiveness can be between individuals of a couple or can involve the entire group. Facilitators should draw attention to this behavior in the group but should also examine their own behavior in interacting with the other group

facilitator to ensure that they are not modeling competitive behavior.

6. **The Would-Be Co-Facilitator** - This member, often a mental health professional, hides behind positive feedback and offering expertise. This member rarely self discloses and the co-facilitators must directly engage this member to encourage them to participate as a member and not a facilitator.

7. **"I Am Just Here For My Spouse"** - The group will typically not allow one partner to hide in denial by attributing the couple's entire problem to the other partner. The group will typically draw attention to this problem early on.

Coche, J., & Coche, E. (1990). Building cohesiveness in couples and groups. In Couples group psychotherapy: A clinical practice model (pp. 61-71). New York, NY: Brunner/Mazel, Publishers.

Remien, R.H.: Couples of mixed HIV status: Challenges and strategies for intervention with couples. In: L. Wicks (Ed.), Psychotherapy and AIDS. Washington, D.C.: Taylor and Francis, pp.165-177, 1997

Steinglass, P., Ostorff, J., Steinglass, A. (2002). The Ackerman/Memorial Sloan-Kettering Multiple Family Discussion Group for Cancer Patients and Their Families *One-Day Workshop Version* Treatment.

4.9 HANDLING PROBLEMS IN THE SESSIONS

In General

1. Ignore inappropriate behavior **and**

2. Redirect participant toward appropriate behavior **and**

3. Reward even the slightest movement toward appropriate behavior.

4.9.1 Specific Situations

(NOTE: For each situation, facilitators will need to decide which responses fit best using their own clinical judgment. These suggestions are adapted from the NIMH Multisite manual, add ref)

Disruptive

Possible reasons for the behavior:
1) Causing trouble has resulted in receiving increased attention.
2) Angry about something and does not know another way to express it.
3) Hides feelings of insecurity.
4) Looking for partner or facilitator respect.
5) Is in a lot of pain.

Facilitator's responses:
1) Ignore, redirect and reward for appropriate behavior.
2) Ask the person to role-play a part (often that of the partner).
3) Take the person aside and suggest that he/she leave and come back later in the session (in extreme

situations only).

Breaking Session Ground Rules

Possible reasons for the behavior:
1) Attention-getting.
2) Angry about something and does not know another way to express it.

Facilitator's responses:
1) Address immediately so that it does not lead to significant damage.
2) Remind individual about group rules.
3) If the behavior occurs again, it is important to check in with individual and partner (couple session) and/or other group members to decide what course of action should be taken.

Overly Talkative

Possible reasons for the behavior:
1) Eager to share ideas.
2) Needs to show-off and receive attention.
3) May know a great deal and wants to show it.
4) Typically talks a great deal.

Facilitator's responses:
1) Do not put the person down.
2) Ask thoughtful questions to make them pause.
3) Interrupt with "That is an interesting point."
4) If couple's session, let the person know that you would like all of us to have equal opportunities to share ideas and talk.
5) Use signals to alert the person to finish speaking.
6) Thank person for sharing, but state need to move on or hear from other partner (when appropriate).
7) Offer to come back to topic if time at end of session (if relevant).

Argues Frequently

Possible reasons for the behavior:
1) Likes to be the center of attention.
2) Keeps people from getting close.
3) Is angry about something.
4) Upset by personal problems.
5) Needs to dominate people.
6) Thinks that arguing demonstrates intelligence.
7) Does not know any other way to interact socially.

Facilitator's responses:
1) Keep your temper in check.
2) Find points in what the person is saying that are of merit.
3) Engage the person in an assertiveness role-play.
4) Use problem solving to resolve the conflict.
5) At a private moment, try to find out if something is bothering the person.
6) Try to talk to person privately.

Will Not Talk

Possible reasons for the behavior:
1) Frightened.
2) Insecure.
3) Bored.
4) Indifferent.
5) Feels superior.
6) Knows all the answers.
7) Wants to be drawn out.
8) Depressed.

Facilitator's responses:
1) Thank person for any small response.
2) Ask for help in role-playing.
3) Ask person how you can help them with the session materials; or in general, in order to open them up.
4) If person is depressed, provide an opportunity to talk and make appropriate referrals.

Complains Frequently

Possible reasons for the behavior:
1) Has a legitimate reason to complain.
2) Has a pet peeve.
3) Gripping is consistent personal style.
4) Uses a great many dysfunctional thoughts.

Facilitator's responses:
1) See if appropriate changes can be made.
2) Point out what can be changed and what cannot.
3) Involve partner (when appropriate) in addressing the issue(s).
4) Create a role-play where someone is unhappy and wants to bring about a change, using "I" statements.
5) Discuss the complaints privately after session or during break.

Rambles On and On

Possible reasons for the behavior:
1) Anxious.
2) Is not clear about the topic.
3) Wants to contribute but does not know how.
4) Has trouble concentrating.
5) Is bothered by dysfunctional thoughts.
6) Trying to impress but has nothing new to add to the discussion.

Facilitator's responses:
1) Orient to the topic.
2) Refocus the session.
3) Interrupt with a question about the topic at hand.
4) Ask the other participant (if applicable) to respond to partner's comments.

5) Reinforce participants for any comments that lead back to topic.
6) Say, "That is interesting, but I do not think I am clear about how that relates to _____."
7) Model staying on target.

One Partner Refuses to Change

Possible reasons for the behavior:
1) Believes strongly.
2) Connects position with self-esteem.
3) Is opinionated.
4) Has not understood other points of view.
5) Feels threatened.

Facilitator's responses:
1) Ask the person to argue against his or her own viewpoint.
2) Have the other participant (if applicable) respond to the point of view.
3) Ask the person to repeat back the other positions that have been stated.
4) Reinforce participant for believing strongly and for expressing other positions.

Focuses on the Wrong Topic

Possible reasons for the behavior:
1) Does not understand the direction of the session.
2) Has a personal agenda.
3) Needs to feel assertive.
4) Does not want to deal with the topic session focuses on.

Facilitator's responses:
1) Take the blame. "Something I said must have got you off the topic. We are talking about _____".
2) Try to find out if the topic the person is on has a personal significance.
3) Ask the participant if the topic is one that needs to get dealt with.
4) Ask the person to think about the correct topic and then discuss their feelings about it.
5) Explore discomfort.

Diverges into Alternate Intervention Content

Possible reasons for the behavior:
1) Does not understand the direction of the session.
2) Concerned about the issue.
3) Does not want to deal with the topic session focuses on.

Facilitator's responses:
1) Validate the participant's raising of the issue.
2) Explain that the issue is out of the scope of the EBAN curriculum and time does not permit the issue to be discussed in depth. "That is a very important issue and it is great that you are thinking about it, unfortunately this program is not set up to deal with this issue."
3) Briefly assess the reasons why the participant raised the issue.
4) Ask the participant if the topic is one that needs to get dealt with.
5) Provide referrals or alternate resources if necessary.

One Partner of a Couple Constantly Seeks Other Partner's Point of View

Possible reasons for the behavior:
1) Wants attention.
2) Looking for advice.
3) Trying to please their partner
4) Trying to model the facilitator's behavior.
5) Does not understand what position is the best one to take.
6) Wants to challenge the facilitator.
7) Trying to put the facilitator on the spot.

Facilitator's responses:
1) Reward participation and paying attention.
2) Throw questions back to them.
3) Give direct answers if appropriate.
4) Do not take away the person's opportunity to solve his or her problem.
5) Ask for situations that demonstrate the question and role-play them.

Makes an Incorrect Statement

Possible reasons for the behavior:
1) Does not know the facts.
2) Believes in certain myths about the topic.

Facilitator's responses:
1) Ask the person what the consequences of the statement would be.
2) Ask partner (if appropriate) to react to the statement.
3) Accept that the person does believe it with "I can see how you feel" or "That is one way of looking at it."
4) Say "I see your point but how does it fit with the session topic?"
5) Have participant try to figure out where he/she got such a belief.
6) Make sure the person does not end up feeling stupid or embarrassed.

Speaks in an Inarticulate Way

Possible reasons for the behavior:
1) Feels awkward speaking in presence of facilitator (and/or partner).
2) Does not have the skills to put thoughts into the right words and the right order.
3) Has ideas but is unsure how to express them.

Facilitator's responses:
1) Do not say, "What you mean is this..."
2) Say, "Let me repeat that to be sure I understand what you said," and use better language.
3) Reinforce close approximations.

Cannot Read Well

Possible reasons for the behavior:
1) Never had the opportunity to learn.
2) Is dyslexic.

3) Need eyeglasses.
4) Has an eye ailment.

Facilitator's responses:
1) Have other participant assist with prompting.
2) Have other participant be the person's shadow and take over only the reading part of exercises.
3) Reinforce participant for trying.

Conflict Between Couple (not domestic violence)

Possible reasons for the behavior:
1) Do not like each other.
2) Lack of skills in social problem- solving.
3) Lack of assertiveness skills.
4) Power struggle from home carried over into group

Facilitator's responses:
1) Emphasize points of agreement.
2) Point out objectives that cut across both positions.
3) Create role-plays for others to perform on resolving the conflict.
4) Have participants find positive qualities in the other.
5) Reinforce positive behavior.
6) Emphasize that relationships often have conflict, and with time they may find a way to compromise with each other.

One or both Partners Is Verbally or Mildly Physically Abusive during Session (see also section 4.9 for more serious abusive behaviors)

Possible reasons for the behavior:
1) Does not know other ways to cope with anger.
2) Feels threatened.
3) Controls have been loosened through drugs or alcohol.
4) Wants to prove something to the facilitator or other participant.

Facilitator's responses:
1) Firmly exert authority and indicate what behavior will not be tolerated.
2) Create a calm atmosphere through speaking softly, slowly, and clearly while talking the person down.
3) Give the person plenty of physical space.
4) Avoid confrontational gestures such as pointing and staring.
5) If necessary, call for escort outside to intervene.
6) Socially reinforce the person for any steps taken to re-instate emotional control and resolve the conflict with words.
7) Do a role-play on anger control, using self-talk.
8) If appropriate, ask participant to leave the room, letting him/her know that they may only return if he/she can keep control.
9) Check in with Clinical Supervisor or Project Manager to determine if it is appropriate to record the incident as an adverse event, and whether the couple should continue with the intervention.
10) If couple will continue with sessions, have them sign a "Contract of No Violence" to continue.

Participant Coming On to Facilitator

Possible reasons for the behavior:
1) Attracted to the facilitator.
2) Seeking attention.
3) Trying to put the facilitator on the spot.
4) Trying to make partner jealous or punish him/her for some reason.

Facilitator's responses:
1) Ignore it.
2) Use humor to diffuse the situation, but be careful not to make fun of the participant.
3) Pointedly mention your boyfriend, girlfriend, or spouse. (Make them up if needed.)
4) Take participant aside and talk with him/her, preferably with another staff person present in the room. Use "I" statements, such as "I am uncomfortable with what is going on here." Reinforce what the sessions are about. Emphasize caring/concern for the participant as a partner in EBAN Project. Thank him/her for the interest and say that you are flattered. Then restate your role as a session facilitator. State that your contract for the job forbids socializing with participants, and doing so would cause you to lose your job.

Facilitator is Attracted to Participant

Facilitators should not see participants outside the sessions, even after the intervention is completed. (This includes establishing friendships with the participants.)

Although the facilitator is not conducting therapy, this is a professional relationship with power differences between the facilitator and participant. According to the ethical principals established by the American Psychological Association (1992), "Psychologists are sensitive to real and ascribed differences in power between themselves and others, and do not exploit or mislead other people during or after professional relationships." Similarly, the National Association of Social Work code of ethics (1996) forbids establishing intimate relationships with clients.

4.9.2 Dealing with HIV+ Participant

In the section on ground rules in the first session, it is made clear that revealing any sensitive information, including HIV status is up to the participant. At the same time, it is common knowledge across all staff and participants that EBAN focuses on mixed status couples. If a participant decides to reveal this information in session, the facilitator should respond as follows: Say, "Thank you for feeling comfortable enough with us to share your experience with group." In EBAN we believe that speaking openly with your partner about your HIV status and all issues that affect your health and relationship is a good thing. The more you talk about these issues, the more you can learn to communicate and negotiate any concerns you may have together

New HIV Disclosures of previously HIV- Participant

EBAN participants must be in a mixed serostatus relationship to be eligible. However, there may be seroconversions among the HIV- partners. Should a previously negative partner disclose that they are HIV+ in the session, it is critical to quickly ascertain whether the HIV+ partner already know or if this is new information (see "Difficult Couple Issues #2, below for protocol). Also, be sure to follow up with anyone disclosing a new HIV infection to make sure they are under medical care and give appropriate referrals. At the next session, follow up to see if the participant contacted the referral resources.

