

# WHAT WORKS

IN HIV PREVENTION

for gay  
men

until it's over  
**AIDS ACTION**

What Works in HIV Prevention for Gay Men is a product of AIDS Action.

What Works in HIV Prevention for Gay Men is the first in a series of prevention guides. Others in the series include What Works in HIV Prevention for Substance Abusers; for Youth; for Women of Color; and for Prisoners. The What Works in HIV Prevention series was produced by AIDS Action with support from the U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention.

AIDS Action is the national voice on AIDS. We are committed to advocating for people affected by HIV/AIDS “Until It’s Over” – until no more people become infected with HIV, until people living with HIV have the care and support they need, and until a cure is found.

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## INTRODUCTION

**H**IV first appeared on the international radar screen in the summer of 1981 when physicians in Los Angeles and New York City reported unexplained immune system disorders among a number of gay men. Although the disease has since spread to other populations — heterosexuals, women, youth and communities of color — gay men and the broader classification of men who have sex with men (MSM) continue to feel the greatest impact of the disease. There are currently an estimated 325,000-475,000 gay and bisexual men living with HIV in the United States. 145,000 of these men were living with AIDS as of 1999 (Centers for Disease Control and Prevention [CDC], 2000). MSM continue to represent a large proportion of the country's new HIV infections each year.

Gay men across the country were the first to respond to HIV/AIDS and identify care and prevention needs in their communities as infection rates soared to roughly 150,000 infections per year in the 1980s. As a result, the gay response to this crisis offers some of the strongest evidence available that HIV prevention programs work. These programs produced unprecedented changes in gay men's sexual behavior, substantially slowing the spread of the disease within the gay community. One study determined that gay men had reduced their riskiest behaviors by more than 90 percent by 1991. As a result, rates of new infections among gay and bisexual men plummeted. By the late 1990s, the same urban centers in which nearly 1 in 2 gay men had been infected a decade earlier saw HIV prevalence drop by as much as two-thirds.

Unfortunately, all MSM have not equally shared in the successes of early HIV prevention efforts in the gay community. For a variety of reasons, gay men of color, young gay men and MSM who do not

identify as gay have been left out of, or not exposed to, the gay community's prevention messages. Consequently, these populations continue to experience major increases in HIV prevalence. In addition, current prevention messages and programs are being virtually ignored due to complacency within the gay community that has resulted from the new HIV treatments that are perceived as a cure for AIDS. These factors are contributing to thousands of new infections among MSM each year. The need for HIV prevention services for MSM must become more intense and diversified.

There are increased prevention needs beyond the MSM population as well. However, funding for new prevention interventions remains flat. This forces all prevention service providers to supply more services with less money. Because of this, scarce prevention funds must be used as effectively and efficiently as possible. In order to do this, community organizations must provide HIV prevention programs that are based on the best available scientific evidence and that are carefully targeted to those with the greatest risk of infection.

This document is designed for community-based organizations (CBOs) to assist them in the development of effective programs to prevent new HIV infections among men who have sex with men. It begins with a description of current epidemiological information and trends for MSM, and continues with an overview of prevention efforts among community-based organizations, including specific examples of successful prevention programs and practices. It concludes with a list of resources that may assist community-based organizations in the development of community-based prevention interventions.

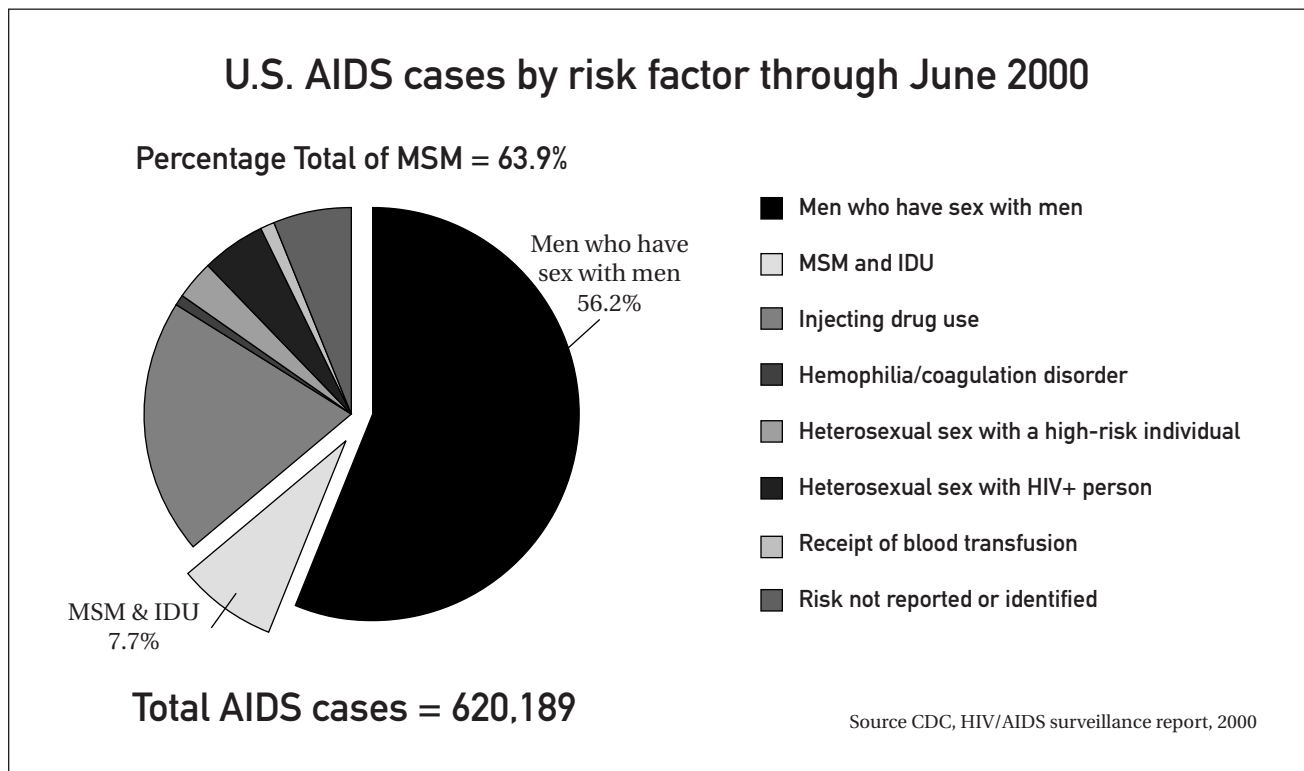
## CURRENT HIV/AIDS TRENDS AMONG MEN WHO HAVE SEX WITH MEN

**W**hen examining trends in the HIV/AIDS epidemic, it is critical to focus on each group within the broad category of MSM, including the diverse gay and bisexual communities as well as MSM that do not identify as gay or bisexual. AIDS continues to spread among men who are not receiving, understanding or responding to HIV prevention messages. This is fueled in part by cultural, social, and economic factors; lack of access to health care and prevention services; complacency and homophobia. It is only when these issues are identified and understood that effective and efficient prevention efforts can be developed.

The June 2000 CDC HIV/AIDS surveillance data identified that MSM accounted for 56 percent of all adolescents and adults diagnosed with AIDS. If MSM with other modes of exposure (injection drugs, hemophilia, heterosexual contact, etc.) were included, they would comprise an absolute majority of almost 64 percent (396,477).

In addition, the CDC estimates that between 325,000 and 475,000 MSM are currently living with HIV in the United States, many of whom do not know their status (CDC, 1999).

Chart 1



## Men of Color Who Have Sex with Men

Men of color who have sex with men are increasingly at risk of acquiring HIV/AIDS. Men of color currently account for almost 37 percent of the total number of AIDS cases among men who have sex with men in the United States. These numbers are disproportionate to the racial and ethnic distribution of the U.S. population, in which African-Americans comprise 12.2 percent of the total population, Latinos constitute 11.9 percent, Asian and

Pacific Islanders are 3.8 percent and American Indian/Alaska Natives are 0.7 percent [U.S. Census Bureau 2000].

While white gay men accounted for the vast majority (69 percent in 1989) of HIV infections among MSM in the 1980s, the typical MSM who seroconverts in 2000 is more likely to be a person of color (CDC, 2000). The CDC reports that almost 46 percent of HIV infections in MSM were among men of color in 2000, up from 31 percent in 1989 (CDC, 2000).

