California Collaborations in HIV Prevention Research: Dissemination Project

INTRODUCTION TO THE DISSEMINATION PROJECT

To support community-based research efforts in California, the State Office of AIDS (OA) and the Universitywide AIDS Research Program (UARP) joined forces in 1998 to provide funding for HIV/AIDS community research collaborations. This program is built upon the collaborative research endeavors initiated by UARP in 1995 and community-based research efforts sponsored by OA. The UARP-OA initiative fosters partnerships among researchers, community-based AIDS service organizations, and local health departments. As a coordinated response to a statewide public health need, it:

- Provides support for evidence-based planning, design, delivery, and evaluation of prevention interventions
- Builds community research capacity
- Disseminates information on HIV/AIDS prevention interventions

UARP and OA have jointly funded 38 community collaborative HIV/AIDS prevention intervention projects. The *California Collaborations in HIV Prevention Research: Dissemination Project* is designed to disseminate information on these research projects and other resources developed through a range of UARP-OA initiatives. All of these materials serve as resources to be used by local health departments, community-based organizations, and research organizations in support of their work in HIV/AIDS prevention and evidence-based planning.

The *Dissemination Project* publishes modules on behavioral risk research, intervention outcome research, and translation research and the Research Summaries. The research modules describe projects that focus on the delivery and content of interventions; the modules do not evaluate prevention intervention effectiveness.

The *Dissemination Project*'s Research Summary series is composed of systematic reviews of HIV/AIDS prevention interventions among peoples of color throughout the United States. These reviews were developed prior to the completion of the UARP-OA– funded community collaborative projects, and thus do not include those California prevention interventions.

The final printed materials in the *Dissemination Project* are Module 7, Module 9, and the second Research Summary. These, as well as all past and future modules and Research Summaries, will be available in PDF format on the UARP website: **http://uarp.ucop.edu.**

GUIDANCE FOR INTERVENTION MODULES

This guidance provides general background and direction on use of the UARP-OA intervention modules. It includes an overview of the literature on community collaborative research, discussion of the issues surrounding adapting and using evidence-based interventions and evaluations in community settings, an overview of the intervention research modules, and guidelines for using the modules. Program planners and coordinators, policy and resource allocation bodies, and researchers and evaluators will be able to adopt some of these materials for their HIV prevention work.

Collaborative Research and Adaptation of Evidence-based Interventions— Current Challenges

One of the critical issues community-based organizations (CBOs) face is the question of how they can best make use of tested interventions with the populations they serve. While

Dissemination Project Publications to Date

- Module 1: *HIV/AIDS Behavioral Risk Research on African American Gay, Bisexual, and MSM*
- Module 2: *The Los Angeles Transgender Health Study*
- Module 3: *Youth Drug Injectors, Needle Exchange Use, and HIV Risk in San Francisco and Santa Cruz*
- Module 4: *Strategies and Tools for Successful Implementation and Evaluation of an Evidence-based Intervention*
- Module 5: *HIV Prevention Outreach Programs in Santa Barbara*
- Module 6: *HIV/AIDS Prevention Intervention Among Urban, At-Risk African Americans*
- Module 7: *HIV Prevention Program for Young Latino Mothers and Fathers*
- Module 8: *Asian and Pacific Islander MSM HIV Prevention Evaluation Study*
- Module 9: *Multi-Infection HIV Prevention Counseling and Testing Intervention*
- Research Summary: *Systematic Review of HIV Behavioral Prevention Research in Heterosexual African Americans*
- Research Summary: *Systematic Review of Interventions to Prevent HIV Infection in MSM of Color*

The Role of Community Collaborative Research in Building Capacity

A general definition of capacity building is a process or activity that improves the ability of a person or entity to "carry out stated objectives."* In practice, capacity building is often equated with the strengthening of organizations and health systems in order to develop and implement effective health program strategies. Lack of capacity therefore refers to the inability to develop such programs due to a number of issues—inadequate knowledge or information or lack of adequate resources.

The UARP-OA Community Collaborative Research Initiative (CCRI) serves a key role in building the capacity of both CBOs and research institutions to develop sustainable HIV prevention programs. It allows for interaction and a "technology transfer" of information and skills between organizations that have historically not been linked effectively—grassroots community organizations and university-based research institutions. The CCRI initiative allows the opportunity for relationship building between CBOs and academic researchers, thus improving their ability to work toward developing effective interventions.

*A. Lafond, L. Brown, and K. Macintyre, "Mapping Capacity in the Health Sector, *International Journal of Health Planning and Management* 17 (2002): 3–22.

resources are available for implementing interventions that have been shown to be effective with certain populations,[1] little guidance is available on systematic processes for adapting, translating (or tailoring), using, or evaluating these interventions in community settings. In addition, current interventions scientifically proven as effective for community-specific implementation are few and far between—other than those included in the Centers for Disease Control and Prevention's "Compendium of Effective Interventions."