4.9.3 Dealing with the Issue of Disclosing HIV to Children

One of the things parents often worry about is whether, how, and when to disclose their HIV to their children. This is an important and complicated issue, but one which should be thoroughly dealt with outside the confines of EBAN. If a participant raises the question of disclosure to children, the facilitator should validate the importance of the issue and inquire of the participant what brought the issue up at that time and what feelings he/she might be having surrounding it. The facilitator should keep this discussion brief and explain to the participants, that although this is an important consideration, it is out of the scope of the EBAN project. Suggest that a referral might be useful and provide if necessary.

4.9.4 Dealing with Participants Who are Upset, Depressed, or Suicidal

If a person looks upset during the session, address her/him directly but gently:

"You look upset Joe, can you tell me what you are feeling?"

(If no – while they are with partner) *"Would you like to talk outside?"*

If participant is crying or his/her emotional state is disruptive to the session, the facilitator should address the upset and should take the person outside. The facilitator should stay with the participant and probe gently to try and identify the source of pain and sadness. Offer to listen or talk until he/she regains composure and feels comfortable returning to the session.

If a participant makes a suicidal statement:

Say, *"you need to know that we take statements like that very seriously. Although sometimes people say things they do not mean, I would like to talk more about what you just said."*

The facilitator should assess if the statements are serious and if so contact the appropriate resource (your Clinical Supervisor, Project Manager, Clinical back-up, site specific back-up or local emergency department). Facilitator should recap:

"When someone is upset enough to talk about hurting themselves, they need immediate attention, so that is why I asked you to talk with me more about this. I will stay with you now and we will get help for you."

4.9.5 Dealing with a Participant Who is Drunk or Under the Influence of Drugs

Working from the general steps outlined in section 4.9, the following steps should be followed if a facilitator suspects one of the participants is drunk or under the influence of another kind of substance:

1. Do not ignore the behavior. Since it is sometimes difficult to judge whether someone is intoxicated, the participant should be approached on the basis of his or her behavior. If a participant is under the influence, you and his/her partner will notice and it will be disruptive to the session. If the person is impaired, he/she may not be able to exert enough self-control and may not settle down if ignored.

2. Try to redirect the participant toward more appropriate (attentive, nondisruptive) behavior. Do not ask if he/she has been using or drinking. See if redirection and rewarding will work.

3. Reward the participant for movement toward more appropriate behavior.

4. A participant who smells of alcohol or who appears obviously under the influence (i.e., overly sedated or overactive/disruptive behavior), may need to be escorted out of the group. If the disruptive behavior continues, even after cycling through steps two and three, speak with the participant outside the group or couple and directly ask if he/she has been drinking or using. Remind the participant of the rule against attending sessions under the influence of alcohol or drugs and that it is disrespectful to the facilitator, his/her partner, and the group (for group sessions). Explain that you may not pay a participant for the session when they arrive on drugs or alcohol; more importantly, explain that just as drugs or alcohol inhibits our ability to protect ourselves, it compromises our ability to get the most out of these very important sessions. Avoid being confrontational which may provoke more disruptive behavior. Make every effort to enjoin the participant in staying drug and alcohol free in order to get the most out of Project EBAN. Ask the person if he/she feels able to participate in the session (let him/her be the one who decides to leave). Remember, the issue is not the person's drinking or using per se, it is his/her disruptive behavior. If use is denied, discuss the problem behavior and determine if they are able to continue the session without any further disruptions.

5. If a person stays but remains disruptive, ask him/her to please leave and emphasize that he/she will be welcome next time if the behavior does not persist.

Where appropriate, provide a referral to alcohol or drug use treatment facilities or to local self-help group meetings (e.g., AA, NA). Offer referrals outside of the group and not in front of other participants.

4.10 HANDLING DIFFICULT COUPLE ISSUES

1. Staying on Time: Finding a balance between the protocol and participant discussion

Conducting standardized sessions can be very challenging, especially when you have been trained professionally to start "where the client is" and to be attentive to the needs and concerns of your clients. While we want to provide the best clinical experience possible for each couple and individual woman, our research agenda requires us to follow a standardized protocol so we may demonstrate its efficacy in changing behavior. In The EBAN HIV/STD risk reduction intervention we want to try to have a 'give and take' with participants. We want to adhere as closely to the protocol as possible, yet allow the couple (or woman) to feel as if they are an integral part of the agenda. Some suggestions are provided below about how to initiate a topic, move the discussion along, and bring closure in a timely fashion:

Beginning in the first session, let the couple know (enthusiastically) that we have a lot of material to cover, and that sometimes you will need to redirect the conversation. Indicate that the material is very beneficial and that you do not want them to miss out on any of the experience. Give positive feedback to participants for their interest, enthusiasm and ideas, and encourage them to continue the discussion at home after the session so that you may move on.

2. Disclosures: Dealing with the immediate impact of ANY new disclosures in the relationship (e.g. other partners, new STD, prior unknown issues related to sexual or drug use history, current drug use, etc.)

There may be occasions when one partner in a couple reveals information that is experienced traumatically by the other. Examples might be secrets, such as disclosure of an affair, of injecting drugs or of a sexually transmitted disease. While we advise during the first session that participants should only share information that they feel comfortable sharing, some may experience these sessions as a safe and appropriate place to do so. In such cases, it is important for the facilitator to follow a series of steps to be sure to contain the episode. Rather than minimize difficult disclosures, facilitators should intervene by containing the episode. The reason for this is that partners sometimes experience hearing such information by having acute dissociative experiences, leading them to miss whatever would be said in the remainder of the session.

- Co- facilitator should first check in with the participant who shared the information and ask if this is new information that they shared.

- Co-facilitator should check in with the other participant in a similar fashion: "Is this the first time you are hearing this information?"

- Co-facilitator should give each partner a chance to express what they are feeling at the time; using the speaker/listener technique if appropriate.

- Facilitator should then normalize such disclosures for the couples by validating feelings and responses: Some examples might be that often in such cases the partner hearing this information for the first time may feel betrayed, lost, hopeless, etc. Also that the disclosing partner may be feeling as if they were being honest, and may not have anticipated the pain that delivery of such a message would cause to their partner.

- Facilitator should use their judgment in the ability of the couple to continue the session, or the need to suspend the session and reschedule the same session for the following week.

- Once the problem is normalized and each partner should have a chance to express feelings and concerns, facilitators should endorse the EBAN HIV/STD risk reduction intervention position that couples experience difficulty, but that this is an opportunity to start fresh, and be healthy and protect one another as their relationship moves forward.

3. Partner Violence or Partner Abuse

The EBAN HIV/STD risk reduction intervention screening and baseline measures screen out participants who report that they are experiencing severe abuse in their relationship. This is measured using the Revised Tactics Scale (Strauss, 1996). Questions specific to severe abuse include:

- whether or not partner has ever been kicked or slammed against a wall;

- punched or hit with something that could hurt her/him;

- beaten, burned or scalded on purpose;

- choked, attacked with a knife or gun; or

- forced (hitting, holding down or using a weapon) to have sex.

While participants experiencing severe abuse are screened out of the intervention, we will still see some participants in the intervention experiencing mild or moderate forms of abuse (i.e. partner twists arm or hair, throws things that can hurt, pushes, grabs or slaps her). Additionally, it is possible that severe abuse is experienced *following* initial screening and baseline, or goes unreported, and then emerges in response to one of the session discussions.

In couple sessions where incidents of domestic violence are reported by one or another participant during a session, the facilitators should explore this openly with the couple. It is critical to gain some understanding of the extent, frequency and duration of the abuse to determine the severity of the abuse to one or both partners. With some couples it may be advisable to have each facilitator pair up with the same gender partner to discuss the problem alone. Later, the couple can reunite to resolve the issues to avoid repeat episodes The facilitator should use language such as:

I am concerned about the physical (or sexual) contact in your relationship that we were hearing about just now. Can you tell me more about when it first started, and about this past time when it happened?

The facilitator speaking with either partner suffering the severe abuse should develop a safety plan for a next episode, including making contact with the Project.

After exploring with participants individually for 5-10 minutes, explain that you need to check in briefly with your co-facilitator for a few moments and then we will come back together. If co-facilitators are concerned that severe abuse is taking place, they should bring the couple together and explain that they are concerned about the safety of the couple and that they need to speak with their Project Manager about the best course of action to take. Make an appointment to meet the following week, and emphasize that you would like them to work at being conflict-free this week. If anything comes up between them, they may contact you or the Project Manager. Your Director may advise discontinuing the intervention and referral to appropriate IPV services, or may negotiate a plan to continue providing the sessions. Any plan to continue providing sessions must include signing a "Contract of No Violence."

In group sessions where incidents of domestic violence are reported by one or another participant during a session, the facilitators should interject that the issue is best discussed with facilitators at the end of the session, and then follow the above protocol when the session has ended.

4. Couple is breaking up

Threats of separation or divorce within the sessions should be handled immediately. In couple sessions, facilitators should check in with both members of the couple to determine if this is something they have agreed on, and whether they would like a referral for services to support this decision. Facilitators should explain that EBAN is for couples who are together, and that the sessions may discontinue if/when they break-up. Chronic threats for break-up are often a sign of dissatisfaction with the relationship, and a call for assistance dealing with issues. Facilitators may suggest that threats are a shield to avoid intimacy or difficult issues, and explore if this is a barrier that can be addressed through the Speaker/Listener technique or problem solving.

If a couple does break up, each individual will be invited back separately for a one-on-one session. Each participant will meet with the same-gender facilitator and review the intervention handbook. Facilitators will provide appropriate referrals and identify alternative resources for the individual.

5. General Distress

Background

If in the course of facilitating a session the participant becomes distressed, the following protocol will help identify the participant's level of distress and the staff member's appropriate response. If you are comfortable dealing with distress, we encourage you to work with the participant for a limited time as best you can to find a resource that will provide support in your absence.

Suicidality/Homicidality
Participant expresses desire to harm him/herself or others. Immediately seek a referral for an evaluation and clinical services.

Acute Distress
Participant is overwhelmed emotionally, or is distracted by disturbing thoughts and/or feelings. This is manifested in uncontrollable crying, disorganized thinking, pressured speech, or preoccupation with/repeated description of a disturbing incident or memory. Comfort person and provide a safe place for the person to express feelings.

Moderate/Mild Distress
Participant is emotional but is able to maintain his/her composure. The moderately or mildly distressed participant may experience any of the following: crying but not uncontrollably, eyes tearing up, voice "choked up", speaking very quietly, avoiding your glance, or being unwilling to stop talking to you and reluctant to leave. Validate the person's feelings and offer to discuss the issues privately.

Protocol

If participant exhibits any signs of distress at the end of the session, suggest the following:

- *"I realize that this has been difficult for you; sometimes talking about painful experiences can make you remember or think about things that you do not want to."*
- Then ask *"Are you all right"* or *"Is everything okay"* or another probe to inquire as to the person's emotional state.

Depending on the person's response, both verbal and non-verbal, the facilitator should respond in the following ways:

Suicidal/Homicidal Participant

If a participant expresses his/her intent to hurt him/herself or someone else, the facilitator must:

- Inform the participant that, as stated in the consent, you are required to notify (contact specific to your site), and that he or she will refer the participant to a social worker for counseling.
- In the event of suicidality only, inform the person that he/she seems to be in need of special care and that you would like to walk with him/her over to the Emergency room to get that care and/or explore the option of calling a crisis line for support while with you.

- Call the Project Manager and let him/her know what is happening

Acutely Distressed Participant

In the unlikely event that a participant becomes *acutely* distressed or expresses an urgent need for assistance at any time during or after the session you should:

- state that "*I can see that you could really use some help right now; there are a few things we can do right now to get you the help you need:*"
  - *I can sit and talk with you for a while (if at all possible facilitator intervention would be preferred);*
  - *we can contact (*local or site specific contact for handling distressed participants*), who will be able to refer you to a social worker to talk to;*
  - *we can contact someone else at The EBAN HIV/STD risk reduction intervention who may be better suited to talk to you or help you with a referral.*"
- Determine the person's preferred course of action and obtain consent to contact one of the above resources.
- If a participant does not accept one of these options, we are limited in our ability to help him/her. Encourage the person again to accept some assistance from one of these sources. If he/she still refuses assistance and is unable to compose him/herself, call the Project Manager to inform her of the situation; add and implement that person's directions.
- Fill out the Referral Form and an Adverse Events Form

Moderately/Mildly Distressed Participant

If the participant becomes moderately or mildly distressed during the session, an attempt should be made to manage the distress as described in the preceding section. If the person becomes or is still distressed when you have completed the session, you can do the following:

- give the person a few moments and the chance to compose him/herself; if the person seems all right, thank the person for his/her time.