Chart 2

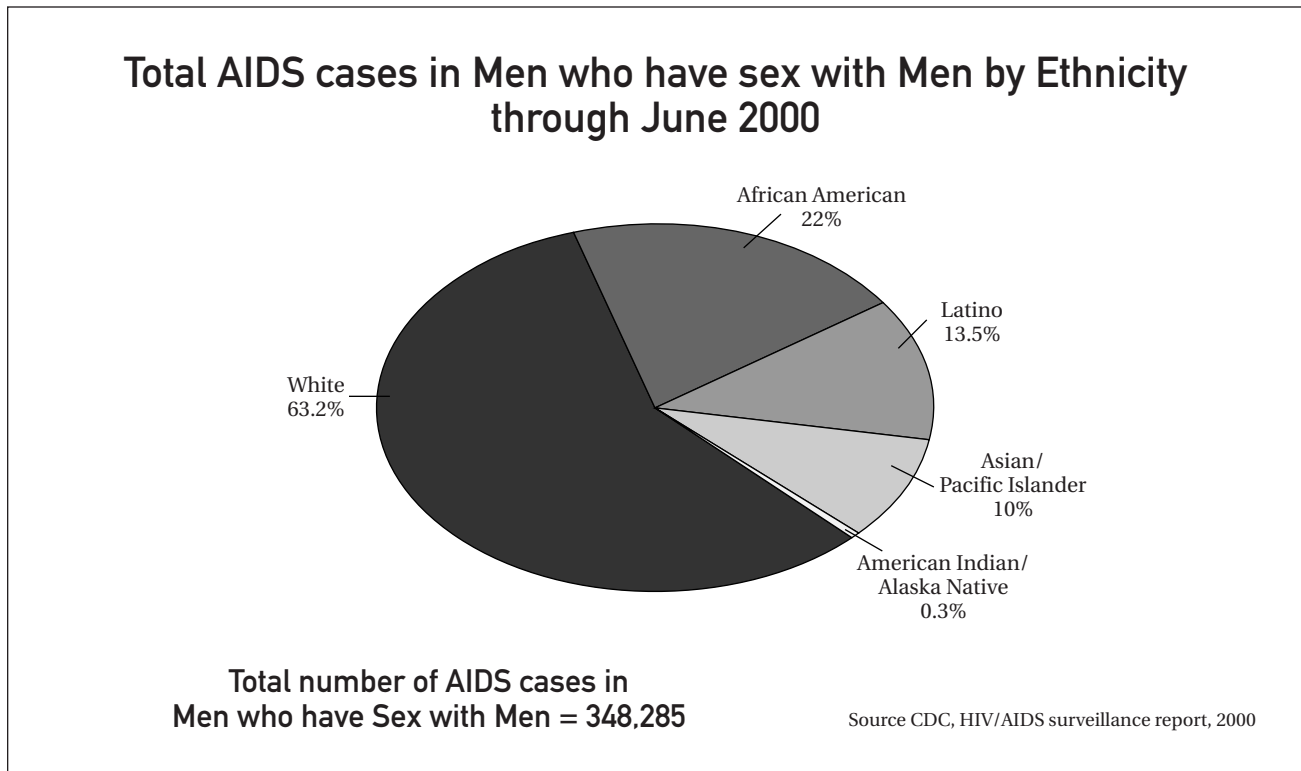
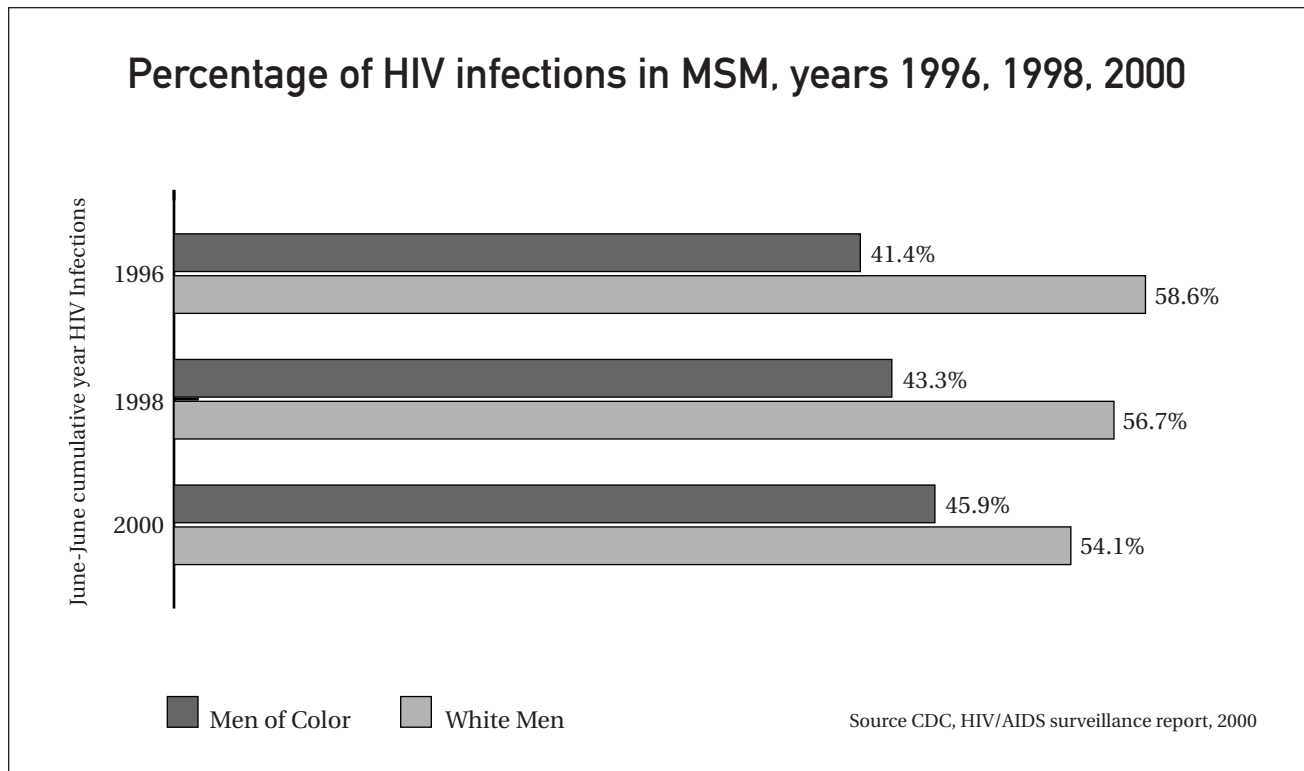


Chart 3



One reason for this shift is that initial prevention efforts in the gay community were produced by, and for, gay white men. These messages did not reach men of color. Homophobia also impacts access to HIV prevention services. While homophobia is found in all communities, within communities of color it has discouraged men who have sex with men from accessing prevention services.

Within the overall population of MSM, there are important social and cultural differences among communities that hinder prevention services from reaching sub-populations of MSM. For example, African-American and Latino MSM may not identify as gay or bisexual. A multi-site CDC study reported that out of 8,780 HIV-positive men who have sex with men surveyed, 24 percent of African-American men, 15 percent of Latino men and 11 percent of Asian Pacific Islander men identified themselves as heterosexual, compared with only 6 percent of white men (MMWR, 2000). Additionally, a study presented by Frank Salerno at the 1999 National HIV Prevention Conference reported that 80 percent of the HIV-positive Latino MSM in Santa Clara County,

California did not identify as gay (Santa Clara County Comprehensive Prevention Plan, December 1995). These percentages indicate that prevention services geared only to gay and bisexual men, even if they are targeted towards men of color, may not reach a large number of men at risk for HIV infection.

*African-American* men account for increasing numbers of AIDS cases and have experienced smaller proportionate declines in AIDS incidence and deaths as compared to their white counterparts. In the mid-late 1990's, 40 percent of the AIDS diagnoses and HIV infections were found in African-American MSM. In 1998 alone, African-American men constituted 33 percent (5958) of all AIDS cases reported for MSM. This is a substantial increase from the 19 percent rate among African-American men found in 1989. The majority of the African-American AIDS cases are occurring in large cities such as New York City, Washington DC and Atlanta (MMWR, 2000).

There are several reasons why African-American MSM continue to be at high risk for contracting HIV. Homophobia may result in low self-esteem and psychological distress leading to higher risk behaviors

(Stokes & Peterson, 1998). The fear of alienation and lack of community support may discourage African-American MSM from identifying as gay or bisexual, which can consequently limit their exposure to prevention efforts targeting gay men.

Poverty and unemployment also impact HIV infection rates within the African American community. The National Commission on AIDS (1992) reports that both poverty and unemployment are associated with high rates of HIV risk behavior.

*Latino* MSM also have experienced disproportionate increases in AIDS cases and smaller proportionate declines in AIDS incidence and deaths than whites. In the mid-late 1990's, Latino MSM constituted 7 percent of the AIDS diagnoses and HIV infections in MSM in the 25 areas with HIV/AIDS surveillance. In 1998 alone, 18 percent (3224) of all AIDS cases reported for MSM were among Latinos. This rate increased from 12 percent in 1989 (MMWR, 2000). The CDC also reported a sharp spike in HIV infections for Latino MSM from 1997 to 1998 in those cities with HIV reporting (CDC, 1997, 1998). The cities with the majority of AIDS cases among Latino MSM are Los Angeles, New York City and Miami (MMWR, 2000).

Like African-American MSM, Latino MSM also face similar issues relating to homophobia. Latino MSM may internalize other cultural influences because some Latino cultures perceive homosexuality as a sin. This may create low self-esteem and personal shame leading to high-risk behaviors or it may prevent Latino MSM from accessing HIV programs (Diaz, 1995). Additionally, Latino MSM also experience disproportionate rates of poverty and unemployment, which (as noted previously) are associated with higher rates of high risk behavior (National Commission on AIDS, 1992).