Thus, CBOs face challenges in three broad areas when considering the use of an existing intervention: accessing information on interventions, finding an appropriate intervention, and tailoring the intervention to their own needs, organizational setting, and client population.

Accessing Information on Interventions

How does a CBO wanting to implement a tested intervention begin? How do they access information on interventions?

Easily accessible information and details on tested interventions with related evaluation materials are not always widely available. Thus, in most cases, CBOs rely on information from CBO and public health networks, rather than academic sources.[2]

An alternative strategy is becoming available. Although the process of translating research-based interventions has yet to be studied systematically, the CDC and a network of researchers participating in the Replicating Effective Programs (REP) project have been involved in disseminating research-based interventions and supporting this dissemination with a technical assistance support system based on a train-the-trainers model.[3] CDC has also invested funding into this effort with the implementation of the Diffusion of Effective Behavioral Interventions (DEBI) Project. This approach[4] relies on CBOs' identifying and adhering to the core elements of interventions that report significant behavior change outcomes, while tailoring key characteristics to fit the unique needs and context of their client populations.[5]

Matching the Intervention to the Organization and Population

What are the key issues that organizations consider when deciding on the adoption and/or adaptation of an intervention? A handful of studies identify these points: contextual issues, key characteristics, and features specific to organizations.

Contextual factors that affect the delivery and selection of interventions by CBOs and local health departments include structural or external conditions; cultural norms; client factors; organizational mission, structure, and operations; staffing resources; and the program's relevance, utility, and effectiveness in meeting the needs of populations.[6] Community organizations base their assessments of the appropriateness of an intervention on a number of key characteristics:[7]

- Degree of compatibility with organizational philosophy about HIV prevention
- Perceived relevance to local culture
- Evidence to support its use
- Feasibility of implementing the intervention
- Ability to fill existing service gaps

1. Centers for Disease Control, "Compendium of HIV Prevention Interventions with Evidence of Effectiveness," in *HIV/AIDS Prevention Research Synthesis Project,* Atlanta: CDC, March 1999.
2. H. Barton-Villagrana, B. J. Bedney, and R. L. Miller,, "The Function of Peer Relationships Among HIV Prevention Providers," *Journal of Primary Prevention* 23 (2002), 217–36.
3. M. Neumann and E. Sogolow, "Replicating Effective Programs: HIV/AIDS Prevention Technology Transfer," *AIDS Education and Prevention* 12, supp. A (2000): 35–48.
4. See E. M. Roger, *Diffusion of Innovations,* 4th ed., New York: Free Press, 1995.
5. J. Kelly et al., "Transfer of Research-based HIV Prevention Interventions to Community Service Providers: Fidelity and Adaptation, *AIDS Education and Prevention* 12, supp. A (2000): 87–98.
6. E. Trickett, "Context, Culture and Collaboration in AIDS Interventions: Ecological Ideas for Enhancing Community Impact," *Journal of Primary Prevention* 23 (2002): 157–74.
7. R. Miller, "Innovation in HIV Prevention: Organizational and Intervention Characteristics Affecting Program Adoption," *American Journal of Community Psychology* 29, no. 4 (2001): 621–47.

Also essential to this decision-making process are organizational commitment and positive attitudes toward the intervention, as well as the availability of technical assistance and other resources to support implementation.

Adapting and Translating Interventions

How does a CBO choose an intervention and, once the choice is made, adapt it? As mentioned above, community organizations often gravitate to interventions that are accessible and *known* in the local network of providers. While these interventions may be responsive to community needs, they may not have gone through a rigorous testing to prove their effectiveness. In other cases, a CBO may select a tested intervention because it has credibility with funding organizations, although it may not be specific to their target population.

In either case, an intervention almost always requires some type of tailoring to fit the organization and its constituency. A variety of strategies are employed to enhance cultural appropriateness, including:[8]

- **Peripheral strategies,** such as packaging that focuses on a certain "look" identified as appealing to certain populations
- **Evidential strategies,** use of evidence of the effectiveness of an intervention
- **Linguistic strategies,** translation of the language used in an intervention for a particular population
- **Constituent-involving strategies,** incorporation of the experiences of community members into the intervention
- **Sociocultural strategies,** placement of the intervention within a broad context of health and life issues for a community

Community Collaborative Research—Intervention Outcome Modules

Community collaborative research addresses the issues of replication, adaptation, and use of evidence-based interventions by partnering research scientists and community providers and by ensuring that research, evaluation, and intervention approaches are realistic and grounded in the real world of community organizations working with populations greatly affected by the epidemic.[9] The field of collaborative research facilitates adaptation, development, implementation, and testing of interventions. Use of related materials specifically tailored for populations is a continuing part of this work.