If the person still seems to need some assistance, and you can:

- say "*If you are interested, we have a list of resources for counseling and other kinds of support that may be helpful to you. We can look through it together if you like*"
- go through the table of contents, and identify with the person the kind of help he/she needs
- go to the listings together and find up to three options that may be a fit based on:
  - proximity
  - language requirement
  - insurance/ payment eligibility requirements

- photocopy the pages
- fill out a referral form

MODULE V

TRAINING FOR EBAN HIV/STD RISK REDUCTION INTERVENTION

Structure of Intervention

This intervention will be highly structured and will be implemented by male and female co-facilitators who will use standardized intervention manuals. The intervention allows facilitators to employ intervention strategies that address the broad array of individual, interpersonal, social, and cultural factors influencing risk behavior among HIV-affected couples. It relies on dyadic and group processes and takes advantage of relationship and group dynamics. It is designed to be educational, but enjoyable, engaging, and culturally appropriate. It is tailored to the realities of urban African American couples and focuses on the enhancement of positive evaluations of self-worth, self-esteem, ethnic pride, and risk avoidance as an investment in the future of African American culture. A combination of empowerment, self-efficacy building, and reframing strategies are employed to help couples in power imbalanced relationships overcome resistance to risk reduction.

Materials and exercises incorporate social cognitive skill-building strategies (i.e., presentation, modeling, and practicing safer sex strategies, including condom use and communication skills) and multimedia presentations. It will involve culturally congruent video clips, games, brainstorming, role-playing, and skill-building activities, and small group discussion that build group cohesion and enhance learning and group discussion. The videos evoke feelings, thoughts, attitudes, beliefs, and stereotypes about risky behavior and prevention skills regarding HIV/STD issues.

The role-play scenarios are designed to provide couples with a wide variety of ways in which they could use the skills for themselves and for talking with their partners. The intervention sessions will include traditional and contemporary African American literary and pop-cultural references (e.g., Maya Angelou's poetry) to further enhance and integrate cultural specificity and pride. Homework assignments will be used to stimulate discussions at home and provide an opportunity to practice and integrate new skills.

The intervention will include sessions with individual couples and sessions with groups of couples. Couple sessions may be optimal for addressing most interpersonal factors associated with sexual-risk reduction. Sessions with groups of couples may be optimal for changing community-level factors associated with safer sex.

This would include:

- Increasing positive peer norms for condom use and safer sex by emphasizing the threat of HIV to the African American community.
- Destigmatizing the impact of living with HIV as an African American couple.
- Increasing social support and coping strategies for HIV risk reduction.

The main objectives of each session are outlined below.

Eban II Risk Reduction Intervention
Session 1: Preparing for the Journey (single-gender group session) Objectives Are To: • Orient participants to the purpose of the intervention, motivate them to attend, explore barriers to attendance, and gain comfort with and commitment to the study. • Learn and Apply Nguzo Saba • Learn about STD/HIV Facts • Enhance Gender Pride and Cultural Pride • Identify Barriers to Practicing Safer Sex Activities Will Include: • Introduce the Journey • Introduce Talking Circle • Introduce the Eban Symbol • Group Rules for Participation • Itinerary for Journey • Introduce the Seven Principles • Review Purpose of Journey

- Enhance Gender Pride
- STD and HIV Facts
- Barriers to Risk Reduction
- Homework

Session 2: Enhancing Couple Communication and Sharing the Load (couple session)

Objectives Are To:

- Learn Better Communication Skills
- Learn Problem Solving Technique Using FENCE
- Learn Good Goal Setting Skills
- Identify Couple's STD/HIV Risks
- Identify Couple's Goals to Reduce Risks
- Learn to Identify Triggers to Risky Behaviors
- Teach Couples How to Plan Ahead to Handle Triggers
- Enhance Decision Making Skills for Health and Safer Sex
- Identify Couple's Barriers to Achieving Goals
- Problem Solve Barriers to Risk Reduction

Activities Will Include:

- Opening and Welcome
- Review Last Session
- Overview of Current Session
- Review Homework
- Patterns of Communication
- Talk and Listen Technique
- Problem Solving Skills
- Risk Behaviors and Barriers to Risk Reduction
- Identifying Triggers to Unsafe Sex and Barriers for Safer Sex
- Things that Affect Decision-Making
- Working Together to Make Decisions
- Working Together to Improve Our Health
- Working Together to Make Better Sexual Decisions
- Couple Goal Setting
- Homework

Session 3: Tools for the Journey (couple session)

Objectives Are To:

- Identify signs, symptoms and treatment for STDs.
- Address Distress About Positive STD Results
- Learn and practice safer sex strategies:
- Identify male and female sexual anatomy.
- Identify best barrier methods and related safer sex accessories.
- Learn, practice, and demonstrate correct male and female condom use.
- Learn strategies for eroticizing safer sex.
- Build self-efficacy to engage in safer sex practices.
- Strengthen confidence in condom use as an effective prevention strategy.

Activities will include:

- Opening and Welcome (10 minutes)
- Review Homework (20 minutes)
- Review of Last Session (5 minutes)
- Overview of Current Session (5 minutes)
- Review Homework (20 minutes)
- Male and Female Anatomy (20 minutes)
- Using Barrier Methods Correctly (20 minutes)
- Making Safer Sex Fun (20 minutes)
- Homework (10 minutes)

Session 4: Sharing the Load (couple session)

Objectives Are To:

- Be able to use the FENCE problem-solving model to overcome structural barriers that impede safer sex.
- Identify and build social networks that support safer sex.
- Problem-solve structural barriers to safer sex
- Discuss social network for the support of safer sex

Activities Will Include:

- Opening and Welcome
- Review of Last Session
- Overview of This Session
- Forming a Village
- Review of Homework
- Enhancing Ethnic Pride
- Overcoming Social Adversity
- HIV Disclosure
- Homework
- Eban Closing Circle Ritual

Session 5: It Takes a Village (group session)

Objectives Are To:

- Identify Barriers to Practicing Safer Sex
- Problem Solve Overcoming Barriers
- Enhance Sexual Communication Skills
- Learn How to Reframe Issues
- Develop Self-Assertiveness Skills
- Develop Strategies to Stay Connected to the Village
- Enhance Identification with the Village

Activities Will Include:

- Opening and Welcome
- Review Last Session
- Overview of Current Session
- Review Homework and Goals
- Sharing the Reality of HIV
- Confronting Triggers
- Reviewing Safer Sex Skills
- Self-Assertiveness Skills
- Reframing Your Requests
- Building Your Village
- Homework
- Saying Good-bye to the Village
- Eban Closing Circle Ritual

Session 6: Strengthening the Village (group session)

Objectives Are To:

- Reinforce Communication and Problem Solving Skills
- Develop Prevention Relapse Strategies
- Re-Commit to Staying Safe
- Bring Closure to Program

Activities Will Include:

- Opening and Welcome
- Review of Last Session
- Overview of Current Session
- Review Homework
- Review Progress on Couples Goals
- Relapse Prevention
- Commitment to Staying Safe
- Closing Ceremony

Session 7: Expanding the Village (group session)

Objectives Are To:

- Enhance Sexual Communication Skills
- Learn How to Reframe Issues
- Develop Self-Assertiveness Skills
- Develop Strategies to Stay Connected to the Village

Activities Will Include:

- Opening and Welcome
- Review Last Session
- Overview of Current Session
- Review of Homework and Goals
- Reviewing Safer Sex Skills
- Self-Assertiveness Skills
- Reframing Your Requests
- Building Your Village
- Homework
- Saying Good-bye to the Village

Session 8: Celebrating Our Relationship (couple session)

Objectives Are To:

- Reinforce Communication and Problem Solving Skills
- Develop Prevention Relapse Strategies
- Re-Commit to Staying Safe
- Bring Closure to Program
-

Activities Will Include

- Opening and Welcome
- Review of Last Session
- Overview of Current Session
- Review Homework
- Review Progress on Couples Goals
- Relapse Prevention
- Commitment to Staying Safe
- Closing Ceremony

Risk Reduction Curriculum Addendum

WORKBOOK

The workbook will be handed out at the beginning of the single-gender session, so that participants can refer to the song lyrics and read the poem.

MATERIALS

The materials list in the curriculum is inaccurate: A supplementary updated materials list has been distributed so that facilitators can use it instead of the one in the curriculum to pick up materials for the sessions.

RR prizes for safer sex jeopardy consists of chocolate body frosting, a brush, multi-colored condoms, and a blindfold (previously they had been discussed as consisting of candles, body lotion, body sponges, body wash, and breath freshener, and may be an alternative). Consolation prizes, scented candles (budget $1) will be purchased.

PROCEDURES

Condoms should be handed out after every session starting with Session 1. The pack will include female condom, strawberry scented, non-lub flavored, non-lub, pleasure plus, and high sensitivity. In addition, 2 polyurethane condoms will be handed out during the intervention, at session 3 and at session 5.

Connection coupons will be handed out every session, starting with Session 3.

The notes on each couple's progress should be jotted down by facilitators after each session, using extra copies of the goal progress worksheets from the workbook. These notes would help facilitators plan for subsequent sessions, and would also help the facilitators complete the facilitator evaluation forms for each couple after Session 6.

If a participant refuses to put a condom on the male penis model in Session 3 or 5, the following alternative procedures will be used. These procedures are for Session 3 and 5, only if one member of the couple refuses to cooperate in demonstrating putting the condom on the male penis model. In Safer Sex Jeopardy in Session 5, the points will be pro-rated depending on what skills are demonstrated.

- If the participant refuses to put a condom on a male penis model, he/she will be offered an opportunity to demonstrate putting a condom on a wooden model, banana, or other phallic-shaped model. Full credit will be awarded for this demonstration of all six steps (OPRAH) in Session 5.

- If the participant refuses to demonstrate condom competence on any phallic-shaped model, he/she will be offered the opportunity to demonstrate it on his/her finger. 150 points awarded for this demonstration of the six steps (OPRAH) in Session 5.
- If the participant also refuses to do put the condom on the finger, he/she can demonstrate partial competence by going through the first five steps. 50 points will be awarded for this demonstration in Session 5.
- The partner who did not refuse to put the condom model on could demonstrate competence by him/herself. If successful, 100 points will be awarded in Session 5.

Facilitators should be sure to guide participants to discuss the pros and cons of each option, every time they use FENCE, when they are naming and discussing options. Facilitators may slightly modify the language in the intervention to be more inclusive when an interracial couple is present.

Proposed procedures to be used in cases where a participant absolutely refuses to put a condom on the male penis model:

Alternative A
If a participant refuses to put a condom on the penis model, facilitator can give the participants the choice of practicing putting the condom on a wooden model, or a banana. The participant would go through all of the steps (OPRAH), following the same procedures they would if they were using the penis model. The partner who didn't refuse could still put the condom on the penis model.
Alternative B
If the participant also refused to put the condom on the wooden model or banana, then the facilitator would turn to alternative B. In this procedure, the participant would be asked to go through the first steps (0 and P) of checking the expiration date on the condom package, squeezing the package to make sure it's sealed properly, carefully opening the package and removing the condom, and pinching the tip of the condom to squeeze the air out. Then they can unroll it over their finger or their hand, and the facilitator would describe the remaining steps.
For Session 5, the couple get 200 points in safer sex jeopardy even if one partner chooses to put the condom on the wooden model or banana instead of the penis model (altemative A), or if one partner refuses to use any model and just goes through the first steps to demonstrate their understanding of how to use a condom (alternative B). Please note that these procedures should be used ONLY if a participant absolutely refuses to put the condom on the male model, not in cases where they feel somewhat awkward and uncomfortable but are willing to try.

Risk Reduction Intervention
Outline for Individual Session following Break-up or Non-Completion of Intervention Session
Facilitator Notes

- The time frame for delivery of the session is a maximum of thirty days following the last intervention session the couple attended prior to breaking up or within thirty days of the cohort completion date.
- Each participant will receive the intervention at no cost.
- One same sex facilitator will deliver the session to each individual partner of the couple; a female facilitator will deliver the session to the female partner and in a separate setting/session, a male facilitator will deliver the session to the male partner of the couple.
- Remind the participants to bring their workbook to the session.