*Asian Pacific/Islander* men constitute less than 2 percent (192) of all AIDS cases reported among MSM in 1998, consistent with the proportion of cases found in 1989 (MMWR, 2000). However, from 1997 to 1998 there was a 131 percent increase in new infections for Asian Pacific/Islander MSM based on CDC reports from areas with HIV/AIDS reporting (CDC, 1997, 1998). Los Angeles had the largest number of AIDS cases for Asian/Pacific Islander MSM (MMWR, 2000).

There are several factors that contribute to Asian/Pacific Islander MSM's continued risk for HIV. These include the cultural avoidance of homosexuality and a lack of peer and community support. Discussions about sexual behavior, illness and death are not often part of the community's cultural norms. In addition, there is limited community support for sexual diversity that may result in low self-esteem and an absence of positive self-identity (Chang et al., 1998). A 1995 study found that 85 percent of gay Asian/Pacific Islanders believed they were unlikely to contract HIV, and 24 percent reported unprotected anal intercourse (Choi et al., 1995). The results indicate that these individuals did not identify the connection between their sexual behaviors and their risk for contracting HIV.

*American Indian/Alaska Native* men constituted less than 2 percent (55) of all AIDS cases reported for MSM in 1998. There was an increase of 41 percent of new infections from 1997 to 1998 reported to the CDC from cities with HIV reporting (CDC, 1997, 1998). Phoenix had the largest number of AIDS cases found in American Indian/Alaska Native MSM (MMWR, 2000).

There are several contributing factors placing American Indian/Alaska Natives at greater risk for HIV/AIDS. This population is socioeconomically disadvantaged and is more likely to be low-income — 31.6 percent of Native Americans live in poverty. Native Americans experience high rates of other sexually transmitted diseases such as gonorrhea and syphilis (MMWR, 1998). For Alaska Native MSM, location is also a risk factor. Although the geographical remoteness may hinder the spread of HIV, that distance also limits Alaska Natives' access to HIV prevention and care services. In some rural villages, seasonal employment brings a host of outsiders (and their potential exposure to HIV) to these communities (National Native American AIDS Prevention Center, 1996).

Recently, federal officials drew attention to the risk of HIV/AIDS for Native Americans, stating that AIDS poses a "serious health threat that could devastate Native American communities" if left unchecked, according to US Surgeon General Dr. David Satcher. Because "there are shortcomings in HIV/AIDS surveillance systems," Satcher added, "we

cannot be certain of the full extent of the problem within American Indian and Alaska Native communities” (Satcher, November 15, 2000).

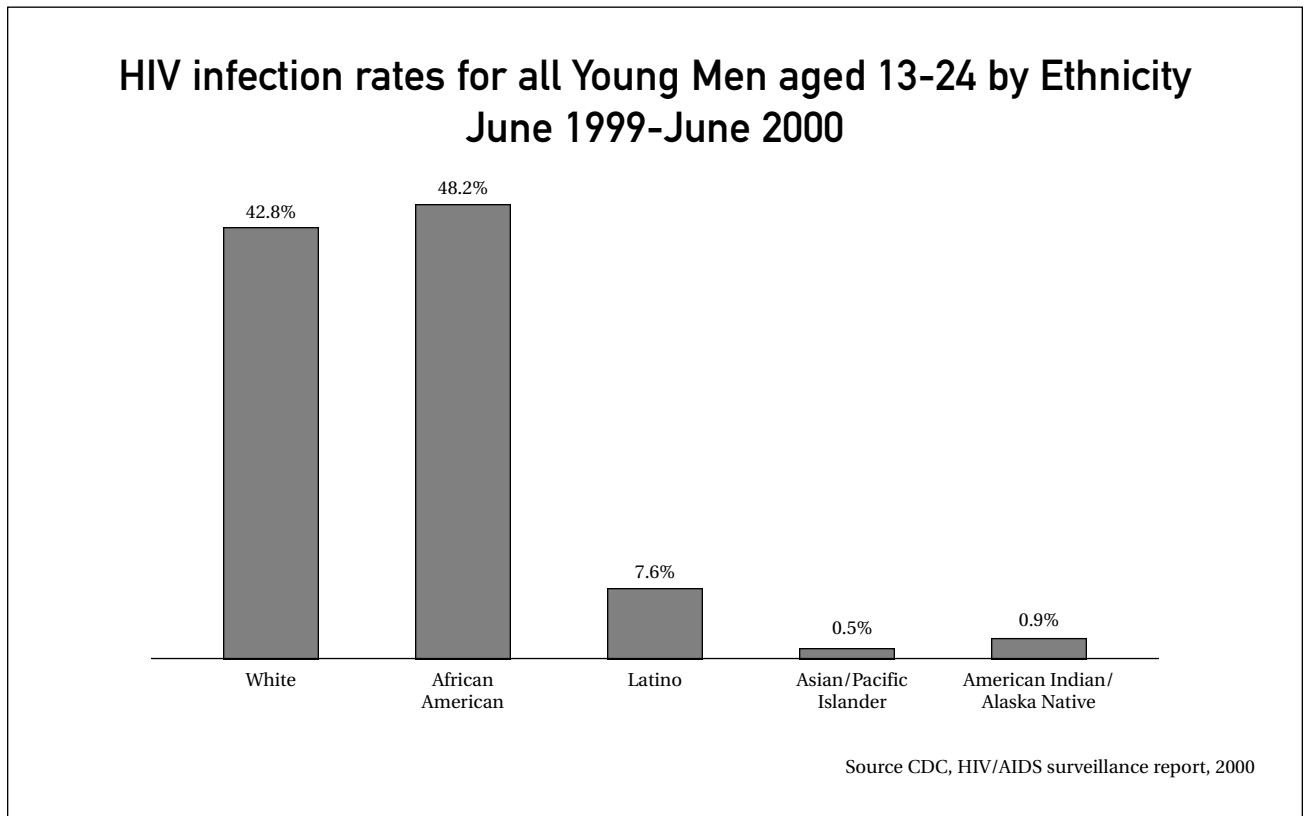
Although statistics indicate that rates of HIV infection are relatively low for Asian/Pacific Islanders and American Indian/Alaska Native MSM, the need for prevention efforts with these populations is important. First, it is possible that the rates of HIV infection in these groups is higher than indicated here because surveillance studies may sometimes misclassify various ethnic groups. In addition, illegal immigrants in the Asian/Pacific Islander community (as well as in the Latino community) might be reluctant to access prevention services for fear of being reported to the authorities. Throughout the epidemic, populations assumed to be low risk have been neglected until large numbers of people have been infected. Focusing on these communities is a critical step in slowing the spread of HIV.

### Young MSM

Young MSM are at high risk of becoming infected with HIV. Racial and ethnic minorities are disproportionately affected. The CDC sponsored Young Men’s Survey found that 7 percent of young men were infected with HIV and that 3 percent were becoming infected each year. The incidence of HIV was also found to increase with age, rising from 2 percent among adolescent men to 4 percent among young men in their 20s. The CDC study also found that in the last six months, 41 percent of the young MSM in the study had engaged in unprotected anal intercourse (CDC, 2000).

As with the general MSM population, young men of color are at greater risk of infection. Recent data indicates 30 percent of young African-American gay men are HIV positive. In 1999 and 2000, infection rates among African-American youth exceeded the rates for all other ethnic groups.

Chart 4



In addition, it was found that among newly infected MSM, disproportionate numbers of infections in men of color were identified in youth aged 13-24, compared with white men (CDC, 2000). This data not only shows that men of color are disproportionately impacted by the disease, but it also suggests that young men of color are being infected in greater numbers.

By incorporating prevention into their culture, the gay community has been able to lower infection rates. However, many young MSM are becoming infected before they are integrated into gay/bisexual networks and exposed to community based HIV prevention programs. Youth that do not identify as gay or bisexual are often overlooked by prevention efforts.

### **Men Who Have Sex with Men Still at Risk**

As the HIV/AIDS epidemic approaches the end of its second decade, MSM remain the group at highest risk of infection. In a six-city study of HIV incidence in STD clinics between 1991 and 1997, researchers found that gay and bisexual men were 17 times more likely than heterosexuals to test HIV-positive. In addition, MSM constituted the single largest group of new infections in 1998 while gay and bisexual men accounted for more than 40 percent of all new reported infections in 1998 and 60 percent of all seroconversions among males (CDC, 2000).

There are other trends in the transmission of sexually transmitted diseases that suggest MSM are becoming less safe in their sexual practices. A 28-city study found that the percentage of gonorrhea cases found in MSM doubled between 1994 and 1998 (from 6 to 12 percent). In Seattle-King County there were no syphilis cases reported in 1996, but 88 cases were reported between 1998 and the first half of 1999, 85 percent of which were found in MSM. There was an outbreak of syphilis among gay men in San Francisco in the summer of 1999 in addition to a doubling of the incidence of rectal gonorrhea among males between 1994 and 1997 (CDC, 2000). In March of 2000, Los Angeles County reported increases in syphilis infection rates among MSM, two thirds of which were already infected with HIV (Marquis, 2000). These statistics suggest that risk behaviors are on the rise and could contribute to increased rates of HIV infection for MSM.