How UARP-OA Collaborative Projects and Intervention Modules Address Current Challenges

UARP-OA collaborative projects are designed to ensure that equal partnerships between academics and community organizations drive the testing and implementation of interventions in community settings. One of the key goals of the *Dissemination Project* is to make materials from evaluation research available to a range of stakeholders: community-based organizations, researchers, and public health providers. The projects presented in the modules represent investigators' work, the collaborative process undertaken, evaluation challenges, and solutions in development of outcome research projects for populations specific to the California context.

Modules include such projects as interventions serving people of color, IDU, youth, women, MSM, and HIV prevention for positives. All modules provide details on the research project, including key findings and collaborative research strategies. The instruments, resource tools, and other sample materials developed to support delivery of the interventions are also included.

In addition to providing key recommendations for community collaborative research within the California HIV prevention programming context, the studies presented in these modules identify methods for placing intervention evaluation in the context of real community settings and tailoring them to the actual people they serve. These collaborative strategies inform the evaluation findings, and in many ways they offer a deeper and more complex perspective on service delivery and evaluation than any one set of outcome findings could provide.

These studies also provide important insights into interventions that are being developed, tested, and implemented, and are therefore useful for health department and CBO intervention planning. Organizations will need to make their own determinations about the appropriateness of the interventions, using the considerations outlined in the preceding section. Applicability will vary depending on the methodological approach and findings from the intervention.

How the Interventions Included in the Modules Have Been Tested—And What This Tells Us

Evaluation research can be charted along a continuum—from initial research on populations to short-term and long-term outcomes of the intervention. Due to their differing purposes and contexts, the UARP-OA evaluation projects include a range of approaches that spans this continuum. The following paragraphs provide an overview of evaluation approaches represented in specific modules and identify how data from various evaluation approaches can be used by stakeholders for intervention design and delivery. Table A links the various modules to the evaluation methods they employed.[10]

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8. M. W. Kreuter et al., "Achieving Cultural Appropriateness in Health Promotion Programs: Targeted and Tailored Approaches," *Health Education & Behavior* 30, no. 2 (2003): 133–46.

9. See K. H. Stanstad et al. (eds.), "Collaborative Community Research: Partnerships Between Research and Practice," *Health Education & Behavior* 26, no. 2 (1999).

10. Although the collaborative research projects illustrated here did not report on intervention efficacy, they did contribute to the understanding of the community context in which such projects occur. Upcoming modules reporting on more-recent research will, as appropriate, include effectiveness data.

Formative evaluation (behavioral risk and context assessment) is used to collect data on consumer populations to ensure that an intervention is targeted to specific behaviors and specific psychological, social, and cultural contexts. Formative data may be used to improve implementation, solve unanticipated problems, and make sure participants are progressing toward desired outcomes.

Process evaluation (intervention implementation) is used to measure the implementation of an intervention in terms of fidelity to core elements, appropriate targeting, and implementation procedures. It describes the components of the intervention, who it is reaching, and how it is implemented. Process data are often used to make sure the intervention is being implemented as planned and is reaching intended populations successfully.

Outcome monitoring (pre- and post-intervention measurement, no control) is used to measure short-term outcomes when control groups are not available or ethical. It is limited in its ability to attribute changes to an intervention, but that can be mitigated somewhat through time-series data collection. Outcome monitoring can be a useful early test for an intervention being implemented at a new site or within a new population. Depending on the number of study participants, this approach can reveal that short-term changes may have taken place, although not necessarily that they are due to the intervention.

Outcome evaluation (quasi-experimental design, nonrandomized control groups) is used to measure short-term outcomes and attribute outcomes to an intervention, in cases where randomization is not feasible. Depending on the number of study participants, this approach can reveal that short-term changes are likely to have occurred as a result of the intervention.

Outcome research (experimental design, randomized control groups) is used to measure short-term outcomes and

Table A Evaluation Methods Employed for *Dissemination Project* Modules

	Evaluation Method				
Module	**Formative Evaluation**	**Process Evaluation**	**Outcome Monitoring**	**Outcome Evaluation**	**Outcome Research**
1: HIV/AIDS Behavioral Risk Research on African American Gay, Bisexual, and MSM	✔	✔			
2: The Los Angeles Transgender Health Study	✔	✔			
3: Youth Drug Injectors, Needle Exchange Use, and HIV Risk in San Francisco and Santa Cruz	✔	✔			
4: Strategies and Tools for Successful Implementation and Evaluation of an Evidence-based Intervention		✔			
5: HIV Prevention Outreach Programs in Santa Barbara	✔	✔			
6: HIV/AIDS Prevention Intervention Among Urban, At-Risk African Americans	✔	✔		✔	
7: HIV Prevention Program for Young Latino Mothers and Fathers		✔	✔	✔	
8: Asian and Pacific Islander MSM HIV Prevention Evaluation Study	✔	✔	✔	✔	
9: Multi-Infection HIV Prevention Counseling and Testing Intervention		✔			✔

Guidelines on Use of Modules

Purpose

The intervention modules are intended to support and provide a supplemental mechanism for evidence-based planning, design, implementation, and evaluation for intervention services through the use of UARP-OA–funded community collaborative research, including behavioral risk assessments, intervention outcomes, and translation research.