Session Outline (up to 92 mins):
1. Outline agenda of meeting **(3** mins)
2. Terminate intervention involvement: (5 mins)
a. Individual self-assessment: What has the individual learned? What has been challenging? How can the individual continue to move toward safety?
b. Facilitator's assessment of individual's growth-praise and positive reinforcement
3. Review Content (up to 84 mins)
a. Session Content (up to 72 mins)
b. Referrals
c. Follow up

d. Update locator information
e. Give condoms, pay, and say good bye

Content
A break up can occur at anytime during the intervention following session 1 and prior to session 8. The content of the break-up meeting includes sessions that have not yet been completed by the couple. As content is reviewed the facilitators will remind the individuals that they can practice safer sex behaviors as a single person and bring these behaviors into future relationships

1. Session 2

1.1. Talk and Listen-Review Talk and Listen Handout in Workbook (3 mins)
1.2. Problem Solving Skills-Review FENCE handout in Workbook (3 mins)
1.3. Barriers to Risk Reduction-Help individual identify personal barriers to risk reduction. (5 mins)
1.4. Triggers to Risky Sexual Behavior-Help individual identify personal triggers to risky behavior (5 mins)
1.5. Goal Setting-Help individual set personal risk reduction goals. Levels of HIV/STD Risk Handout (5 mins)

2. Session 3

2.1. Male and Female Anatomy-Use posters to review male and female anatomy (3 mins)
2.2. Review Sexual Health (3 mins)
2.3. Using Barrier Methods Correctly-review steps to putting male and female condom on correctly (model and practice) (10 mins)
2.4. Making Safer Sex Fun-Review Eban II Project Café Menu (3 mins)

3. Session 4

3.1. HIV disclosure- (5 mins)

4. Session 5

4.1. Self Assertiveness Skills (5 mins)
4.2. Confronting Triggers-(5 mins)

5. Session 6

5.1. Review progress on goals-Support individual to continue work on goal as an individual. (5 mins)
5.2. Review skills learned (10 mins)
5.3. Relapse Prevention (5 mins)

6. Assess need for referrals and give-(3 mins)
7. Review follow up appt schedule- (3 mins)
8. Update locator info-(3 mins)
9. Give condoms, pay, and say goodbye (3 mins)

MODULE VI

PROCESS EVALUATION PLAN

6.1 PROCESS EVALUATION PLAN

Several process evaluation measures will be collected in order to monitor the process by which the intervention is implemented.

6.2 Process Measures

6.2.1 Negative Incident Report Form - to be filled out by facilitators or other project staff when they encounter circumstances that result in negative reactions from one or more participants. Project Manager should file first page of case report with first name and last initial in the case files of participants and give negative incident report with participant ID#s to the PI to determine if it needs to be reviewed by DSMB and IRB as a potential adverse event.

6.2.2 Attendance Sheet – to be filled out by the co-facilitators at the end of each session.

6.2.3 DCC Attendance Report Form – To be filled out by the Project Manager at the end of the last session of the Cohort/Group and then submitted to DCC.

6.2.4 Facilitator Evaluation Form –To be filled out by facilitator at the end of the last session. This form assesses each couple's participation, motivation, and progress with respect to intervention mediators, including Talker/Listener technique, alternatives to and eroticizing safe sex, and intentions to use condoms.

6.2.5 Session adherence and protocol deviation form – to be filled out by both co-facilitators at the end of each session as a way of assessing adherence to protocol, protocol deviations and participants' step-by-step progress in achieving safer sex goals related to condom use. Project Manager and PI should assess nature of protocol violation to determine whether it is necessary to submit protocol violation form to UCLA.

6.2.6 UCLA Protocol Violation Form - to be filled out by Principal Investigator when s/he determines that there has been a violation of the standardized intervention protocol.

6.2.7 Participant Evaluation Forms – To be filled out by participants and their partners (if in couple condition) at the end of the first and last group sessions (session #5 and session #7). The first evaluation form for session #5 will ask the participants to give feedback on their satisfaction with their individual couple sessions. The second evaluation form for session #7 will ask participants to give feedback on the group sessions. Facilitator should give this form and an envelope to the participants and ask them to fill it out before they leave the session. Facilitator should instruct participants to fill out the form, emphasizing the importance of giving honest answers. Facilitator should ask participants in the not to discuss their questions with one another and to seal their form in the manila envelope when they are done. In order to allow participants privacy to answer questions, facilitators should leave the room after they give the form to the participants. Facilitators may take sealed forms back to the office.

6.2.8 Participant Referral Form – to be filled out by any Project Eban staff making a referral a participant, regardless of whether the participant actually pursues the referral. Should be filed in case file.

6.2.9 UCLA Referral Report Form - to be filled out by Site Coordinator on each participant upon completion of the last assessment on referrals and services received during course of the study and submitted to UCLA.

PROCESS MEASURES (applicable to both HP and RR)
Some sections in the process measures are not applicable for the make-ups since they're shortened – Process measures for make-ups will be revised.

Boxes in process measures will be used only for the purpose of supervision. So it is important to include any issues that came up in the open-ended questions as well.

It is ideal if there is at least 2 days between each session. If there is less than 2 days between sessions, facilitators should describe the reason on the open-ended section of the process measures, so that the reasons can be captured.

The order of the couple IDs has to match on the 2nd and 3rd page of the attendance forms: Otherwise data entry will enter it incorrectly. Please be sure the couple IDs are listed in the same order on the pages of the attendance form.

The date at the top of the attendance form has to match for all three pages, otherwise the UCLA can't enter the form. Even though you may complete pages of the attendance form at different times, please put the same date on the top of all pages. Please wait until after the last couple completes the 8th session before dating the header of the attendance form, and then please put this same date on all 3 pages.

MODULE VII

QUALITY CONTROL & QUALITY ASSURANCE

APPENDICES

APPENDIX 2A

AFRICAN AMERICAN COUPLES STUDY - EBAN

Pre-training Reading Syllabus for Facilitators

WORKING WITH AFRICAN AMERICAN COUPLES

1. Pinderhughes, E. B. (2002). African American marriage in the 20th century. *Family Process, 41* (2), 269-282.

2. Boyd-Franklin, N., & Franklin, A. J. (1998). African American couples in therapy. In M. McGoldrick (Ed.), *Re-visioning family therapy: Race, culture, and gender in clinical practice* (pp. 268-281). New York, NY: The Guilford Press.

3. Black, L. W. (2000). Therapy with African American couples. In P. Papp (Ed.), *Couples on the fault line: New directions for therapists* (205-221). New York, NY: The Guilford Press.

WORKING WITH HIV SERODISCORDANT COUPLES

4. Padian, N., van de Wijgert, J. H. H. M., & O'Brien, T. R. (1994). Interventions for sexual partners of HIV-infected or high-risk individuals. In R. J. DiClemente & J. L. Peterson (Eds.), *Preventing AIDS: Theories and methods of behavioral interventions. AIDS prevention and mental health* (pp. 227-242). New York, NY: Plenum Press.

5. VanDevanter, N., Thacker, A. S., & Arnold, M. (1999). Heterosexual couples confronting the challenges of HIV infection. *AIDS Care, 11* (2), 181-193.

WORKING WITH COUPLES IN GROUPS

6. Coche, J. (1995). Group therapy with couples. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of couple therapy* (pp. 197-211). New York, NY: The Guilford Press.

7. Coche, J., & Coche, E. (1990). Building cohesiveness in couples and groups. In *Couples group psychotherapy: A clinical practice model* (pp. 61-71). New York, NY: Brunner/Mazel, Publishers.

8. Feld, B., & Urman-Klein, P. (1993). Gender: A critical factor in a couples group. *Group, 17* (1), 3-12.

SPECIAL ISSUES

9. Margolin, G. (1998). Ethical issues in marital therapy. In R. M. Anderson & T. L. Needels, et al. (Eds.), *Avoiding ethical misconduct in psychology specialty areas* (pp. 78-94). Springfield, IL: Charles C. Thomas.

10. Jackson-Gilfort, A, Mitrani, V. B., & Szapocznik, J. (2000). Conjoint couple's therapy in preventing violence in low income, African American couples: A case report. *Journal of Family Psychotherapy, 11* (4), 37-60.

11. Penn, C. D., Hernandez, S. L., & Bermudez, J. M. (1997). Using a cross-cultural perspective to understand infidelity in couples therapy. *American Journal of Family Therapy, 25* (2), 169-185.

TEACHING BEHAVIOR CHANGE

12. Watson, D. L., & Tharp, R. G. (Eds.). (2002). Adjustment and the skills of self-direction. In *Self-directed behavior: Self-modification for personal adjustment* (8th ed., chapter 1). New York, NY: Thomson-Wadsworth.

13. Watson, D. L., & Tharp, R. G. (Eds.). (2002). Forethought: Specifying targets, anticipating obstacles, and creating goals. In *Self-directed behavior: Self-modification for personal adjustment* (8th ed., chapter 2). New York, NY: Thomson-Wadsworth.

14. Watson, D. L., & Tharp, R. G. (Eds.). (2002). Antecedents. In *Self-directed behavior: Self-modification for personal adjustment* (8th ed., chapter 5). New York, NY: Thomson-Wadsworth.

15. Watson, D. L., & Tharp, R. G. (Eds.). (2002). Behaviors: Actions, thoughts, and feelings. In *Self-directed behavior: Self-modification for personal adjustment* (8th ed., chapter 6). New York, NY: Thomson-Wadsworth.

16. Watson, D. L., & Tharp, R. G. (Eds.). (2002). Consequences. In *Self-directed behavior: Self-modification for personal adjustment* (8th ed., chapter 7). New York, NY: Thomson-Wadsworth.

APPENDIX 4A
HIV/AIDs & STD FAQs

What is the difference between HIV and AIDS?

HIV is the virus that causes AIDS.

H	**Human**	because this virus can only infect human beings
I	**Immuno-deficiency**	because the effect of the virus is to create a deficiency, a failure to work properly, within the body's immune system
V	**Virus**	because this organism is a virus, which means one of its characteristics is that it is incapable of reproducing by itself. It reproduces by taking over the machinery of the human cell
A	**Acquired**	because it is a condition one must acquire or get infected with; not something transmitted through the genes
I	**Immune**	because it affects the body's immune system, the part of the body which usually works to fight off germs such as bacteria and viruses
D	**Deficiency**	because it makes the immune system deficient (makes it not work properly)
S	**Syndrome**	because someone with AIDS may experience a wide range of different diseases and opportunistic infections

How is HIV Transmitted?

HIV can be transmitted from an infected person to another through:
- Blood (including menstrual blood)
- Semen
- Vaginal secretions
- Breast milk

Blood contains the highest concentration of the virus, followed by semen, followed by vaginal fluids, followed by breast milk.

Activities That Allow HIV Transmission

- Unprotected sexual contact
- Direct blood contact, including injection drug needles, blood transfusions, accidents in health care settings or certain blood products
- Mother to baby (before or during birth, or through breast milk)

Sexual intercourse (vaginal and anal) - In the genitals and the rectum, HIV may infect the mucous membranes directly or enter through cuts and sores caused during intercourse (many of which would be unnoticed). ***Vaginal and anal intercourse is a high-risk practice.***

Oral sex (mouth-penis, mouth-vagina) - The mouth is an inhospitable environment for HIV (in semen, vaginal fluid or blood), meaning the risk of HIV transmission through the throat, gums, and oral membranes is lower than through vaginal or anal membranes. There are however, documented cases where HIV was transmitted orally, so we cannot say that getting HIV-infected semen, vaginal fluid or blood in the mouth is without risk. ***However, oral sex is considered a low risk practice.***

Sharing injection needles - An injection needle can pass blood directly from one person's bloodstream to another. It is a very efficient way to transmit a blood-borne virus. ***Sharing needles is considered a high-risk practice.***

Mother to Child - It is possible for an HIV-infected mother to pass the virus directly before or during birth, or through breast milk. Breast milk contains HIV, and while small amounts of breast milk do not pose significant threat of infection to adults, it is a viable means of transmission to infants.

The following "bodily fluids" are NOT infectious:

- Saliva
- Tears
- Sweat
- Feces
- Urine

What are the symptoms of HIV?

Primary HIV infection is the first stage of HIV disease, when the virus first establishes itself in the body. Some researchers use the term ***acute HIV infection*** to describe the period of time between when a person is first infected with HIV and when antibodies against the virus are produced by the body (usually 6- 12 weeks).

Up to 70% of people newly infected with HIV will experience some "flu-like" symptoms. These symptoms, which usually last no more than a few days, might include fevers, chills, night sweats and rashes (not cold-like symptoms). The remaining percentages of people either do not experience "acute infection," or have symptoms so mild that they may not notice them.
Given the general character of the symptoms of acute infection, they can easily have causes ***other*** than HIV, such as a flu infection. For example, if you had some risk for HIV a few days ago and are now experiencing flu-like symptoms, it might be possible that HIV is responsible for the symptoms, but it is also possible that you have some other viral infection.

What are the symptoms of AIDS?