Studies indicate that this increase in unprotected behavior may be related to gay men's perceptions regarding advances in HIV/AIDS treatments. A 1999 survey of gay men in West Hollywood, California, found that as a gay man's confidence in the outlook for HIV treatments increased, he was more likely to engage in unprotected sex (CDC, 2000). Although there is hope for new and more effective treatments, prevention is critical in minimizing the number of MSM living with HIV.

## COMMUNITY-BASED PREVENTION EFFORTS TARGETING MEN WHO HAVE SEX WITH MEN

The HIV prevention story in the United States begins with the gay community's initial response to the disease. As HIV ravaged their communities, gay men mobilized, raising public awareness, creating AIDS service organizations, and advocating for greater political attention to all aspects of the disease. During this time, the very notion of "safe sex" was initially formulated and popularized by a gay doctor and his patients. In addition, newly established gay organizations began safe sex education programs where the concept of HIV prevention was born. These efforts demonstrated how community-centered, culturally appropriate HIV prevention initiatives could save lives.

The earliest HIV prevention programs for gay men focused on information presented through brochures, pamphlets, and other publications. Prevention educators sought to sell safe sex to their constituents through posters, special events, and by innovative means such as sexually provocative cartoon strips. These prevention strategies in the gay community shared the following characteristics:

- **Frank talk about sex**  
HIV prevention programs targeted gay men in a straightforward way describing risky sexual behaviors and the activities that prevent HIV transmission.
- **Skills Building**  
Developing prevention skills that support safer sex practices (both condom use and negotiation) with other gay men promoted realistic discussions and strategies.
- **Cultural appropriateness**  
Successful prevention outreach spoke to gay men in language they could understand.

Rather than deplore the gay sexual culture, prevention educators took advantage of places where gay men gathered, such as clubs, gyms and festivals, to deliver safe sex messages.

- **Peer-delivered**  
Gay men themselves staffed virtually all of the early HIV prevention programs targeting the gay community. Gay men therefore received HIV prevention messages from individuals who "looked like themselves."
- **Community ownership**  
The gay community wholeheartedly embraced the fight against AIDS after the realization that HIV posed a serious threat to the community. Building community support for safe sex was an important component of the community's ownership of the epidemic. Many of the early HIV prevention initiatives in the gay community were premised on community organizing principles borrowed from the women's health movement.
- **Combating stigma**  
Prevention programs targeting gay men were coupled with efforts to fight the stigma associated with AIDS. At a 1983 meeting in Denver, the persons with AIDS (PWA) empowerment movement was born. Their platform, which came to be known as the Denver Principles, maintained that people with AIDS had the right to confidential medical care, access to support services and the right to live and die with dignity (Senterfitt, May 1998). That same year, gay organizations began to seek legal remedies to the discrimination experienced by people with AIDS in housing, employment and public benefit programs.

These early efforts were very successful in leveraging both private and public investments in prevention, which resulted in large decreases in the numbers of new infections annually. The Center for AIDS Prevention Studies reported that from 1982 to 1992 the number of new infections in San Francisco dropped from an estimated 8,000 annually to 1,000 per year (Decarlo & Coates, 1998).

There are now signs, however, that risk behaviors are increasing among MSM. One indication is the rise of other sexually transmitted diseases. The CDC reported that gonorrhea cases among MSM held steady at about 4 percent from 1988 to 1992 but started to rise thereafter, tripling by 1998 (MMWR, 1999). Other signs are increases in infections among men of color and reported complacency within MSM due to advances in medical treatment.

In response to these challenges, community-based educators and their research partners devised

a range of innovative approaches to encourage and sustain behavioral changes and address the psychological, social and economic factors that have been associated with risky sexual behavior for MSM. Whereas early prevention programs sought to encourage behavior change in the midst of a sudden health emergency, subsequent efforts were premised on the likelihood that HIV/AIDS would require lifelong changes in gay men's sexual behaviors. Similarly, while early prevention strategies targeted gay men whose culture, social networks, and life perspective had been radically altered by the disease, later initiatives had to address the prevention needs of teenagers and young adults, some of whom had little or no exposure to the HIV epidemic. The effectiveness of these prevention efforts is demonstrated in the reduced number of new infections among gay men as well as the results of carefully controlled scientific studies.

## SUCCESSFUL HIV PREVENTION PROGRAMS FOR MEN WHO HAVE SEX WITH MEN

Over the years researchers and practitioners have studied a variety of HIV prevention approaches for MSM. These studies have confirmed that several approaches are effective in reducing the behaviors that lead to HIV transmission. They also have found that programs must be carefully targeted and evaluated to ensure their effectiveness. This evidence enables community organizations to base their prevention interventions in sound science.

In this section, a variety of HIV prevention programs that can be used by community-based organizations will be examined. They begin with a description of a broad prevention strategy and the goals of that particular strategy. The description of HIV prevention programs includes program results, the resources needed for a community-based organization to successfully run such a program and contacts for the program. This section concludes with a discussion of the importance of program evaluation.

### Peer Leadership and Role Modeling in Communities

While some programs focus on strategies for individuals, others focus on altering the behavioral norms and attitudes of entire social networks. This is done through peer leadership and role modeling. This method of reaching sub-populations, including youth and men of color, is effective because it uses individuals with whom community members directly interact, and respect, to deliver the targeted prevention message.

#### PREVENTION MODEL - POPULAR OPINION LEADERS

The Popular Opinion Leaders program was developed and evaluated by Kelly, St. Lawrence, Stevenson, et al. (1992) and was tested with gay men in three small cities in the southeastern United

States over a three-year period: Biloxi, Mississippi; Hattiesburg, Mississippi; and Monroe, Louisiana. The intervention trained popular men within gay communities to serve as proponents of behavioral change among their peers. The objective was to establish a group of already known, trusted, and well-liked persons who were taught to actively and visibly endorse the importance and acceptability of behavioral change. In doing so, these men conveyed strategies for changing high-risk behaviors.

The intervention consisted of two components. First, popular opinion leaders were identified by local bartenders who recognized them as the most popular within the gay community (e.g., men that were greeted the most, men that greeted others the most and men that were sought after by others for advice). These individuals were recruited to take part in the program and were required to participate in four weekly training sessions, each one lasting 90 minutes. These sessions were intended to teach opinion leaders the specific social skills needed to serve as educators of risk reduction. The sessions trained the opinion leaders how to:

- Correct misconceptions concerning HIV risk;
- Recommend strategies to implement risk reduction to their peers (e.g., keeping condoms nearby if sexually active, avoiding sex when intoxicated, negotiating safe sex in advance with a potential sexual partner, and assertively refusing unsafe sex coercion); and
- Personally endorse the benefits, importance, and social acceptability of making behavioral changes.

The trainings were completed using group discussions, modeling of effective health promotion messages and role-playing.

Upon the completion of the training, the second component of the intervention began. Popular opinion leaders committed to at least 14 conversations about safer sex with their peers in gay bars. In addition, opinion leaders would wear buttons at the local bars that matched project promotion posters. These buttons and posters were intended to stimulate conversation among bar patrons. Opinion leaders were also asked to monitor the number of educational conversations they had with peers during a 17-day, post-intervention period.

Through pre and post-intervention surveys with nearly 1500 participants, the popular opinion leaders program was shown to be effective in decreasing risk behaviors. Results indicated that there were decreases in insertive anal intercourse ranging from 14 - 29 percent and decreases in receptive anal intercourse ranging from 26 - 28 percent in all three cities. In addition there were increases in condom use between the pre- and post-interventions ranging from 4 - 17 percent. Finally, the surveys revealed that there were increases in the perceived social acceptability of insisting upon safer sex practices among the participants. Surveys done of the opinion leaders revealed that they had an average of 6 peer conversations during the post-intervention period.

RESOURCES

REQUIRED: Trainers  
Space/facilities for the trainings  
Program advertising  
(buttons and posters)

CONTACT: Jeffrey A. Kelly, PhD  
Medical College of Wisconsin  
Milwaukee, WI  
www.cair.mcw.edu

**CBO PROGRAM - ENTERTAINERS AGAINST AIDS**

When staff at The AIDS Resource Center of Wisconsin tried to implement the Popular Opinion Leaders prevention model in the gay community in Wisconsin, they experienced some difficulties. Men who had been identified as popular opinion leaders did not necessarily want to become activists or take

on the responsibility of conducting HIV prevention in the community.

Entertainers Against AIDS began when Paul Jacobs, a Prevention Specialist at The AIDS Resource Center of Wisconsin, and Jeff Jennings, an eighth grade English teacher in the Green Bay area, were discussing the amount of money raised by local entertainers in the Wisconsin area. The two realized that the entertainers would be an excellent resource for promoting HIV prevention efforts.