Using the Modules

While best practices for adaptation/translation of tested interventions have yet to be firmly established, the following describes generally the process and practice of using modules and supporting materials for intervention work.

Assessing a Module's Relevance to Your Organization

Step 1: Assess your organization, population, and environmental context, outstanding needs, and available resources with respect to the use of evidence-based prevention and evaluation.

Step 2: Review available intervention and evaluation strategies, findings, and tools in modules, and determine the general fit with or responsiveness to your organization's needs, context, and target population.

Step 3: Based on the results of steps 1 and 2, determine how the relevant intervention or evaluation materials and strategies could best be tailored for use by your organization for the population you intend to serve.

Adapting and Adopting Strategies, Findings, and Materials to Your Organization

Select the components of intervention or evaluation strategies and the materials that speak to specific issues and situations facing your organization, population, and intervention needs. For example, it may be possible to select parts of an evaluation tool that answer questions you have about an intervention or population. Or there may be components of an overall intervention approach that provide relevant support for your work. Also keep in mind that evaluation findings are linked to core elements, so eliminating those elements could impair the effectiveness of the intervention.

- **Behavioral risk findings** can be used to guide program planning and intervention delivery.
- **Intervention findings and materials** can be used for design and delivery of interventions.
- **Tested interventions** can be adapted for implementation in local settings. Maintaining fidelity to core elements is fundamental, although key characteristics should be tailored to local context and population.
- **Research protocols and instruments** can support targeted data collection on local populations and intervention effectiveness, either in their original form or after adaptation to the individual context.
- **Training materials** can support training on delivery of interventions and implementation of program evaluation—again, either as provided or in customized form.
- **Tested interventions and existing interventions** can be linked to provide evidence-based support for existing interventions.

attribute outcomes to an intervention. The control group is randomized in terms of population or site, controlling for the influence of variables unrelated to the intervention. Depending on the number of study participants, this approach can reveal short-term changes as a result of the intervention.

All of the intervention projects tell us about outcome monitoring in community settings, collaborations among multiple partners, tailoring and implementation of interventions, documentation of the process of implementation, consumer responses to interventions, and consumer populations in California.

Evaluation Research in Community Settings

Evaluation of community-based HIV prevention interventions is complex for a number of reasons, including the need for comprehensive service delivery; the challenge of developing linkages among research, public health, and consumer groups; recruitment challenges caused by the multiple contextual factors affecting consumer groups; resource limitations; infrastructure issues; and measurement challenges. In answer to these issues, the UARP-OA Community Collaborative Research Initiative (CCRI) has created opportunities for partnerships between researchers and public health providers to ensure that evaluation and intervention methods are realistic and appropriate to populations being served.

MODULE 7

HIV Prevention Program for Young Latino Mothers and Fathers

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Module in a Nutshell

Reports on:

- HIV prevention for young Latino parents
- Insights and life views of young Latino fathers
- A culturally appropriate prevention intervention
- Collaboration between CBOs and academic researchers

Provides:

- Insight in using qualitative research methods to inform intervention and study design
- Analysis of qualitative data from focus groups and key informant interviews
- Tools for an enhanced HIV prevention program

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PURPOSE OF MODULE 7

Module 7 provides findings and supporting materials from a two-phase study that aimed to develop and test the feasibility of a culturally appropriate HIV prevention program targeting adolescent parents. The collaborative research project took place from 1999 to 2002 in East Los Angeles. The principal investigators were Deborah Koniak-Griffin, UCLA School of Nursing; Barbara Kappos, Bienvenidos Family Services; and Jerry Tello, National Latino Fatherhood and Family Institute (NLFFI). Janna Lesser, UCLA School of Nursing, served as project director. The findings present informative data on young fathers and mothers of predominately Latino background.

Results from the two phases of the research project yield important insights on issues affecting young parents' risk-taking behaviors and on barriers to HIV prevention, and they provide outcome data for preliminary evaluation of the 12-hour, six-session intervention for young parents. This module presents contextual data and risk behaviors of young parents, and the results of the process and outcome evaluations of an HIV prevention program, as well as information about the collaborative team.