There are no common symptoms for individuals diagnosed with AIDS. When immune system damage is more severe, people may experience ***opportunistic infections*** (called "opportunistic" because they are caused by organisms which cannot induce disease in people with normal immune systems, but take the "opportunity" to flourish in people with HIV). Most of these more severe infections, diseases and symptoms fall under the Centers for Disease Control's definition of full-blown "AIDS." The median time to receive an AIDS diagnosis among those infected with HIV is 7-10 years.

How long after a possible exposure should I be tested for HIV?

The time it takes for a person who has been infected with HIV to ***seroconvert*** (test positive) for HIV antibodies is commonly called the "Window Period". The California Office of AIDS, published in 1998, says about the window period: "When a person is infected with the HIV virus, statistics show that 95-97% (perhaps higher) of

all infected individuals develop antibodies within 12 weeks (3-months)." The National CDC has said that in some rare cases, it may take up to six months for one to seroconvert (test positive). At this point the results would be 99.9% accurate.

What does this mean for you?

The three-month window period is normal for approximately 95% of the population. If you feel any anxiety about relying on the 3-month result, by all means you should have another test at 6 months.

I have heard there are many different types of HIV tests. How do I know which one I should take?

The combination of an Elisa/Western Blot ***HIV Antibody Test*** is the accepted testing method for HIV infection. This combination test is looking for the ***antibodies*** that develop to fight the HIV virus. There are two ways to conduct this test. Either through a ***blood draw*** or through the "***Orasure***" method (a sample of oral mucus obtained with a specially treated cotton pad that is placed between the cheek and lower gum for two minutes). Both forms, by blood draw or orally, have the same accuracy with their results.
Other tests that you will hear about are ***Viral Load*** tests. These tests are used by physicians to monitor their patients who have already tested positive for HIV antibodies. Viral Load tests are very costly and should not be used to determine if one is HIV+.

What is the difference between an anonymous and confidential test?

Anonymous and Confidential use the same testing method. The only difference is one does not have your name attached to the results.

Anonymous antibody testing is available at Anonymous Test Sites in most California counties. Anonymous testing means that absolutely no one has access to your test results since your name is never recorded at the test site.
Confidential antibody testing means that you and the health care provider know your results, which may be recorded in your medical file.

Which test should I have done, the anonymous or confidential?

It is recommended that one have an ***anonymous*** test. The results will only be known to you and will not appear on any records.
Some reasons that one would need a confidential test would be: a result is required for immigration purposes or for some international travel visas; a pregnant woman who is clearly at risk might choose to be tested through her doctor, rather than anonymously, since the result is of key importance to the course of her medical care.

What do the test results mean?

A positive result means:
- You are HIV-positive (carrying the virus that causes AIDS).
- You can infect others and should try to implement precautions to prevent doing so.

A negative result means:
- No antibodies were found in your blood at this time.

A negative result does ***not*** mean:
- You are not infected with HIV (if you are still in the window period).

- You are immune to AIDS.
- You have a resistance to infection.
- You will never get AIDS.

Is there anything I can do to stay healthy?

The short answer is ***yes***. There are things that you can do to stay healthy.

Emotional support may be very important for HIV-positive people because it breaks the isolation and provides a safe way of sharing both feelings and practical information

Medical Care: Once you find a doctor or clinic, your main objective is to get an evaluation of your general health and immune function.
Many doctors do the following:

- Administer lab tests to evaluate your immune system.
- Determine if you have other diseases that might become problematic in the future, including syphilis, TB, hepatitis-B, and toxoplasmosis.

If you are already infected with one or more of these other illnesses, there may be treatments or prophylaxis available to prevent it from becoming more serious or recurring in the future. If you are not already infected, doctors may be able to prevent future infection by:

- Administering vaccines. Many HIV+ people get a hepatitis-B vaccine and bacterial pneumonia vaccines, since contracting these diseases could be dangerous for immune suppressed people.
- Prescribing antiviral treatments and protease inhibitors when tests show immune system impairment.
- Scheduling regular checkups. Checkups may be scheduled every three to six months. Some people need more frequent check-ups, particularly when they are starting new antiviral drugs.

Do the drugs I hear about cure you?

The drugs you are referring to are a class of anti-HIV drugs known as ***protease inhibitors***. There is NO cure for AIDS, but these drugs are helping to prolong the lives of many people with AIDS and delaying the onset of AIDS in many people with HIV. You should consult your own health care provider surrounding ***treatment*** issues. There is no standard treatment for everyone. Your health care provider will discuss your individual options.

What does "STD" mean?

STD is short for "sexually transmitted disease." Another term you may have heard is "venereal disease," or VD.

What are sexually transmitted diseases (STDs)?

The term "sexually transmitted diseases" or "STDs" represents a group of more than 25 different diseases that can be passed from one person to another through sexual contact.

What is the difference between "STD" and "STI"?

STD is short for sexually transmitted disease. STI is short for sexually transmitted infection. They are synonymous; STI is the latest accepted terminology.

What is the difference between bacterial and viral STDs?

The main difference between these two categories of sexually transmitted diseases (STDs) is what causes them -- bacterial STDs are caused by bacteria and viral STDs are caused by viruses. As a result of being caused by different microorganisms, bacterial and viral STDs vary in their treatment. Bacterial STDs, such as gonorrhea, syphilis, and chlamydia, are often cured with antibiotics. However, viral STDs, (the four "H's) such as HIV, HPV (genital warts), herpes, and hepatitis (the only STD that can be prevented with a vaccine), have no cure, but their symptoms can be alleviated with treatment.

In addition to bacteria and viruses, STDs can also be caused by protozoa (trichomoniasis) and other organisms (crabs/pubic lice and scabies). These STDs can be cured with antibiotics or topical creams/lotions.

One of the most common symptoms of an STD is ***no*** symptoms. So it is important to go for check-ups. 80 percent of women and 40 percent of men diagnosed with chlamydia may not experience symptoms. STDs need to be diagnosed correctly and fully treated as soon as possible to avoid complications that could be serious and/or permanent.

How should I know if I need treatment?

If you are having any of the following symptoms: a discharge from the penis or vagina, burning, itching, a sore or sores (either painless or painful) or your sexual partner has been diagnosed with an STD, you should seek treatment.

How common are STDs?

STDs are very common in the United States. With more than 12 million people in the U.S. infected each year, at least 1 person in 4 will be infected with a STD at some point in his or her life. In the United States, there is approximately 4 million new chlamydia infections a year, over 40 million people have herpes and 30 million have genital warts.

What are the typical symptoms of STDs?

Many STDs have no noticeable symptoms. When they occur, typical STD symptoms for women may include unusual vaginal discharge (flow), sores, bumps, burning when urinating, and redness or itching around the vaginal area. Typical symptoms for men may include discharge from the penis, burning when urinating, and sores, bumps, or redness on or around the penis

How can I tell if my partner has an STD?

In most cases, you cannot tell by looking if someone has an STD. STDs often do not have visible symptoms.

How are STDs transmitted?

STDs can be transmitted through oral, anal or vaginal sex. They can be transmitted from partner to partner with or without visible signs or symptoms. Many people can pass an STD to a sex partner without knowing it. Some STDs can be passed without having intercourse; they can be passed through skin-to-skin contact in the genital area.

Can herpes be passed when there are no symptoms?

Yes, it is possible to infect someone with herpes, even when you do not have any symptoms. Once thought to be transmitted only when sores were present, recent research has shown that herpes simplex virus (HSV) can be passed even when no visible signs are present.

Can I get STDs from a towel or a toilet seat?

Most STDs, such as chlamydia, gonorrhea, syphilis, herpes, and genital warts, are spread only through direct sexual contact with an infected person. Crabs (pubic lice) or scabies, which are often sexually transmitted, can be passed through contact with infested items like clothes, sheets, or towels.

What should I do if I think I have an STD?

If you think you have an STD, see a health care provider immediately. Seeking treatment early will help to minimize the long-term effects of most STDs. Avoid sexual contact until you are cured.

Can I get an STD more than once?

You are not "immune" to an STD if you have had it before. STDs caused by bacteria (chlamydia, gonorrhea, and syphilis) can be treated and cured, but you can get them again if exposed. Viral STDs cannot be cured and may remain in your body forever.

Above FAQs taken from the California HIV/AIDS Hotline at 800/367-AIDS or http://www.aidshotline.org/crm/asp/refer/hotline.asp

APPENDIX 4B
HIV TREATMENT INFORMATION

For this section I like a publication from the DHHS called "HIV and Its Treatment: What you should know." Please review at www.hivatis.org and let me know what you think! Thanks.

PROJECT EBAN
Negative Incident Report
Case File Report

Name: _____
Position: _____
Staff ID#: _____
Site: _____ Cohort/Group ID#_____
Today's Date: _____

_____

Date of Incident: __ __/__ __/__ __

Time of Incident: : pm/ am

Where did incident take place?

_____
_____

First Names and Last Initials of all participants involved in or affected by incident

___ ___ ___ ___ ___(participant 1) ___ ___ ___ ___ ___(participant 2)
___ ___ ___ ___ ___(participant 3) ___ ___ ___ ___ ___(participant 4)
___ ___ ___ ___ ___(participant 5) ___ ___ ___ ___ ___(participant 6)
___ ___ ___ ___ ___(participant 7) ___ ___ ___ ___ ___(participant 8)
___ ___ ___ ___ ___(participant 9) ___ ___ ___ ___ ___(participant 10)
___ ___ ___ ___ ___(participant 11) ___ ___ ___ ___ ___(participant 12)

Describe Incident (Please be as specific as possible and use participant first names and last initials only)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Confidential Material

(SC – PLEASE MAKE COPIES OF REPORT AND PLACE IN PARTICIPANT CASE FILES. FILL OUT PAGE 2 WITH PARTICIPANT ID NUMBERS AND SUBMIT TO PI FOR REVIEW).

PROJECT EBAN
Negative Incident Report

Name: _____
Position:_____
Staff ID#:_____
Site:_____
Today's Date:_____

Date of Incident: __ __/__ __/__ __

Time of Incident: : pm/ am

Where did incident take place?

PROJECT DIRECTOR FILL OUT NEXT TWO QUESTIONS

1. Study ID numbers of all participants involved in or affected by incident

___ ___ ___ ___ ___(participant 1) ___ ___ ___ ___ ___(participant 2)
___ ___ ___ ___ ___(participant 3) ___ ___ ___ ___ ___(participant 4)
___ ___ ___ ___ ___(participant 5) ___ ___ ___ ___ ___(participant 6)
___ ___ ___ ___ ___(participant 7) ___ ___ ___ ___ ___(participant 8)
___ ___ ___ ___ ___(participant 9) ___ ___ ___ ___ ___(participant 10)
___ ___ ___ ___ ___(participant 11 ___ ___ ___ ___ ___(participant 12)

2. Describe Incident (Please be as specific as possible and use IDs# instead of names)

3. Describe any follow up actions taken by staff in response to incident

PROJECT EBAN
Negative Incident Report

4. List names of any staff or non-participants who witnessed incident.

Witness 1: _____ phone number(s):_____
Witness 2 _____ phone number(s):_____
Witness 3 _____ phone number(s):_____
Witness 4 _____ phone number(s):_____

5. Was this incident captured on audiotape? YES/NO
If yes, please submit a copy of audiotape with this report to PI

6. *Was incident reported to police or any other authorities?* YES/NO
If yes to whom and when was incident reported?

_____
_____
_____

Signature of Staff making report_____ **Date:**__ __/__ __/__ __

(To be filled out by Principal Investigator)

Name of Principal Investigator:_____

Assessment of Incident (Please indicate how you reviewed incident and whether or not in your opinion this may constitute an adverse event)

_____
_____
_____
_____
_____
_____
_____
_____

Disposition of Incident (Check relevant category)
( ) This Incident does not constitute an adverse event and no further review is needed
( ) I have reported this incident to DCC for further review to determine if it is an adverse event of the study on __ __/__ __/__ __(indicate date of report to DCC).

Recommended Follow up Actions to Incident:

_____
_____
_____
_____

Signature of Principal Investigator:_____**Date:** __ __/__ __/__ __

PROJECT EBAN
ATTENDANCE SHEET

This attendance sheet should be filled out after all participants in cohort group have completed the session.

1. **Co-Facilitator ID#:__ __ __ __**
   Co-Facilitator ID#:__ __ __ __

2. **Site #: __ __**

3. Cohort/Group #: _____ __ ___

4. Session # ___ ___

5. **If group session, date of session ___ ___/___ ___/___ ___**

Please indicate first names and last initials of <u>all participants</u> (including participants who have withdrawn) in Cohort/Group, whether or not they attended session or an abbreviated review of session (no/ yes/ attended abbreviated review of session), and date of session if it was a couple session or an abbreviated review session of a missed group session.