The Center subsequently decided to modify its approach. Many local entertainers had performed in benefit events for The AIDS Resource Center. Jacobs and Jennings decided to see if some of the performers would offer to serve as leaders in their HIV prevention program. The two sent letters out to performers inviting them to a brainstorming session about the program. The response was overwhelming and the first meeting was held in January 1998. Entertainers Against AIDS was born.

Entertainers Against AIDS focuses primarily on serving the gay community of northeastern Wisconsin. However, all events are open to, and often reach, the general public.

The program is operated entirely by volunteers, including staff from the AIDS Resource Center. Currently there are about 18 volunteers in the program, half of whom are entertainers. No formal support is given to the Entertainers Against AIDS Program from the Center, except for materials and printing assistance.

The group meets once a month in various locations, including restaurants, homes and business offices. During these monthly meetings, the group shares information and plans their events/activities. There are several information cards available for entertainers to read during their performances. They contain information about HIV/AIDS, places to get tested, and AIDS statistics, and resources and services available in the community. Members can also make referrals to service providers in the area based on an individual's care or prevention needs. In keeping with the structure of the prevention model, group members who perform regularly in area venues, including gay clubs, educate their audiences about HIV prevention before, after, and sometimes during their performances.

Entertainers Against AIDS has produced more than 35 posters that have been placed in the restrooms of various bars and clubs. These posters – the *Urinal Gazette* targeting men and the *Tinkle Tribune* targeting women — carry AIDS statistics and prevention information as well as referrals to local service organizations.

The largest event held by the group each year is a World AIDS Day Performance, which is free to the public and includes music, theatre, dance and other performances. Both senior citizen and youth groups are invited to attend and perform, and usually the mayor and County Health Department are involved as well.

Entertainers Against AIDS is funded through money that is raised by the entertainers on their own time and through private donations. While there is no formal budget, the group operates its program with about \$4,000 each year.

Entertainers Against AIDS has no formal evaluation system, but there is a strong sense that the program is working. Feedback from the community indicates that the program is raising awareness of HIV disease and prevention. In addition, the group has been the subject of profiles in the local media, which has helped bolster its efforts to get the word out about HIV prevention.

CONTACT: AIDS Resource Center Wisconsin  
Green Bay Office  
920-437-7400  
www.arcw.org

### **Multi-Session Interventions**

After initial HIV prevention programs were introduced and tested throughout the early years of the epidemic, some prevention experts believed that longer interventions with multiple sessions would be more likely to produce behavioral change that could be sustained over time. Accordingly, various multi-session interventions were developed to explore the complicated issues surrounding sexual decision-making.

### **PREVENTION MODEL - THE AFRICAN-AMERICAN MEN'S HEALTH STUDY**

In keeping with the structure of the Opinion Leaders prevention model, The African-American Men's Health Study was conducted by Peterson, Coates, Catania, et al (1996). The study focused on African-American gay and bisexual men in the San Francisco Bay area and evaluated the impact of culturally appropriate, community-based HIV risk reduction interventions in modifying high-risk sexual behaviors. The study compared three groups: those who participated in a three-session intervention, those who participated in a one-session intervention, and those in a control group who did not participate in any interventions.

The one session intervention met one day for a three-hour small group meeting while the three-session intervention met for three hours weekly for three weeks. Both interventions covered the same topics. Participants were recruited from bars, bathhouses, erotic bookstores, gay African-American organizations, street outreach, advertisements in gay mainstream and African-American newspapers and personal referrals from other participants. Participants were reimbursed for the baseline, 12-month and 18-month interviews at \$15, \$25 and \$30 respectively.

The session(s) included videotapes, games and role-plays that were extensively tested for their accuracy and cultural relevance for African-American gay/bisexual men. Two African-American gay men facilitated the sessions. The four components of the session(s) were as follows:

- Self-identity and development of social support: The facilitators reinforced participants' self-identities as members of both racial and sexual minority groups, encouraging feelings of pride in belonging to both groups. Discussions focused on the consequences of poor self-identity in risk-taking behaviors. Participants watched a video called "Tongues Untied" about the African-American gay male experience, discussed negative and positive experiences associated with being gay and African American, and discussed perceptions of their HIV risks as members of a sexual minority group.

- **AIDS risk education:** Participants took part in two activities to increase their knowledge of risk reduction and condom use. The first, “AIDS Jeopardy,” gave facilitators an opportunity to present information about HIV transmission, emphasize the importance of HIV antibody testing and correct participants’ misconceptions regarding HIV. Participants also played the “Condom Game” which allowed them to examine their positive and negative emotions about low-risk activities.
- **Assertiveness training:** This activity taught participants how to negotiate low-risk activities and refuse high-risk activities with current and new sexual partners. The group then formed dyads to practice what they had learned through role-playing.
- **Behavioral commitment:** This component allowed participants to share amongst themselves strategies they had used to reduce their risks of infection. In addition, all participants made a verbal commitment with the rest of the group to change their own risk behaviors.

Both the single and triple session participants reported comparable rates of risky behavior before the intervention. However, the triple session participants reported a decline in unprotected anal intercourse by 50 percent at both the 12 and 18-month follow-up interviews. The single session participants reported only slight declines at follow-up. The group that had not participated in either intervention reported little to no change in risk behaviors. The results indicate that multi-session HIV prevention interventions can reduce risk-taking behaviors among gay African American men.

**RESOURCES**

**REQUIRED:** Program recruitment advertising  
Facilitators  
Culturally appropriate games and videos  
Space for the sessions

**CONTACT:** John Peterson, PhD  
Georgia State University  
Atlanta, GA  
[www.gsu.edu/~wwwpsy/](http://www.gsu.edu/~wwwpsy/)

**CBO PROGRAM - DEEPER LOVE**

AID Atlanta’s Deeper Love program, now in its fifth year, chose to implement The African American Men’s Health Study because of AID Atlanta’s familiarity with John Peterson’s work and research. The Deeper Love program consists of 2 ? hour sessions that meet once a week over four weeks. Participants are recruited into the program by word of mouth, although Deeper Love also advertises through local publications, staff presentations at various forums in the community, including bars and clubs, and referrals from AID Atlanta. Approximately 95 percent of program participants are African American and the other 5 percent are primarily Latino. Most of the outreach to advertise the program is done by volunteers, many of who have attended the four-week workshop. Deeper Love has an active volunteer list of 10-12 people but only 3 or 4 volunteers are used per session.

Deeper Love is funded through a private foundation called Health First. The annual operating budget of the program, including the coordinator’s salary, is approximately \$40,000. Program Coordinator Anthony McWilliams, who has been with the program for over a year, is a former Deeper Love participant. Explains McWilliams, “I really loved participating in the sessions. So when at my last session the program coordinator announced he was leaving, I thought ‘Wow, what a cool job that would be.’

“As a participant, this program changed my life. I love my job because I love the fact that I can recreate the experience I had for someone else,” he says.

Typically, there are 10-15 participants in each weekly session. Each month, the day of the week on which the sessions occur is modified to provide clients with more opportunities to participate. The sessions are structured as follows:

- **Week 1:** Participants begin by talking about their experiences as gay, African American men. They discuss what it means to belong to these communities. Goals are established for the remaining weeks of the program.
- **Week 2:** Participants discuss relationships, including the qualities they look for in a partner, what their past and current relationships have

been like, and what motivates them to behave in certain ways. Role playing activities are also included in this session.

- **Week 3:** By week 3, participants are more comfortable with the group and the friendships they are developing. Since they are more comfortable sharing personal experiences with the group, the topic of sex and sexual behavior is introduced. Participants discuss HIV and STDs, as well as condom use and negotiation skills.
- **Week 4:** The final session is referred to as “triggers and resolutions.” A facilitator addresses what participants plan to do with the information they have learned and discussed during the four weeks. After this discussion, the facilitator and the participants evaluate the progress of the group. They do this by addressing the goals they established in week one and also by identifying any goals they may have missed. Finally, there is a graduation ceremony where participants are given certificates of merit.

The Deeper Love program differs from The African American Men’s Health Study prevention model in that workshop attendees are not reimbursed for their participation in the workshops. When the program first began, explains McWilliams, participants were charged \$10 dollars to participate in the workshops. Today the \$10 fee is an optional donation to the program.

Deeper Love is a good example of a program that has incorporated an evaluation component, including pre- and post-testing and expected targets that define a successful intervention. Participants are asked to complete three surveys and questionnaires: one before they begin the program, one at the end of the program, and one three months after they complete the program. These surveys assess if participation in the program impacts on participants’ knowledge and attitudes regarding HIV and their ability to assess their own risk, as well as to determine whether there has been a change in the participants’ behavior as a result of participation in the program. Data on the effectiveness of the Deeper Love program is not currently available, but Deeper Love program staff are hopeful that participants will demonstrate at least a 20 percent increase

in HIV knowledge, ability to identify risk behaviors, and changes in attitudes towards condom use after completing the sessions.

“Black Coffee” is a social/support group that has developed out of the Deeper Love workshop. Each month approximately 10-15 members attend Black Coffee to discuss a range of issues and receive support from their peers. This group meets once a month at various off-site locations and has recently met at the Gay and Lesbian Center, group member’s homes, and local coffee houses. They try to have a different location each time so that the program does not get boring. The purpose of Black Coffee is to continue to bring the group together and build a community.