RESEARCH PROJECT

The study described in this module grew out of a longitudinal research project evaluating the effectiveness of an HIV prevention program for predominately Latina, adolescent mothers in Los Angeles.[1,2] As the project progressed, it became clear that involvement of both partners in HIV prevention was necessary, since the majority of HIV infections among young people occurs through sexual contact.[3] A team of researchers from UCLA collaborated with staff from Bienvenidos Family Services and its NLFFI program (which had experience with culturally based intervention programs for Latino males) to develop and pilot an HIV prevention program targeting young Latino couples.

> Among teenagers, the male is more likely to be the one who makes the decision to use a condom.[4]

Previous research had not examined the involvement of teen fathers in HIV prevention programs, in part due to the difficulty of recruiting this hard-to-reach population. Although there is a body of research that examines the role of maternal identity as a motivation to reduce risk behaviors, data describing the experience of young men and fatherhood is lacking. The collaborators designed a two-part study: In Phase 1 they would seek to determine effective recruitment and retention methods, as well as to understand teen fathers' perceptions of fatherhood and risk, and use this information to inform the HIV prevention program for couples. In Phase 2 they would pilot-test a couple-focused HIV prevention intervention.

A variety of research methods were employed for the study design—both qualitative and quantitative. The study design was based on the model for Participatory Action Research (PAR),[5] which seeks to strengthen the capacity of individuals and groups to improve their lives through their own efforts. The collaborators also agreed that utilizing these ethnographic research methods offered the opportunity to view life experiences through the eyes of the young fathers.[6]

More detailed descriptions of both phases of the project are presented below. An overview of each phase's purpose, objectives, and research methods is included.

Background

In Los Angeles County, the adolescent birth rate exceeds that for both the country and the state, and 80% of teen births are to Latinas.[7] As a group, young pregnant Latinas and young Latina mothers and their infants face a host of AIDS risk factors:

> "It has been estimated that at least half of all new HIV infections in the United States are among people under 25, and the majority of young people are infected sexually."[3]

- Nationally, rates of HIV infection among people of color are increasing relative to those of other groups. In 2000, for example, Hispanics made up 12% of the population, but 19% of new HIV infections.[8]
- According to the Centers for Disease Control and Prevention, "it has been estimated that at least half of all new HIV infections in the United States are among people under 25, and the majority of young people are infected sexually."[3]
- Inner-city youth in particular are at risk for HIV, due to factors that accompany poverty and disenfranchisement, including substance abuse, early initiation of sexual intercourse, a history of sexually transmitted infection (STI), and incarceration.
- In 2000, females accounted for 61% of new HIV cases in the 13–19 age group,[3] but only 30% of new cases in the general population.[8]
- Due to physiological factors, both pregnancy and adolescence increase the risk of HIV infection for women.*

*Differences in the cervix during pregnancy and adolescence (as opposed to other times of life) are thought to contribute to risk for STDs, including HIV. For example, a protective lining over the cervix, present in mature women, has yet to develop in adolescents. Likewise, the cervix begins to open during late pregnancy. In both cases, the result is to further expose highly vascular tissue that is known to be the primary invasion site for chlamydia and gonorrhea, and may be for the AIDS virus as well.[9]

Teen mothers are motivated to change high-risk behaviors by protective feelings for their children.[10] However, dynamics regarding gender roles and power in sexual relationships mean that these women are often unable to, for instance, make the decision about whether to use a condom during intercourse. Until now, little information has been available on the concerns of adolescent fathers for their children, or on the effect of partner involvement and couple interactions on sexual negotiation and decision making in relationships. Understanding the teen father's perspective was seen as a prerequisite to the development of an intervention that would address feelings of paternal identity, responsibility, and protectiveness as motivators for risk reduction.

The following sections describe the two phases of the study: the formative evaluation and the intervention pilot study.

Phase 1—Formative Evaluation

Summary and Purpose

The purpose of Phase 1 of the study was to (1) investigate the factors that affect young fathers' perceptions of fatherhood and risk for HIV and other STIs, and (2) develop recruitment and retention methods that would be effective in persuading this hard-to-reach population to participate in an intervention study. The aim was to utilize the findings in the development and pilot testing of a couples intervention.

Specific objectives of Phase 1 were:[11]

- To identify young men's feelings related to their experience of fatherhood
- To discover young fathers' perceptions of their risk for HIV and resources for prevention
- To discover the socioeconomic and cultural issues that young fathers perceive put them at risk for and/or prevent them from contracting HIV and STDs
- To identify young fathers' perspectives about effective recruitment and retention strategies

The use of ethnographic methods provided an opportunity to view life experiences through the eyes of the young fathers.

Phase 1 of the study also provided the collaborators with an opportunity to begin integrating community-based principles and practices with more-academic health behavior theories. Tello's theoretical framework, "Healing the Wounded Spirit,"[12] describes "rites of passage" that can help youth transition into adulthood and learn to make healthy choices. This framework served as the basis for developing an alternative decision-making process for reducing HIV risk behaviors, which was then incorporated into the adapted intervention.