	Attendance Status (circle one) **(no/ yes / abbreviated)**	Date of Session **(if couple or review)**
1. **Participant 1** _____	**(no/ yes / abbreviated)**	__ __/__ __/__ __
2. **Participant 2** _____	**(no/ yes / abbreviated)**	__ __/__ __/__ __
3. **Participant 3** _____	**(no/ yes / abbreviated)**	__ __/__ __/__ __
4. **Participant 4** _____	**(no/ yes / abbreviated)**	__ __/__ __/__ __
5. **Participant 5** _____	**(no/ yes / abbreviated)**	__ __/__ __/__ __
6. **Participant 6** _____	**(no/ yes / abbreviated)**	__ __/__ __/__ __
7. **Participant 7** _____	**(no/ yes / abbreviated)**	__ __/__ __/__ __
8. **Participant 8** _____	**(no/ yes / abbreviated)**	__ __/__ __/__ __
9. **Participant 9** _____	**(no/ yes / abbreviated)**	__ __/__ __/__ __
10. **Participant 10**_____	**(no/ yes / abbreviated)**	__ __/__ __/__ __
11. **Participant 11** _____	**(no/ yes / abbreviated)**	__ __/__ __/__ __
12. **Participant 12** _____	**(no/ yes / abbreviated)**	__ __/__ __/__ __

CONFIDENTIAL MATERIAL

Participant ID NO	Cohort/ Group ID NO	SESSION 1 00= No, did not attend 01=Yes, attended full session 02=attended review or abbreviated	SESSION 2 00= No, did not attend 01=Yes, attended full session 02=attended review or abbreviated	SESSION 3 00= No, did not attend 01=Yes, attended full session 02=attended review or abbreviated	SESSION 4 00= No, did not attend 01=Yes, attended full session 02=attended review or abbreviated	SESSION 5 00= No, did not attend 01=Yes, attended full session 02=attended review or abbreviated	SESSION 6 00= No, did not attend 01=Yes, attended full session 02=attended review or abbreviated	SESSION 7 00= No, did not attend 01=Yes, attended full session 02=attended review or abbreviated	SESSION 8 00= No, did not attend 01=Yes, attended full session 02=attended review or abbreviated	
		00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	
		00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	
		00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	
		00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	
		00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	
		00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	
		00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	
		00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	
		00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	
		00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	
		00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	
		00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	00 01 02	

DATE OF FIRST SESSION FOR COHORT/GROUP ___ ___/___ ___/___ ___ CO-FACILITATOR 1IDNO ___ ___ ___ ___ ___
NAME OF PERSON FILLING OUT SHEET_____ CO-FACILITATOR 2DNO ___ ___ ___ ___ ___

THE EBAN II PROJECT
Session Adherence and Protocol Deviation Form
HIV/STI Risk Reduction Session 1
[Adapted from the NIMH Multisite HIV Prevention Trial Facilitator Rating Scale I]

The purpose of this instrument is to assess facilitators' adherence to providing the planned content of this module of the intervention. It is designed to rate audio recordings of sessions. It is imperative that you be familiar with the Eban HIV/STI Risk Reduction Intervention and with all the criteria specified in the *Rater's Manual* (in development as of this document printed on 07Jan10).

Although full instructions are provided in the *Rater's Manual*, an abbreviated summary is provided below for convenience:

- Rate every item. Make your best rating but do not leave any item blank. If you can not answer an item or it is not applicable, indicate this by writing a "88" symbol in the space provided.

- Three-point Likert-type scales: A two-step decision rule should be used when rating each item:
  (1) Determine whether the facilitators met the criteria listed in the Rater's Manual for a rating of "sufficient."

  (2) If the answer is no to sufficient, then review the criteria for a rating of "limited" and if appropriate, assign a value of 1.
  If the answer is yes to sufficient, ask if it is better than sufficient
  (a) If the answer is no to better than sufficient, assign a rating of 2.
  (b) If the answer is yes to better than sufficient, review the criteria for "complete" and, if appropriate, assign a value of 3.

Criteria for 3-point Likert Scales:

- Limited: limited number of topics for element from module provided; lowest level of coverage of elements in module; numerous opportunities missed to make the points in element or to provide further elaboration

- Sufficient: most topics from elements from module provided; probed in order to assess comprehension; clear examples provided; missed some opportunities to clarify or provide elaboration of information

- Complete: highest level of coverage of information; proved in order to assess comprehension; numerous examples provided; facilitators used examples provided by members during group; all topics in each element in protocol covered.

Session Adherence and Protocol Deviation Form:
HIV/STI Risk Reduction Session 1

Cohort/Group ID#: _____ Date of Session: ____/____/____
Date of Rating: ____/____/____
Session Facilitator ID#:_____

Section/Topic	Was Topic Addressed?	How adequately? 1=limited; 2=sufficient; 3=complete	Comments
Couples Group 1. Introduce and discuss EBAN Project • Intro. Journey • Intro. EBAN Symbol • Group Rules • Intro. & Why • How Journey will be taken	Y N	1 2 3	
2. Increasing Ethnic/ Cultural Pride	Y N	1 2 3	
3. Explaining why we are splitting into single gender groups	Y N	1 2 3	
Single Gender: Female 4f. Revisit why participants are taking this journey	Y N	1 2 3	
5f. Enhance Gender Pride	Y N	1 2 3	
6f. HIV/AIDS & STD transmission facts	Y N	1 2 3	
7f. Identify individual risk behaviors that increase risk for HIV/STD	Y N	1 2 3	
8f. Setting individual sex risk reduction goals	Y N	1 2 3	
9f. Personal barriers to risk reduction	Y N	1 2 3	

10f. Discuss other barriers that affect risk reduction	Y N	1 2 3	
11f. Make a commitment to participating in EBAN and working on risk reduction	Y N	1 2 3	
12f. Activities at home	Y N	1 2 3	
Single Gender: Male 4m. Revisit why participants are taking this journey	Y N	1 2 3	
5m. Enhance Gender Pride	Y N	1 2 3	
6m. HIV/AIDS & STD transmission facts	Y N	1 2 3	
7m. Identify individual risk behaviors that increase risk for HIV/STD	Y N	1 2 3	
8m. Setting individual sex risk reduction goals	Y N	1 2 3	
9m. Personal barriers to risk reduction	Y N	1 2 3	
10m. Discuss other barriers that affect risk reduction	Y N	1 2 3	
11m. Make a commitment to participating in EBAN and working on risk reduction	Y N	1 2 3	
12m. Activities at home	Y N	1 2 3	

A1. Please describe material that was covered/discussed that was outside of the written protocol as well as the time spent (in minutes) for each outside topic:

A2. Please describe any unusual events that you observed during the session:

A3. Please describe what goals/objectives you set with participants at the end of the session

PROJECT EBAN
Session Adherence and Protocol Deviation Form
HIV/STI Risk Reduction Session 1

[Adapted from the NIMH Multisite HIV Prevention Trial Facilitator Rating Scale I]

The purpose of this instrument is to assess facilitators' adherence to providing the planned content of this module of the intervention. It is designed to rate audio recordings of sessions. It is imperative that you be familiar with the Eban HIV/STI Risk Reduction Intervention and with all the criteria specified in the *Rater's Manual* (in development as of this document printed on 07Jan10).

Although full instructions are provided in the *Rater's Manual*, an abbreviated summary is provided below for convenience:

- Rate every item. Make your best rating but do not leave any item blank. If you can not answer an item or it is not applicable, indicate this by writing a "φ" symbol in the space provided.

- Three-point Likert-type scales: A two-step decision rule should be used when rating each item:
  (1) Determine whether the facilitators met the criteria listed in the Rater's Manual for a rating of "sufficient."

  (2) If the answer is no to sufficient, then review the criteria for a rating of "limited" and if appropriate, assign a value of 1.
  If the answer is yes to sufficient, ask if it is better than sufficient
  (a) If the answer is no to better than sufficient, assign a rating of 2.
  (b) If the answer is yes to better than sufficient, review the criteria for "complete" and, if appropriate, assign a value of 3.

Criteria for 3-point Likert Scales:

- Limited: limited number of topics for element from module provided; lowest level of coverage of elements in module; numerous opportunities missed to make the points in element or to provide further elaboration

- Sufficient: most topics from elements from module provided; probed in order to assess comprehension; clear examples provided; missed some opportunities to clarify or provide elaboration of information

- Complete: highest level of coverage of information; proved in order to assess comprehension; numerous examples provided; facilitators used examples provided by members during group; all topics in each element in protocol covered.

Session Adherence and Protocol Deviation Form:
HIV/STI Risk Reduction Session 2

Cohort ID#: _____ Staff ID Completing Form: _____
Date of Session: ___/___/___ Date of Rating: ___/___/___
Co-Facilitator ID#: _____

Section/Topic	Was Topic Addressed?	How adequately? 1=limited; 2=sufficient; 3=complete	Comments
1. Opening • African Proverb & Review	Y N	1 2 3	
2. Explore couple-related expectations, review ground rules for couples & review last session	Y N	1 2 3	
3. Foster Couple Pride (Sharing what they value about each other and why they want to protect each other & stay safe)	Y N	1 2 3	
4. Communicate Skills and Fence • Describe FENCE approach to problem solving and communication • Identify patterns of communication • Strategies for empathy and communication • Choosing options for communication & de-escalation • Practice FENCE and communication option	Y N	1 2 3	
5. Identify couples risk behaviors that increase risk for transmission of HIV/STDs	Y N	1 2 3	
6. Set couple sex risk reduction goals	Y N	1 2 3	
7. Identify barriers to sex risk reductions for couples	Y N	1 2 3	
8. Couple commitment to sex risk reduction/contract signing	Y N	1 2 3	
9. Activities at home	Y N	1 2 3	

A1. Please describe material that was covered/discussed that was outside of the written protocol as well as the time spent (in minutes) for each outside topic:

A2. Please describe any unusual events that you observed during the session:

A3. Please describe what progress was made with respect to goals/objective which were set last session:

HIV/STI Risk Reduction Session 3
[Adapted from the NIMH Multisite HIV Prevention Trial Facilitator Rating Scale I]

The purpose of this instrument is to assess facilitators' adherence to providing the planned content of this module of the intervention. It is designed to rate audio recordings of sessions. It is imperative that you be familiar with the Eban HIV/STI Risk Reduction Intervention and with all the criteria specified in the *Rater's Manual* (in development as of this document printed on 07Jan10).

Although full instructions are provided in the *Rater's Manual*, an abbreviated summary is provided below for convenience:

- Rate every item. Make your best rating but do not leave any item blank. If you can not answer an item or it is not applicable, indicate this by writing a "φ" symbol in the space provided.

- Three-point Likert-type scales: A two-step decision rule should be used when rating each item:
  (1) Determine whether the facilitators met the criteria listed in the Rater's Manual for a rating of "sufficient."

  (2) If the answer is no to sufficient, then review the criteria for a rating of "limited" and if appropriate, assign a value of 1.
  If the answer is yes to sufficient, ask if it is better than sufficient
    (a) If the answer is no to better than sufficient, assign a rating of 2.
    (b) If the answer is yes to better than sufficient, review the criteria for "complete" and, if appropriate, assign a value of 3.

Criteria for 3-point Likert Scales:

- Limited: limited number of topics for element from module provided; lowest level of coverage of elements in module; numerous opportunities missed to make the points in element or to provide further elaboration

- Sufficient: most topics from elements from module provided; probed in order to assess comprehension; clear examples provided; missed some opportunities to clarify or provide elaboration of information

- Complete: highest level of coverage of information; proved in order to assess comprehension; numerous examples provided; facilitators used examples provided by members during group; all topics in each element in protocol covered.

Session Adherence and Protocol Deviation Form:
HIV/STI Risk Reduction Session 3

Cohort ID#: _____ Staff ID Completing Form: _____
Date of Session: ____/____/____ Date of Rating: ____/____/____
Session Facilitator ID#:_____

Section/Topic	Was Topic Addressed?	How adequately? 1=limited; 2=sufficient; 3=complete	Comments
1. Opening/review • Proverb • Review homework • Review goal progress • Review what was covered in last session • Objectives for current session	Y N	1 2 3	
2. Understanding purpose and building self-efficacy: Taking Control of Life" exercise	Y N	1 2 3	
3. Teaching safer sex or repair work • Male and female sexual anatomy • Discuss sexual health & hygiene related to risk reduction • Identify best barrier methods and related safer sex accessories • Using male condoms: demonstration & practice • Using female condoms: demonstration & practice • How to get condoms	Y N	1 2 3	
4. Creativity in the relationship or repair work -Strategies for eroticizing safer sex -EBAN café game	Y N	1 2 3	
5. Activities for home (Practice using EBAN café menu, progress on couple goals)	Y N	1 2 3	

A1. Please describe material that was covered/discussed that was outside of the written protocol as well as the time spent (in minutes) for each outside topic:

A2. Please describe any unusual events that you observed during the session:

A3. Please describe what progress was with respect to goals/objectives:

Session Adherence and Protocol Deviation Form:
HIV/STI Risk Reduction Session 4
[Adapted from the NIMH Multisite HIV Prevention Trial Facilitator Rating Scale I]

The purpose of this instrument is to assess facilitators' adherence to providing the planned content of this module of the intervention. It is designed to rate audio recordings of sessions. It is imperative that you be familiar with the Eban HIV/STI Risk Reduction Intervention and with all the criteria specified in the *Rater's Manual* (in development as of this document printed on 07Jan10).