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www.aidatlanta.org/  
educatio.htm#aago

## **Interventions for the Hard-to-Reach**

The programs discussed above focus on men who self-identify as gay or bisexual. However, some individuals may not associate themselves with organizations or social networks that are connected to those communities. Other individuals may not want to engage in or commit to intervention sessions in a formal setting. Conducting HIV prevention with MSM who do not identify as gay or bisexual is a unique challenge. The prevention models described below provides HIV prevention in a low-key setting, using community members to engage their peers in HIV prevention activities.

### **PREVENTION MODEL 1 - AIDS COMMUNITY DEMONSTRATION PROJECT**

The AIDS Community Demonstration Project was developed by the CDC’s Community Demonstration Projects Research Group (1999). This multi-year intervention was directed towards non-gay-identified men who have sex with men and other hard-to-reach populations including youth in high-risk situations, commercial sex workers, injection drug users, female partners of injection drug

users and residents in census tracts with high rates of sexually-transmitted diseases. The project was conducted in Dallas; Denver; Seattle; New York City; and Long Beach, California. Peer volunteers were recruited from the targeted communities to distribute intervention materials in their communities. The goal of the project was to increase condom use with main and non-main partners and/or to increase disinfection of needles and other injection equipment.

The intervention consisted of three components:

- Mobilization of community members to distribute and verbally reinforce prevention messages and materials among their peers;
- Creation of small media materials featuring theory-based prevention messages in the form of role-model stories;
- Increased availability of condoms and bleach kits; and
- Community newsletters, pamphlets, and baseball cards which related real-life stories of community members and their experiences adopting safe behaviors into their lives were distributed in the community.

To evaluate the intervention, anonymous field interviews were conducted prior to the program's implementation and then throughout the intervention. More than 1500 people were interviewed in conjunction with the project, which served over 15,000 people. The evaluation interviews were conducted with all of the targeted sub-populations rather than focusing exclusively on men who have sex with men. Exposure to the intervention increased from 5 percent in the second month to 54 percent during the 27th month. Condom carrying among those exposed to the intervention increased by 74 percent, and those who said they intended to use condoms with their main partner increased from 30 – 44 percent. Those who reported using condoms with their non-main partners increased from 25 – 33 percent.

#### RESOURCES

REQUIRED: Program recruitment advertising  
Program materials

CONTACT: Behavioral Intervention  
Research Branch  
Division of HIV & AIDS Prevention  
Centers for Disease Control  
and Prevention  
Atlanta, GA 30333  
[www.cdc.gov/nchstp/hiv\\_aids/  
projects/acdp/acdp.htm](http://www.cdc.gov/nchstp/hiv_aids/projects/acdp/acdp.htm)

#### CBO PROGRAM - BiCEPPS

Begun in 1997, Bilingual Community Education Prevention Program Services (BiCEPPS) is located in Brawley, California. This small town is located in Imperial County, which geographically is one of the largest counties in California but has a population of less than 50,000, is mostly rural, and has a large undocumented migrant population. Imperial County is nestled in the southeast corner of California and is unique in that its metropolitan center, Mexicali, is on the other side of the Mexican border, which affects the community's economy, workforce, and social services. In addition, the two ports of entry into the United States from Mexicali are major drug trafficking highways.

BiCEPPS utilizes harm reduction and behavioral change principles in its education and prevention activities. These principles are integrated into the outreach program, risk reduction counseling services and educational activities. Felipe Garcia, program coordinator, started the program after he attended an AIDS Community Demonstration Project training in San Diego, hosted by California State University at Long Beach. He recruited and trained peer volunteers for the program and used materials he acquired during his own training.

The program operates out of a 3,200 square-foot storefront off the Main Street of Brawley. There are currently six staff working on the program: a Project Coordinator, a Youth Center Coordinator; a Case Manager/Prevention Specialist; a Bilingual Health Educator; an Outreach Coordinator/Community Educator and an Outreach Worker. In addition, there is a volunteer team of outreach workers/peer educators. The program is funded by the county health department and has an annual operating budget of between \$70,000 and \$79,000, of which

\$10,000 is directed toward activities for MSM.

The program targets five specific populations: injection drug users, youth at risk, women at risk, border crossing populations and men who have sex with men. Eighty percent of the clients are Latino, and 15 percent are migrants.

The largely volunteer staff began distributing general information on HIV and its transmission at various outreach sites around Brawley, including known cruising areas and bars. Flyers were also disbursed, seeking volunteers willing to share their own personal experiences in reducing their sexual/substance use risks, and information was provided about available HIV prevention services and resources.

After a few visits to each site, staff were able to return with information that was very specific to the population. They tried to talk to people they had seen before and get feedback about the impact of the materials they had distributed. By engaging these people in conversation, the staff was able to not only recruit volunteer outreach workers but also gain valuable information about the types of educational materials that were most effective with a particular group or population.

A year later, BiCEPPS began developing their own materials for MSM and once they were convinced the materials were effective, they began translating them into Spanish. Among the materials used was a collection of role model stories, including Garcia's own, detailing how individuals had reduced their risks for HIV infection. As the staff continued to conduct outreach, Garcia would note interesting client stories and write them down. Over time he acquired a sizable collection of first-hand accounts of HIV risk reduction.

The program is comprised of 10-15 percent of clients who identify themselves as gay. "The majority of our clients," says Garcia, "do not identify themselves as either gay or bisexual, although they do have sex with men."

This has proved to be one of the most challenging things about the program, according to Garcia. "The community in which we work, being rural, is rather conservative. Therefore, it is not always readily accepting of our outreach program, given the populations we work with," he says. "It has taken a

lot of patience and tactful communication to build the support network that the BiCEPPS program now has. Many of the men who engage in same sex behavior are not open about their sexuality and can be apprehensive of materials that target the MSM population. Creativity in design and content has proven to be the most effective tools in reaching these clients." BiCEPPS has developed HIV prevention materials with unique advertising and different gift ideas, such as water bottles and lubricant gift bags, that have proven to be effective in reaching this population.

Participants in the program are asked to complete an initial questionnaire addressing attitudes, beliefs, sexual and substance use risk behaviors, injection drug use behaviors, and principles of behavior change and harm reduction. Clients are also offered literature and condoms in the hopes that they will both use and distribute these items to their peers and friends. A risk reduction counselor reviews the initial questionnaire and then a systematic plan of action is developed for, and with, the client. An "ultimate" risk reduction goal is identified, and a plan of incremental steps is outlined to achieve this goal. The steps may vary in number from 5 to 10.

Clients are seen by staff over the course of a few weeks to help them achieve their personal goals. During this process, the program provides whatever is necessary for clients to achieve their goals, including skills building sessions, safer sex supplies, education, and referrals to other STD treatment programs. The program utilizes incentives, such as water bottles and pens, to encourage continued client participation in the risk-reduction counseling program. After clients complete 10 visits, or brings four friends to sign up, they receive a t-shirt.

The program hosts Safer Sex House Parties, or "Rubber Parties," as clients like to call them. It's like a "Tupperware party" of sorts, explains Garcia. A volunteer usually hosts it, and food, drink and music are provided. Partygoers are required to participate in an HIV/AIDS education session, which is generally 30 - 40 minutes long. Throughout the rest of the night, attendees have an opportunity to speak with outreach workers at the party regarding risk behaviors, condom usage, condom negotiation skills, and

other issues. As an incentive for speaking with an outreach worker, the client receives a gift bag of 10 types of condoms and lubricants. The interaction with the outreach worker follows the structured outreach encounter model in which the outreach worker identifies a potential risk reduction goal with the individual, usually targeted for one or two weeks. The outreach worker then makes an appointment with the individual, or provides that person with information on the next scheduled outreach event, so that there can be a follow-up intervention.

BiCEPPS is also currently working on an agreement with the local health department to establish their facility as an alternative test site for HIV, as well as STDs. They have close working relationships with the health department and other local provider agencies to coordinate information sharing and activities. There is also a network of community business owners that support outreach activities by allowing BiCEPPS to use their storefronts, sponsoring events/activities, and donating incentives/gifts.

The BiCEPPS program is working to strengthen its evaluation activities by seeking funding to expand the evaluation component of the program. Currently, in addition to the initial questionnaire conducted with clients, staff administers a follow-up survey after a client has been with the program for three months. This survey assesses changes in attitudes, beliefs, and risk behaviors of clients that may be attributable to participation in the program. In addition, the impact of incremental goal setting is assessed.

BiCEPPS uses many components of the AIDS Community Demonstration Project prevention model. BiCEPPS assessed the community's needs through an informal needs assessment done at high-risk locations such as local bars, and expanded its program to meet those needs. This program has evolved beyond the prevention model by hosting social activities and seeking funding to become an HIV testing site.