Research Methods

Two ethnographic methods—focus groups and key informant interviews—were used to carry out the above objectives. These qualitative methods were selected because they provide rich detail and data that can describe social norms, values, and life experiences of a particular population, in this case young Latino fathers.

Eligibility and Recruitment

All Phase 1 participants were young Latino men residing in the East Los Angeles area. To be eligible to participate, the men had to be a father or expectant father, 14–19 years of age, and speak English or Spanish. Participants' average age was 19 years.

Young fathers were recruited from NLFFI, which provides family- and community-oriented services to Latino men.

Ten participants from the focus groups were then asked to participate in key informant interviews. Participants received $25 as compensation for time spent in either a focus group or an interview.

Data Collection

The process of collecting data from the Phase 1 focus groups and one-on-one interviews is described below.

Community involvement enhances the odds that intervention activities will be socially and contextually appropriate.[6]

Focus Groups

A series of four focus groups was held with a total of 26 young male participants. Each focus group was led by two facilitators, one female and one male—one from the staff of Bienvenidos/NLFFI and one from the academic collaborator. A list of questions developed by the collaborative partners (Appendix A) was used to direct the discussion. A trained research associate (a UCLA graduate student in public health) audiotaped the groups, recorded notes, and documented interactions of the participants.[13] The observations were used to compile detailed notes within 24 hours of the session, and audiotapes were transcribed for analysis. The data were then read and reread, coded, categorized, and ultimately organized into themes.

At the conclusion of each focus group, the young men participating filled out a questionnaire in order to collect some demographic and risk behavior data.

Key Informant Interviews

The project director (a UCLA researcher) conducted the 10 key informant interviews. The interviewees had also participated in the focus groups. The interviews provided more in-depth perspective on the culturally specific themes and ideas raised in the focus groups.

Young Latino Fathers' Areas of Concern[13]

- Growing up in poverty, in a climate of violence, drug and alcohol abuse, and social oppression
- Gang membership
- Taking on the paternal role, which includes leaving the gang, gaining empathy for others, and modifying their view of male-female relationships

The interviews were conducted at least one week after the focus group the participant had attended. In the interview, the young man was asked to review lists the researchers had compiled from the focus group data, and to choose any words or phrases that accurately reflected his own experience. This ethnographic technique is used to check the initial interpretation of the data.[13]

The themes that emerged in Phase 1 (see sidebar: Young Latino Fathers' Areas of Concern) were used to inform the intervention curriculum to assure that it would be culturally appropriate and effective with the young fathers, as well as their female partners, in Phase 2.

Phase 2—Intervention Pilot Study

Summary and Purpose

The purpose of the second phase of the study was to pilot test for feasibility an HIV intervention targeting young couples and to evaluate its effectiveness using a quasi-experimental design. The HIV prevention program intervention curriculum, *Respeto/Proteger* (Respect/To Protect), represents an integration of strategies drawn from three sources:

- Tello's theoretical framework for practice, which is based on culturally rooted concepts and values of the indigenous teachings and writings of the ancestors of many Latino people[12]
- Specific HIV prevention activities borrowed from an adapted form of Be Proud! Be Responsible![2,14]
- Data collected in Phase 1, including issues of trust, communication, and mutual respect in intimate relationships

Because the study was designed to develop and pilot test the intervention for feasibility, both process and outcome evaluation methods were used.

Specific objectives for Phase 2 were:

- To describe the characteristics of young men and women participating in an HIV prevention program for couples (sociodemographics, duration of relationship, quality of relationship, substance use, depression, history of abuse, past and present sexual behaviors).
- To conduct both process and outcome evaluations of the HIV prevention project for couples.

Research Methods

This section describes the research protocol, target population, eligibility and recruitment, training, and data collection, including the tools used in the processes for the intervention phase of the study. Descriptions of the intervention and comparison conditions follow this section.

Research Protocol

In the second phase, following the protocol devised for the study (Appendix B), research staff recruited and screened potential participants. Details of these processes follow.

Those who met the criteria for participation were then assigned to either a six-week intervention or a single-session comparison condition. The pilot HIV prevention program followed (see the Implementation section) and participants were tracked for six months following the program, as described under Data Collection.

Recruitment

Incentives

- $15 per class
- $15–$35 per questionnaire
- Childcare provided
- Travel reimbursement

Recruitment specifically for the pilot test of the intervention was limited to preapproved sites: four community-based organizations (CBOs), including Bienvenidos Family Services, and seven alternative schools with pregnant minor and parenting programs. Flyers (Appendix C) were posted at these locations, but more active, ongoing recruitment efforts were necessary to come close to the desired sample size of 50 couples. Teen parents who heard about the program through word of mouth and wished to participate were also eligible if they initiated contact.