Although full instructions are provided in the *Rater's Manual*, an abbreviated summary is provided below for convenience:

- Rate every item. Make your best rating but do not leave any item blank. If you can not answer an item or it is not applicable, indicate this by writing a "φ" symbol in the space provided.

- Three-point Likert-type scales: A two-step decision rule should be used when rating each item:
  (1) Determine whether the facilitators met the criteria listed in the Rater's Manual for a rating of "sufficient."

  (2) If the answer is no to sufficient, then review the criteria for a rating of "limited" and if appropriate, assign a value of 1.
  If the answer is yes to sufficient, ask if it is better than sufficient
    (a) If the answer is no to better than sufficient, assign a rating of 2.
    (b) If the answer is yes to better than sufficient, review the criteria for "complete" and, if appropriate, assign a value of 3.

Criteria for 3-point Likert Scales:

- Limited: limited number of topics for element from module provided; lowest level of coverage of elements in module; numerous opportunities missed to make the points in element or to provide further elaboration

- Sufficient: most topics from elements from module provided; probed in order to assess comprehension; clear examples provided; missed some opportunities to clarify or provide elaboration of information

- Complete: highest level of coverage of information; proved in order to assess comprehension; numerous examples provided; facilitators used examples provided by members during group; all topics in each element in protocol covered.

Session Adherence and Protocol Deviation Form:
HIV/STI Risk Reduction Session 4

Cohort ID#: _____ Staff ID Completing Form: _____
Date of Session: ____/____/____ Date of Rating: ____/____/____
Session Facilitator ID#:_____

Section/Topic	Was Topic Addressed?	How adequately? 1=limited; 2=sufficient; 3=complete	Comments
1. Opening/review • Proverb • Review homework • Review goals progress • Review what was covered in last session • Objectives for current session	Y N	1 2 3	
2. Cooperative economics & discussing the balance of power in the relationship	Y N	1 2 3	
3. Discuss decision making in the relationship (Owning our decisions)	Y N	1 2 3	
4. Discuss couples sexual scripts	Y N	1 2 3	
5. Problem solving barriers in the relationship that affect risk reduction, including HIV stigma, abuse histories, etc.	Y N	1 2 3	
6. Faith in themselves and faith in the couple	Y N	1 2 3	
7. Assessment of couple, goal achievement, and discussion of moving forward to the group	Y N	1 2 3	
8. Activities for home • Improving couple connection with coupons for sharing love & affection/date your mate ideas; progress on couple goals	Y N	1 2 3	

A1. Please describe material that was covered/discussed that was outside of the written protocol as well as the time spent (in minutes) for each outside topic:

A2. Please describe any unusual events that you observed during the session:

A3. Please describe what progress was made with respect to goals/objectives you set with participants during last session (indicate any revised goals/objectives)

Session Adherence and Protocol Deviation Form:
HIV/STI Risk Reduction Session 5
[Adapted from the NIMH Multisite HIV Prevention Trial Facilitator Rating Scale I]

The purpose of this instrument is to assess facilitators' adherence to providing the planned content of this module of the intervention. It is designed to rate audio recordings of sessions. It is imperative that you be familiar with the Eban HIV/STI Risk Reduction Intervention and with all the criteria specified in the *Rater's Manual* (in development as of this document printed on 07Jan10).

Although full instructions are provided in the *Rater's Manual*, an abbreviated summary is provided below for convenience:

- Rate every item. Make your best rating but do not leave any item blank. If you cannot answer an item or it is not applicable, indicate this by writing a "φ" symbol in the space provided.

- Three-point Likert-type scales: A two-step decision rule should be used when rating each item:
  (1) Determine whether the facilitators met the criteria listed in the Rater's Manual for a rating of "sufficient."

  (2) If the answer is no to sufficient, then review the criteria for a rating of "limited" and if appropriate, assign a value of 1.
  If the answer is yes to sufficient, ask if it is better than sufficient
    (a) If the answer is no to better than sufficient, assign a rating of 2.
    (b) If the answer is yes to better than sufficient, review the criteria for "complete" and, if appropriate, assign a value of 3.

Criteria for 3-point Likert Scales:

- Limited: limited number of topics for element from module provided; lowest level of coverage of elements in module; numerous opportunities missed to make the points in element or to provide further elaboration

- Sufficient: most topics from elements from module provided; probed in order to assess comprehension; clear examples provided; missed some opportunities to clarify or provide elaboration of information

- Complete: highest level of coverage of information; proved in order to assess comprehension; numerous examples provided; facilitators used examples provided by members during group; all topics in each element in protocol covered.

Session Adherence and Protocol Deviation Form:
HIV/STI Risk Reduction Session 5

Cohort ID#: _____ Staff ID Completing Form: _____
Date of Session: ___/___/___ Date of Rating: ___/___/___
Session Facilitator ID#:_____

Section/Topic	Was Topic Addressed?	How adequately? 1=limited; 2=sufficient; 3=complete	Comments
1. Opening review -Talking circle/introduction -Review of EBAN-the Village -Review group rules and confidentiality -Review homework (couple connection coupons) -Review goal progress -Review what was covered in last session -Objectives for current session	Y N	1 2 3	
2. Purpose –building ethnic pride, identifying AA community strengths, discuss "Still I Rise"	Y N	1 2 3	
3. Overcoming social adversity—taking responsibility and owning your sexual decisions "Why practice safer sex?"	Y N	1 2 3	
4. Group discussion of HIV disclosure	Y N	1 2 3	
5. Unity-building social support for risk reduction • Assess social support & support for risk reduction	Y N	1 2 3	
6. Staying connected closing ritual: EBAN unity circle and talking circles	Y N	1 2 3	
7. Activities for home • Using strategies for increasing social support for risk reduction, progress on couple goals)	Y N	1 2 3	

A1. Please describe material that was covered/discussed that was outside of the written protocol as well as the time spent (in minutes) for each outside topic:

A2. Please describe any unusual events that you observed during the session:

Session Adherence and Protocol Deviation Form:
HIV/STI Risk Reduction Session 6
[Adapted from the NIMH Multisite HIV Prevention Trial Facilitator Rating Scale I]

The purpose of this instrument is to assess facilitator's adherence to providing the planned content of this module of the intervention. It is designed to rate audio recordings of sessions. It is imperative that you be familiar with the Eban HIV/STI Risk Reduction Intervention and with all the criteria specified in the *Rater's Manual* (in development as of this document printed on 07Jan10).

Although full instructions are provided in the *Rater's Manual*, an abbreviated summary is provided below for convenience:

- Rate every item. Make your best rating but do not leave any item blank. If you can not answer an item or it is not applicable, indicate this by writing a "φ" symbol in the space provided.

- Three-point Likert-type scales: A two-step decision rule should be used when rating each item:
  (1) Determine whether the facilitators met the criteria listed in the Rater's Manual for a rating of "sufficient."

  (2) If the answer is no to sufficient, then review the criteria for a rating of "limited" and if appropriate, assign a value of 1.
  If the answer is yes to sufficient, ask if it is better than sufficient
    (a) If the answer is no to better than sufficient, assign a rating of 2.
    (b) If the answer is yes to better than sufficient, review the criteria for "complete" and, if appropriate, assign a value of 3.

Criteria for 3-point Likert Scales:

- Limited: limited number of topics for element from module provided; lowest level of coverage of elements in module; numerous opportunities missed to make the points in element or to provide further elaboration

- Sufficient: most topics from elements from module provided; probed in order to assess comprehension; clear examples provided; missed some opportunities to clarify or provide elaboration of information

- Complete: highest level of coverage of information; proved in order to assess comprehension; numerous examples provided; facilitators used examples provided by members during group; all topics in each element in protocol covered.

Session Adherence and Protocol Deviation Form:
HIV/STI Risk Reduction Session 6

Cohort ID#: _____ Staff ID Completing Form: _____
Date of Session: ___/___/___ Date of Rating: ___/___/___
Session Facilitator ID#: _____

Section/Topic	Was Topic Addressed?	How adequately? 1=limited; 2=sufficient; 3=complete	Comments
1. Opening and review • Proverb/talking circle • Review homework (using speaker/listener to discuss group activity, problem solving triggers to risk) • Review goal progress • Review what was covered in last session • Objectives for current session	Y N	1 2 3	
2. Collective work and responsibility-Sharing the load of HIV • Group within a group activity on living with HIV and how it affects sex risk reduction • Debriefing • Group discussion of solutions-how we can help each other, learn from each other, overcome barriers, incorporate condoms? • Discussion of "How to ask for support to remain healthy from Partner & Social Support Network"	Y N	1 2 3	
3. Cooperative Economics-overcoming obstacles and triggers for risk • Identify triggers to risk • Problem solve triggers using the FENCE approach • Using RELAX model for emotion triggers • Intersection of drugs/alcohol and HIV/STDs	Y N	1 2 3	
4. Letting go ritual (letting go of risky behaviors & barriers)	Y N	1 2 3	
5. Staying connected closing ritual: EBAN unity circle and talking circle	Y N	1 2 3	

6. Activities at home • Use speaker/listener to discuss what they heard in group and how it affects protecting each other, problem solve triggers to risk, progress on couple goals	Y N	1 2 3	

A1. Please describe material that was covered/discussed that was outside of the written protocol as well as the time spent (in minutes) for each outside topic:

A2. Please describe any unusual events that you observed during the session:

Session Adherence and Protocol Deviation Form:
HIV/STI Risk Reduction Session 7
[Adapted from the NIMH Multisite HIV Prevention Trial Facilitator Rating Scale I]

The purpose of this instrument is to assess facilitators' adherence to providing the planned content of this module of the intervention. It is designed to rate audio recordings of sessions. It is imperative that you be familiar with the Eban HIV/STI Risk Reduction Intervention and with all the criteria specified in the *Rater's Manual* (in development as of this document printed on 07Jan10).

Although full instructions are provided in the *Rater's Manual*, an abbreviated summary is provided below for convenience:

- Rate every item. Make your best rating but do not leave any item blank. If you can not answer an item or it is not applicable, indicate this by writing a "φ" symbol in the space provided.

- Three-point Likert-type scales: A two-step decision rule should be used when rating each item:
  (1) Determine whether the facilitators met the criteria listed in the Rater's Manual for a rating of "sufficient."

  (2) If the answer is no to sufficient, then review the criteria for a rating of "limited" and if appropriate, assign a value of 1.
  If the answer is yes to sufficient, ask if it is better than sufficient
    (a) If the answer is no to better than sufficient, assign a rating of 2.
    (b) If the answer is yes to better than sufficient, review the criteria for "complete" and, if appropriate, assign a value of 3.

Criteria for 3-point Likert Scales:

- Limited: limited number of topics for element from module provided; lowest level of coverage of elements in module; numerous opportunities missed to make the points in element or to provide further elaboration

- Sufficient: most topics from elements from module provided; probed in order to assess comprehension; clear examples provided; missed some opportunities to clarify or provide elaboration of information

- Complete: highest level of coverage of information; proved in order to assess comprehension; numerous examples provided; facilitators used examples provided by members during group; all topics in each element in protocol covered.