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## PREVENTION MODEL 2 - MPOWERMENT

Mpowerment was designed to educate young gay men about HIV prevention. The program was developed and evaluated by Kegeles, Hays and Coates (1996) in Eugene, Oregon. Mpowerment was crafted to address a number of issues facing young gay men: the difficulty in reaching young gay men for individual interventions; the limited effect that individual-level interventions have on social systems as they influence risk behaviors; and the reality that young men rarely seek out HIV prevention information. The program was guided by four principles:

- To relate HIV risk-reduction to other needs of young gay and bisexual men;
- To build on the power of peer influence for young gay and bisexual men to develop a peer-based intervention;
- To mobilize and empower the young gay and bisexual men's community; and
- To use the theory of diffusion of innovations<sup>1</sup> to make safer sex a mutually accepted norm in the young gay and bisexual men's community.

Mpowerment was run by a Core Group consisting of 12 - 15 young gay men and advised by a Community Advisory Board. The Core Group developed the project's name, logo and image, decided how to conduct outreach, and determined what social events would be conducted in conjunction with the intervention. The involvement of young people in the development and oversight of the intervention was intended to instill a sense of ownership of the program in the Core Group participants, as well as both a commitment to HIV prevention and an incentive to carry out the intervention. The Community Advisory Board consisted of "elders" from the AIDS, public health, gay and lesbian, and university communities who provided advice, information and support to the Core Group.

This program consisted of three components. In the first, members of the Core Group and other volunteers conducted informal and formal peer outreach in the community. The informal outreach was intended to engage individuals within each volunteer's social networks in safer sex behaviors and to

recruit additional men into the project. The volunteers learned how to conduct this outreach via small group sessions where safe sex materials were distributed for broad dissemination. The formal outreach involved the development of Outreach Teams who would go to places patronized by young gay and bisexual men to distribute safer sex materials and invite the men to attend other project activities such as large-scale dance parties, movie nights, rap groups at the project center, picnics and hikes.

The second component of this project consisted of one-time meetings called M-Groups. These regularly held groups of young gay men were designed to be fun and interactive. The M-Group session as presented by Mpowerment was structured the following way:

- **Introduction:** Ground rules were presented and participants engaged in an icebreaker exercise. The topic of the first role-play (issues in meeting and getting to know other young men) was not directly related to HIV but it was fun and provided a context for discussing the sexual topics that followed.
- **Clearing up Misconceptions about Safer Sex:** The group discussed questions or thoughts they had about safer sex guidelines. The facilitators primarily focused on clarifying any misconceptions or questions that participants may have had.
- **Eroticizing Safer Sex:** The group next performed an exercise designed to help them think more creatively about safer sex. Participants brainstormed about fun, erotic, safe acts they could do with various parts of the body.
- **Promoting Condom Use:** The group learned about the correct use of a condom by practicing with different dildos and humorous, phallic-shaped objects. Participants received gift packages filled with an assortment of different types of condoms and lubricants.
- **Verbal and Nonverbal Safer Sex Strategies:** The group discussed on various strategies for orchestrating safer sex with partners. They brainstormed and role-played various verbal and nonverbal ways to increase the likelihood of safer sex. Scenarios for negotiating with casual partners and with boyfriends were included.

- **Informal Outreach:** The members of each M-Group were encouraged at the end of the session to try and educate their friends about the need for consistently engaging in safer sex. Participants were asked to commit themselves to invite several friends to an M-Group and were given invitations and safer sex packages to give to friends. By doing this, additional young men were educated and recruited into the program.

The third component of this project was a small-scale publicity campaign in the local gay community. This campaign included articles and advertisements in gay newspapers, outreach materials distributed by young gay and bisexual men and by informal conversations among the Core Group members and those in their social networks.

Pre- and post-intervention surveys with program participants indicated that 77 percent of young men taking part in the intervention had attended at least two of the project activities. In addition, the number of men reporting unprotected anal intercourse decreased from 41 to 30 percent, including decreases from 20 to 11 percent with non-primary partners and 59 to 45 percent with boyfriends. Participants also reported enhanced sexual communication skills after the intervention. Since its inception, Mpowerment has been replicated in three other cities: Albuquerque, Austin and Phoenix.

RESOURCES

- REQUIRED:
- Volunteer trainer
  - Community Advisory Board
  - Core volunteers
  - Program advertising
  - Space for special events and programs

CONTACTS:

- Ben Zovod or MPowermentProject  
Project Assistant  
Eugene, OR
- Center for AIDS Prevention Studies  
San Francisco, CA
- [www.caps.ucsf.edu](http://www.caps.ucsf.edu)

## **CBO PROGRAM - MPOWER**

California's Center for AIDS Prevention Studies (CAPS) conducted a study to test the Mpowerment program in various cities around the country. CAPS implemented Mpowerment in cities with a university population, at least one gay bar and a gay publication. Albuquerque fit the bill, and the program was started in 1997 in collaboration with New Mexico AIDS Services. When the CAPS study ended, New Mexico AIDS Services appealed to the state department of health for funding to continue the intervention. The program, *Mpower*, now has an \$110,000 annual budget and is still supported by the state, in addition to donations and grants from the private sector.

One of the initial Core Group members, John Hamiga, became Connections Coordinator in August of 1997. He organizes the small group safe sex workshops. This group meets on a weekly basis and usually consists of 8-10 participants. John Hamiga is one of two full-time employees: the other conducts outreach and they split the responsibilities of Connections groups. The program runs out of a house, as opposed to a storefront, because, as Hamiga explains, "it makes participants feel like they are part of a family gathering in a home." The program is located in the Knob Hill area of Albuquerque, which is a liberal neighborhood in the city.

The house acts as a central meeting location and all weekly events are held there. The two coordinators, with the help of the Core group, keep the house open almost every day until 10 p.m. The Core group meets three times a month to plan program activities. The theory behind having the Core group plan events is that they will plan things they enjoy and will be more likely to participate, and bring their friends. If events are forced on participants, says Hamiga, they will be less successful.

Hamiga explains that after three years of working with the Core group, the following weekly schedule has developed:

➤ **Monday:** Coffee Talks, discussion groups hosted by various men or guest speakers, including older gay men and members of the gay community who have dealt with challenging issues in their lives. One recent Coffee Talk speaker dis-

cussed the topic of alcoholism in the gay community.

- **Tuesday:** Core group meetings
- **Wednesday:** Alternate between book club and creative writing sessions
- **Thursday:** Generally closed
- **Friday:** Movie nights
- **Saturday:** Outings that are done in collaboration with the Santa Fe Mountain Center. Recent Saturday outings have included white water rafting, camping and rappelling.
- **Sunday:** During the summer months, volleyball and "Wild Café" [open mic night].

The Community Advisory Board serves as an advocacy group within *Mpower*. The board discusses how the program should operate and advocates for coordination between the Core group and the larger organization. The board also does fundraising for the program. Various participants from the community serve on the advisory board: the owner of a gay bookstore, community activists, business owners, and retired community leaders.

According to the program coordinator, *Mpower* strives to make the house a meeting place rather than an AIDS center. Research has shown that young gay men are not interested in going to places that identify themselves solely with HIV/AIDS prevention. Hamiga feels that if *Mpower* had been advertised as an HIV/AIDS program, there might not have been any interest in the program. However, advertising *Mpower* as a gay men's group with HIV prevention as one component of a larger program has made people more receptive. *Mpower* strives to supply visitors with a lot of information and keeps the lobby stocked with reference materials and informational pamphlets. The staff also refer visitors to other support services in the community. The program recognizes that it is important to know each organization's boundaries and offer referrals to those who require services beyond what each CBO has to offer.

Once people feel comfortable in the house and *Mpower* gains their trust, men are invited to participate in the Connections seminar. The Connections

seminar is the intensive HIV prevention component of the program. The Connections group meets once a month to discuss HIV prevention. During Connections, there is a video presentation, discussion of safer sex guidelines, and role-playing. The program is based on CAPS research and basically has three components. First, it is established that the group is a safe place where everyone can be comfortable sharing their thoughts and feelings. Second, the program focuses on correcting any misconceptions about sex, HIV/AIDS, and STDs in general. Finally, the program deals with safer sex and ways to eroticize safer sex.

As the program has become more successful, outreach activities have declined. This is largely attributed to the staff being occupied with other events. The Core group has discussed the need to reengage in outreach. However, it seems as though the Core group needs motivation from one of the coordinators to actually conduct outreach. The Core group struggles with issues of motivation due to personal events in their daily lives.

The *Mpower* program as implemented by New Mexico AIDS Services has provided a community space for young men in addition to providing HIV prevention information. While the Connections seminar is an important component of the program, New Mexico AIDS Services does not focus on HIV prevention education and information until the young men have become comfortable in the group setting. The house and group activities effectively recruit members, rather than using the Mpowerment model of relying on participants to bring their friends to prevention education sessions.

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[www.nmas.net/programs/mpower.html](http://www.nmas.net/programs/mpower.html)

### **PREVENTION MODEL 3 - HLS**

Hermanos de Luna Y Sol (HLS) was developed by Diaz and Fernandez-Peña (1998) for immigrant, Spanish-speaking gay/bisexual men in San

Francisco's Mission district. The program focused on modifying high-risk sexual behaviors. These behaviors are believed to result from sociocultural factors that contribute to decreased self-esteem, the perception of low sexual control, a sense of social isolation, and fatalism regarding the inevitability of HIV infection.