Initially, it was planned to recruit all participants in both phases though NLFFI, with the young women being recruited through their partners. This proved impracticable, however, and recruitment was broadened so that in many cases the initial contact was with the young woman. The original age range of 14–19 was also expanded to include young adults up to 25 years old.

Recruitment procedures (see Appendix B) and consent forms (Appendix D) were approved by UCLA's Institutional Review Board. Potential subjects were told that participation was voluntary and were informed about the incentives and other available assistance (see Incentives sidebar).

Recruitment challenges included identifying eligible young fathers and mothers who were both currently in a romantic relationship and willing to attend an HIV prevention program with their intimate partner.[6]

Phase 2 Eligibility Criteria

- Parent or expectant parent.
- In intimate relationship with partner (baby's mother or father) for three months or more.
- 14–25 years of age.
- English- or Spanish-speaking.
- Not have used injection drugs, crack cocaine, methadone, or heroin in past six months.
- Ages of partners not such that the older would be reportable for statutory rape.
- Planning to remain in Los Angeles County for at least six months after the program.

Eligibility and Screening

Potential subjects who put their names on a sign-up sheet following the recruitment presentation were contacted by phone within one week whenever possible.

A staff member contacted the potential participant by telephone, answered any questions, and asked whether they had had an opportunity to speak with their partner about participating. Since it was mandatory that both partners participate, further screening was delayed until the partners had discussed the possibility of being in the study and both expressed an interest.

At that point, the staff member completed a screening form (Appendix E) for each person to assure that they met the study's requirements (see the Eligibility Criteria sidebar). Those who met all criteria were scheduled for review and signing of the written informed consent form (see Appendix D) and baseline data collection.

Those who did not meet the criteria during either screening were referred to other HIV prevention programs.

Enrollment

The recruiter carefully reviewed the informed consent form (see Appendix D) with potential participants and answered their questions to ensure they understood the study. Although parental consent was waived for adolescents who were under age 18, recruiters encouraged the young men and women to inform their parents about their involvement in the project. After their signatures were obtained, participants filled out a locator guide (Appendix F), which contained information needed for future contacts regarding classes and data collection. Participants then completed the baseline questionnaire (Appendix G).

Participants were assigned to either the single-session control group or the six-week intervention program depending on site of recruitment. Staff members from Bienvenidos/NLFFI felt strongly that all participants recruited from their agency should receive the intervention.

Confidentiality and Risks

As part of the enrollment process, participants were informed of the following (see Appendix B):

- No medical procedures were involved in the study.
- Participants had the right to withdraw from the study at any time or to refuse to answer specific questions during the study
- The study was protected by a certificate of confidentiality, which allowed the staff to refuse to cooperate with a subpoena or directive from any local, state, or federal court to release information about participants (about, for example, a parole violation).
- Specific instances of abuse of a minor (including sexual abuse and statutory rape), domestic violence, or specific plans to hurt oneself or others would be reported.
- Randomly selected interviews would be recorded (on audio- or videotape) for quality-assurance purposes.

At the beginning of data collection, participants were reminded of the importance to the study of not discussing their interview responses with their partners.

At the beginning of each data collection interview, participants were reminded of the following points:

- Confidentiality would be broken only if the participant gave details about current abuse of a minor, plans to harm another person, or plans to harm themselves.
- The information provided would not be shared with parents, partners, or anyone else (except as mentioned above).
- Income sources or drug use would not be reported to any agency or individual.

Staff and Training

Trained research assistants were responsible for participant screening and enrollment, and for data collection (see below). All project staff completed an online training course offered by UCLA's Office for Protection of Research Subjects. The training consisted of four general modules and a series of social-behavioral submodules. The coursework fulfills National Institutes of Health (NIH) requirements for "key personnel" in NIH-supported studies involving human subjects.

Data Collection

Phase 2 data were collected by means of a series of questionnaires that included sections on AIDS knowledge, behavioral intentions to use condoms and sexual risk behaviors, as well as selected sociodemographic information. The questions were read aloud in Spanish or English by trained research assistants to separate small groups of young women and men. Each participant then entered a written response on the questionnaire.

Participants completed questionnaires at baseline (see Appendix G), immediately following completion of the intervention workshops or the comparison session (Appendix H), and at three-month (see Appendix H) and six-month (Appendix I) follow-ups. The questionnaires took approximately 45–90 minutes to complete. Participants were compensated for the time spent completing each instrument. Incentives began at $15 for the first questionnaire and rose incrementally to a maximum of $35.