Session Adherence and Protocol Deviation Form:
HIV/STI Risk Reduction Session 7

Cohort ID#: _____ Staff ID Completing Form: _____
Date of Session: ___/___/___ Date of Rating: ___/___/___
Session Facilitator ID#: _____

Section/Topic	Was Topic Addressed?	How adequately? 1=limited; 2=sufficient; 3=complete	Comments
1. Opening and review • Opening ritual (proverb/talking circle) • Review homework (using speaker/listener to discuss group activity, problem solving triggers to risk) • Review goal progress • Review what was covered in last session • Objectives for current session	Y N	1 2 3	
2. Assertiveness and self advocacy • Review communication skills for safer sex • Practice using FENCE to negotiate condom use • Discussion "How to ask for safer sex from partner"	Y N	1 2 3	
3. Review of condom use skills	Y N	1 2 3	
4. Review of other safer sex strategies	Y N	1 2 3	
5. Discuss attitudes about safer sex	Y N	1 2 3	
6. Being an agent of change (promoting community education and peer advocacy)	Y N	1 2 3	
7. Faith and group solidarity	Y N	1 2 3	
8. Continuing social support for the future	Y N	1 2 3	

9. Rededication and renewal of vows	Y N	1 2 3	
10. Saying goodbye to group			
11. Activities for home • Sharing risk reduction messages, progress on couple goals)			

A1. Please describe material that was covered/discussed that was outside of the written protocol as well as the time spent (in minutes) for each outside topic:

A2. Please describe any unusual events that you observed during the session:

:

Session Adherence and Protocol Deviation Form:
HIV/STI Risk Reduction Session 8
[Adapted from the NIMH Multisite HIV Prevention Trial Facilitator Rating Scale I]

The purpose of this instrument is to assess facilitators' adherence to providing the planned content of this module of the intervention. It is designed to rate audio recordings of sessions. It is imperative that you be familiar with the Eban HIV/STI Risk Reduction Intervention and with all the criteria specified in the *Rater's Manual* (in development as of this document printed on 07Jan10).

Although full instructions are provided in the *Rater's Manual*, an abbreviated summary is provided below for convenience:

- Rate every item. Make your best rating but do not leave any item blank. If you can not answer an item or it is not applicable, indicate this by writing a "φ" symbol in the space provided.

- Three-point Likert-type scales: A two-step decision rule should be used when rating each item:
  (1) Determine whether the facilitators met the criteria listed in the Rater's Manual for a rating of "sufficient."

  (2) If the answer is no to sufficient, then review the criteria for a rating of "limited" and if appropriate, assign a value of 1.
  If the answer is yes to sufficient, ask if it is better than sufficient
    (a) If the answer is no to better than sufficient, assign a rating of 2.
    (b) If the answer is yes to better than sufficient, review the criteria for "complete" and, if appropriate, assign a value of 3.

Criteria for 3-point Likert Scales:

- Limited: limited number of topics for element from module provided; lowest level of coverage of elements in module; numerous opportunities missed to make the points in element or to provide further elaboration

- Sufficient: most topics from elements from module provided; probed in order to assess comprehension; clear examples provided; missed some opportunities to clarify or provide elaboration of information

- Complete: highest level of coverage of information; proved in order to assess comprehension; numerous examples provided; facilitators used examples provided by members during group; all topics in each element in protocol covered.

Session Adherence and Protocol Deviation Form:
HIV/STI Risk Reduction Session 8

Cohort ID#: _____ Staff ID Completing Form: _____
Date of Session: ___/___/___ Date of Rating: ___/___/___
Session Facilitator ID#:_____

Section/Topic	Was Topic Addressed?	How adequately? 1=limited; 2=sufficient; 3=complete	Comments
1. Opening and review • Opening (proverb discussion) • Discuss what couple learned in group & what was successful) • Review homework (sharing risk reduction messages) • Assess couple goal progress & achievement • Review what was covered in last session • Objectives for current session	Y N	1 2 3	
2. Review of skills learned in EBAN intervention • Review communication • Review decision making and problem solving • Review safer sex strategies	Y N	1 2 3	
3. Build skills for relapse prevention • Identify situations that could lead to unprotected sex • Problem solving to avoid relapse • Coping with slips using self-talk and speaker/listener • Review of the seven principles (integrated in self-talk) • Rewards for continuing safer sex/sexual enjoyment as a reward	Y N	1 2 3	
4. Commitment • Commitment to staying safe • Commitment to interconnectedness	Y N	1 2 3	
5. Closing ceremony	Y N	1 2 3	
6. Assessment of project	Y N	1 2 3	

A1. Please describe material that was covered/discussed that was outside of the written protocol as well as the time spent (in minutes) for each outside topic:

A2. Please describe any unusual events that you observed during the session:

A3. Please describe what progress was made with respect to goals/objectives you set with participants during last session (indicate any revised goals/objectives)

UCLA PROTOCOL VIOLATION REPORT FORM

PROJECT MANAGER AND PI SHOULD FILL OUT THIS FORM IF AND WHEN THEY DETERMINE THERE HAS BEEN A SIGNIFICANT DEVIATION FROM THE INTERVENTION PROTOCOL

Name: _____
Position:_____
Staff ID#:_____
Site:_____
Today's Date:_____
Cohort/Group:_____

1. Study ID numbers of all participants involved in or affected by incident

___ ___ ___ ___ ___(participant 1) ___ ___ ___ ___ ___(participant 2)
___ ___ ___ ___ ___(participant 3) ___ ___ ___ ___ ___(participant 4)
___ ___ ___ ___ ___(participant 5) ___ ___ ___ ___ ___(participant 6)
___ ___ ___ ___ ___(participant 7) ___ ___ ___ ___ ___(participant 8)
___ ___ ___ ___ ___(participant 9) ___ ___ ___ ___ ___(participant 10)
___ ___ ___ ___ ___(participant 11 ___ ___ ___ ___ ___(participant 12)

2. Describe How Protocol was Deviated (Use Participant ID numbers not names when describing incident)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

3. How long did deviation take? ___ ___ ___ minutes

4. Describe any follow up actions taken by staff in response to incident

_____
_____
_____
_____

5. Was this incident captured on audiotape? YES/NO
If yes, please submit a copy of audiotape with this report to PI

Signature of Staff making report_____ Date:

Name of Principal Investigator:_____

Assessment of Incident where protocol was deviated (Please indicate how you reviewed incident and whether or not in your opinion this may constitute a protocol violation)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Disposition of Incident (Check relevant category)
( ) This Incident does not constitute a protocol violation.
( ) I have reported this incident to UCLA to be reviewed as protocol violation on
__ ___/__ __/___ ___(indicate date of report to UCLA).

Recommended Follow up Actions to Incident:

_____
_____
_____
_____
_____

Signature of Principal Investigator: _____

Date: __ __/__ __/__ __

Project Eban Participant Mid Intervention Evaluation Form

Your Co-Facilitator's Names: _____

Today's Date: _____/_____/_____

Thank you for your participation in Project Eban. In order to make our Project the best it can be, we need your feedback. Please answer the following questions about your individual couple sessions (session # 2 - # 4) with the co-facilitators. Your honest opinions are very valuable to us. Thank you.

1. What about the Project Eban sessions with your partner have you liked the most so far?

_____
_____
_____
_____

2. What about the Project Eban sessions with your partner have you liked the least so far?

_____
_____
_____
_____

3. What was the *most helpful* thing you have learned so far in Project Eban?

_____
_____
_____
_____

4. What do you hope to learn in the remaining sessions?

_____
_____
_____
_____
_____

5. What are ways do you think we can improve sessions#2 -#4?

_____
_____
_____
_____

6. Overall, how satisfied were you with couple sessions #2 - #4 with Project Eban? (please circle your answer)

05 04 03 02 01

THANK YOU VERY MUCH FOR YOUR FEEDBACK! IT WILL HELP US TO MAKE PROJECT EBAN EVEN BETTER FOR FUTURE PARTICIPANTS.

Project Eban Participant Final Evaluation Form

Your Co-Facilitator's Names: _____
Today's Date: _____/_____/_____

Date of Last Session: _____/_____/_____

Thank you for your participation in Project Eban. In order to make our Project the best it can be, we need your feedback. Please answer the following questions. Your honest opinions are very valuable to us. Thank you.

1. What about the Project Eban sessions did you like the most?

_____
_____
_____
_____

2. What about the Project Eban sessions did you like the least?

_____
_____
_____
_____

3. What did you learn in Project Eban?

_____
_____
_____
_____

4. Did the things you learned in Project Eban help you? (please *circle your answer*)

YES 01
NO 00 If NO, skip to question 5

4a. If YES, please tell us how these things helped you?

_____
_____
_____
_____

5. What was the *most helpful* thing you learned in Project Eban?

_____
_____
_____
_____

6. Have you talked to your friends or family about what you've learned in Project Eban?

YES 01
NO 00 If NO, skip to question 16

6a. If YES, How many friends or family members did you talk with?

_____ Friends or family members

6b. If YES, What did you talk to them about?

_____
_____
_____
_____

7. Overall, how satisfied were you with Project Eban? (please circle your answer)

05	04	03	02	01
Very Satisfied		Somewhat Satisfied		Not at all Satisfied

8. Overall, how satisfied were you with the male co-facilitator who worked with you in Project Eban? (please circle your answer)

05	04	03	02	01
Very Satisfied		Somewhat Satisfied		Not at all Satisfied

9. Overall, how satisfied were you with the female co-facilitator who worked with you in Project Eban? (please circle your answer)

05	04	03	02	01
Very Satisfied		Somewhat Satisfied		Not at all Satisfied

10. Overall, how honest did you feel you could be during Project Eban sessions? (please circle your answer)

05	04	03	02	01
Completely honest		Somewhat honest		Not at all honest

11. Do you have any suggestions for improving Project Eban?

YES 01
NO 00 If NO, skip to question 20

11a. If YES, what are some of your suggestions:

_____
_____
_____
_____
_____

THANK YOU VERY MUCH FOR YOUR FEEDBACK! IT WILL HELP US TO MAKE PROJECT EBAN EVEN BETTER FOR FUTURE PARTICIPANTS.

EBAN II
PARTICIPANT REFERRAL FORM

PARTICIPANT Name (First Name and Last Initial): __ __ __ __ __

(If Couple referral) PARTNER Name (First Name and Last Initial)__ __ __ __ __

COHORT/GROUP ID# __ __ __ __ __

NAME OF STAFF MAKING REFERRAL: _____
STAFF IDNO#: _____

TODAY'S DATE __ __/__ __/__ __

1. Date of Referral: __ __/__ __/__ __

2. Briefly describe participant's presenting problem or issue that led to referral:

_____
_____
_____
_____

3. Was referral made as a direct result of distress or negative incident that participant experienced in Project Eban (Circle)?

00=NO 01=YES 02=NOT SURE

3a. If yes or not sure, please describe circumstances which led to referral?

_____
_____
_____
_____

4. What Agencies/services did you refer participant to? (PLEASE INDICATE ALL REFERRALS)

Name of Agency/Service(REFERRAL 1):_____
*Type of services referred for:*_____

Address of Agency/Service:_____

Phone Number of Agency/Service: ( ) _____

Name(s) of Contact: _____

Did staff or participant contact Agency/Service?
00=NO, not yet 01=YES 02=NOT SURE

If yes, Services Requested: _____

If yes, Disposition of Referral: 00- Participant did not receive services
01- Participant received services .
02- Not sure

Name of Agency/Service (REFERRAL 2):_____
Type of services referred for:_____

Address of Agency/Service:_____

Phone Number of Agency/Service: ( ) _____

Name(s) of Contact: _____

Did staff or participant contact Agency/Service?

00=NO, not yet 01=YES 02=NOT SURE

If yes, Services Requested: _____

If yes, Disposition of Referral: 00 Participant did not receive services
01 Participant received services
02 Not sure.

Name of Agency/Service(REFERRAL 3):_____
Type of services referred for:_____

Address of Agency/Service:_____

Phone Number of Agency/Service: ( ) _____

Name(s) of Contact: _____

Did staff or participant contact Agency/Service?

00=NO, not yet 01=YES 02=NOT SURE

If yes, Services Requested: _____

If yes, Disposition of Referral: 00- Participant did not receive services
03 Participant received services
04 Not sure.

UCLA Participant Referral Form

SC-FILL OUT FORM AND SUBMIT TO UCLA AT END OF LAST ASSESSMENT SESSION FOR EACH PARTICIPANT WHO RECEIVED REFERRALS.

Participant ID# __ ___ ___ ___ ___

Cohort/Group ID#__ __ __ __ __

Site __ ___

Today's Date: __ __/__ __/__ __

Type of Referral Made	Was a referral made As a result of distress/negative incident from EBAN? 00 no 01 yes		Did participant receive service? 00 No 01 Yes 02 Don't Know		
Mental Health Services or Individual Counseling/Therapy	00	01	00	01	02
Couple Counseling/Therapy	00	01	00	01	02
Family Counseling/Therapy	00	01	00	01	02
Job Counseling/Placement	00	01	00	01	02
Health-related services/ Medical Doctor	00	01	00	01	02
Referral for Children	00	01	00	01	02
Housing/residential services	00	01	00	01	02
Alcohol/Drug treatment	00	01	00	01	02
Domestic Violence Services	00	01	00	01	02
HIV Support Services	00	01	00	01	02
SSI/AFDC/Food Stamps	00	01	00	01	02
Other _____(specify)	00	01	00	01	02