HLS consisted of three components. Initially, bar outreach and recruitment involved gay Latino bar patrons who were asked to answer eight questions. This short survey was intended to help participants reflect on HIV/AIDS issues and safer sex as well as to promote discussion and awareness of HIV transmission and prevention. In addition, the survey served as an advertisement and recruitment for the group sessions. The survey questions were as follows:

- How do you identify yourself with respect to sexual orientation?
- Where, other than the bar, can you meet, talk and have fun with other Latino gay men?
- As a Latino gay man, what concerns you the most?
- Please tell me how important are the following concerns to you (to be rated on a 4-point scale of relative importance). Lovers/boyfriends; sexuality; family; friendships; your health; work/profession; rejection of gay people; social acceptance.
- Who can you talk to about these concerns on a regular basis?
- On a scale of 1-10, how concerned are you about HIV/AIDS?
- What is the most difficult thing for you about the practice of safer sex?
- What has helped you most to practice safer sex?

After the interviews, participants were given condoms, tokens for non-alcoholic drinks at the bar and cards with the name, logo and phone number of the program. Those who called the number were enrolled into the group sessions.

The second component of HLS consisted of four small group sessions each lasting two hours. Two Latino gay men trained in health education using the principle of empowerment education facilitated

these sessions.<sup>2</sup> Each session was devoted to a specific topic.

- **Session 1:** An examination of participants' lives as Latino gay men, including experiences of rejection/abuse for being gay, coming out to family, sources of social and community support, lover/boyfriend relationships, and related hardships of immigration, poverty, and minority status.
- **Session 2:** An in-depth examination of the impact of AIDS in the participants' lives, including their sexuality.
- **Session 3:** An examination of the practice of safer sex—including barriers and facilitators.
- **Session 4:** Training for the group in the use of the safer sex journal. The sessions are reviewed and there is an integration of the lessons learned in the group.

Participants were compensated \$10 for each of the first three sessions and \$20 for the last session. Food was provided at each session. In addition, those who participated in all four sessions received T-shirts with the program's name and logo.

The third component of HLS consisted of follow-up activities to ensure that safe sex behaviors were sustained over time. Participants were encouraged to keep safer sex journals and take part in social support groups and activities. They received a program newsletter and access to prevention case management services. Social activities were available to graduates of the program.

The preliminary findings of the program found that the program's effectiveness was promising. Pre and post-intervention data identified increases in anal intercourse but decreases in the number of sexual partners from 8.75 to 4 percent. In addition, 80 percent of those reporting increases in anal intercourse reported consistently practicing safer sex. For all men in the follow-up sample, consistent condom use increased from 50 to 58 percent for insertive anal intercourse and from 33 to 58 percent for receptive anal intercourse.

#### RESOURCES

**REQUIRED:** Interviewer(s) for bar outreach survey  
Session and social support group facilitators

Space for sessions and support groups  
Access to prevention case managers

#### CONTACTS:

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[www.caps.ucsf.edu/projects/hlsindex.html](http://www.caps.ucsf.edu/projects/hlsindex.html)

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#### CBO PROGRAM - HERMANOS DE LUNA Y SOL

Hermanos de Luna y Sol is part of the prevention program at Clinica Esperanza in the Mission District of San Francisco, an area with a high Latino population. The Hermanos program is focused entirely on Latinos and funded through the youth component of a GAP grant as well as the CDC and the city of San Francisco.

Initially, participants were involved in four sessions over four weeks that addressed HIV prevention in the context of the cultural, familial and social issues that affect gay Latinos. When interest in the program grew, staff increased the sessions to six weeks and established a follow-up group, comprised of those who completed the program. This group meets once a week.

The breakdown of the sessions is as follows:

- **Week 1:** In week one, guidelines are established through introductory exercises. The ground rules are designed to give people a sense of safety so that they will feel more comfortable sharing their life stories and experiences.
- **Week 2:** The discussion focuses on the difficulties of being gay and Latino, and how each of the group members feels about being gay.
- **Week 3:** After a series of exercises aimed at making people feel more at ease with the group, the

discussion begins to focus on sexual behavior.

- **Week 4:** More in-depth discussion about sex. This week, the discussion delves deeper into sex patterns, fears, sexual experiences, and intimacy.
- **Week 5:** Participants begin to talk about HIV and how it has affected individual members of the group. The goal is to assess each member's understanding of HIV. During this discussion, it is often revealed that the group is a mix of HIV positive and negative individuals.
- **Week 6:** HIV/AIDS is discussed in more depth. Individuals assess their own behaviors and determine if and how those behaviors put them at risk for HIV. Safer sex negotiation skills are explored within the group.

Some of the program staff would like to expand the program to eight weeks to ease the transition between the small group and the large, follow-up group. The six-week group typically consists of 8-12 members while the follow-up group consists of about 40-45 members who sporadically attend meetings.

The staff currently consists of a three-person team. There are also two community health educators, one focusing on youth and one on recruitment activities. The program relies on about 10 volunteers/participants, who help with the organization of special events, such as the program's annual picnic.

Participants in the six-week sessions are recruited by word of mouth and through bar outreach. A

more comprehensive recruitment plan, which includes a presentation about the program, is under development.

Evaluation is an on-going process consisting of three components. First, a behavioral risk assessment survey is given to participants when they begin the program. The survey asks questions about sexual activities and basic information about HIV/AIDS. The same questionnaire is given four months after participants complete the program. Dr. Diaz, the program's founder, also visits each group at the end of the sessions to evaluate the program and ask participants questions.

Thus far, the program has been very successful. Program coordinator and primary facilitator Mario Huerta says, "In beginning an HIV prevention program it is important to have enough funding and a carefully thought out strategy. It is also of utmost importance to create a program that takes into account both the psychological and spiritual well-being of the participants."

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hlsindex.html

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<sup>1</sup>Community change comes about through a process of informal communications and modeling by peers within their interpersonal networks (Rogers, 1983)

<sup>2</sup>Diaz (1998) notes that empowerment models of interventions do not "transmit" information or resources unless requested. Instead, it involves engaging the participants in "a reflective dialogue that promotes critical thinking and self-observation about matters of crucial importance to the group."

## EVALUATION OF HIV PREVENTION PROGRAMS

**E**valuation is critical to the development and continued success of HIV prevention programs. Evaluation provides an opportunity for continued improvement in prevention programs, and ensures that CBOs meet prevention program goals in a cost-effective manner. In addition, evaluation helps to identify what works and what doesn't work, and contributes to program replication in other settings.

Early HIV prevention initiatives developed as a rapid response to the epidemic. As systems of care matured and HIV treatments developed, prevention efforts were assessed for their impact on changing risk behaviors. Over time, research has generated important information on best practices in HIV prevention, including those highlighted in this guide, for men who have sex with men.

The need to demonstrate program effectiveness is increasingly important to the survival of individ-

ual programs. Funders are emphasizing evaluation as a critical component of all HIV programs and using the results of evaluations as the basis to initiate or continue funding.

For these reasons, CBOs would be well advised to incorporate evaluation into their prevention programs at the point of inception and to consider it an integral part of their prevention efforts. Evaluation can be a valuable tool to CBOs not just in securing future funding for programs, but also in ensuring that their clients are served efficiently and effectively. CBOs who routinely incorporate evaluation into their prevention activities realize its benefits in numerous ways. For more specific and comprehensive information on evaluating prevention programs, visit the following website: [http://hivinsite.ucsf.edu/prevention/evaluating\\_programs/](http://hivinsite.ucsf.edu/prevention/evaluating_programs/).

## TAILORING HIV PREVENTION PROGRAMS TO FIT YOUR NEEDS

This guide presents model prevention programs and examples of how they have been implemented in specific communities. One of the central tenets of prevention research is that one size does not fit all. Yet there are elements of each model presented here that can be applied to diverse populations with similar impact. CBOs can adapt these models to meet the individual needs of the client populations they serve. It is important to maintain the core elements of each prevention model while customizing the delivery of the HIV prevention message.

For example, the popular opinion leader intervention described above was tested primarily on white gay men who regularly visit gay bars, but the principles on which it is based – that peer influence, behavioral standards and social norms may play a powerful role in influencing personal behaviors – apply to a broad range of social networks. While this particular model was first tested in the early 1990’s

with gay men in the South, it has been successfully implemented with diverse populations around the country.

Community-based organizations bring to prevention work an expert knowledge of the communities they serve. What CBOs can do with this knowledge is to take the models presented here and shape them according to the culture of their communities, the available resources, and the strength and expertise of their staff. In addition, CBOs can ensure the effectiveness of their prevention efforts by seeking input from the groups or individuals they plan to serve.

The challenge of meeting the constant demand for new, innovative, and successful HIV prevention strategies can only be addressed through the development of additional HIV prevention models for diverse communities. Prevention works. Each CBO should determine how and in what form HIV prevention can reach the people it serves.

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