Intervention—Experimental Condition

The pilot HIV education program—Respecting and Protecting Our Relationships—took the young parents' feelings of protectiveness toward their children as a starting point for reducing risky sexual behavior.[6] The program built upon an existing intervention,[14] as well as integrating traditional/cultural teachings from NLFFI's *Con Los Padres* program.[12]

> The pilot program took the young parents' feelings of protectiveness as a starting point for reducing risky sexual behavior.[6]

Themes uncovered from the focus group series also were used to augment the curriculum (Appendix J) to make it relevant to young fathers as well as young mothers. Sessions were designed to challenge adolescents' knowledge and beliefs about risky behaviors, HIV transmission, and who gets AIDS.

Format

The workshop sessions were led by trained teams of male and female facilitators. The 12-hour curriculum entailed six 2-hour sessions.

Facilitators utilized a mirroring process (*espejo*) as a teaching method. Storytelling, reflection, and guidance were key methods of conveying information.

For some of the discussions, participants were separated by gender into different discussion groups, each led by a facilitator of the same gender. This technique eases discussion of sensitive issues, such as sexuality, sex with primary and secondary partners, gender roles, sexual inequalities in intimate relations, and relationship violence.

Curriculum

The core curriculum integrated Tello's framework[12] with psychological theories (Social-Cognitive Theory and Theory of Reasoned Action, along with concepts from the Theory of Gender and Power). It addressed issues surrounding sexual relationships and sexual risk behaviors (see Appendix J). The curriculum also highlighted traditional values and practices widely accepted among diverse ethnic groups by using ancient teaching methods, including storytelling and "rites of passage" lessons. Other parts of the program included a variety of interactive activities and games.

HIV Prevention Topics

- HIV awareness
- Understanding vulnerability to HIV infection
- Attitudes and beliefs about HIV and safer sex
- Building condom-use, refusal, and conflict-negotiation skills
- Contraception and disease prevention
- Influence of gender and power on sexual risk-taking

Feelings of maternal and paternal protectiveness were called upon as motivation to reduce risky sexual behavior. For example, in the third session, participants were asked to identify the people that make up their "*Palabra* Circle" (circle of relationships): children, partner, family, friends, teachers, and neighbors—anyone who would be affected if something good or bad happened to them. They were asked to imagine how these people would react to their becoming infected with HIV, or how it would affect them if someone in their circle were to become ill. This activity was followed by a presentation by a woman living with HIV, who described how it affected her family and life plans.[6]

Control Condition

The control condition consisted of a 90-minute session designed as a lecture (with no demonstrations or interactive activities) in which participants viewed a culturally sensitive videotape with AIDS information. A facilitator who was not involved in implementing the experimental HIV prevention program presented information on the incidence of HIV/AIDS, modes of transmission, signs and symptoms, and methods of prevention. After the presentation, participants had the opportunity to ask questions, and they received an educational pamphlet with referral numbers for HIV/AIDS information.

RESEARCH FINDINGS

Key results from both phases of the study are shown on page 9. Table 1 shows baseline data for demographic characteristics and risk behaviors for both intervention and comparison participants in Phase 2. (The sidebar to the right shows similar selected data for Phase 1 participants.) Table 2 shows findings for condom-use intention scores and AIDS knowledge scores for both groups from baseline to six months post-intervention.

Among young men who reported multiple sexual partners, those in the experimental group reported a greater decrease in number of partners from baseline to the three-month follow-up than did those in the control group.[15]

Due to attrition and the small sample size, the study was not able to develop findings that demonstrate intervention effectiveness. Despite this, qualitative findings from Phase 1 of the project provide an in-depth descriptive analysis of how the role of fatherhood may provide an impetus for change in the lives of young Latino fathers. Although the overall project findings are not generalizable, the collaborators' approach in developing a community-driven intervention targeting high-risk young Latino couples provides some constructive lessons (see Lessons Learned sidebar on page 10).

Intervention Study Issues: Attrition[6]

A total of 98 participants were enrolled in the two pilot-test groups, intervention and control. Baseline data only were collected from nine male participants and eight females in the intervention condition, most of whom attended no more than one workshop session. In the control group, two males and two females completed only the baseline survey.

Attendance at the intervention classes varied, with five males (19%) attending only one class and eight (30%) attending all six classes. Among the females, six (23%) attended only one class and nine (35%) attended all of the sessions.

Retention is an inherent challenge of longitudinal studies like this project, and working with a young inner-city population makes this aspect particularly challenging. Family responsibilities, relationship breakups, unstable living situations, irregular work schedules, and in one case a spinal injury caused by a gunshot, all contributed to attrition.

Phase 1 Focus Group Participant Characteristics (N = 26)[15]

Demographics

- Ethnicity: 100% Latino
- Sex: 100% male
- Age: Average = 19, range = 15–25
- Marital status: Married or long-term partner = 23%
- At least one child: 85%

Sex and Risk Behaviors (last three months)

- Sex partners: 0–1 = 71%
- Sex episodes: Average = 52, range = 2–300
- Sex episodes without condom: Average = 30, range = 0–300

Qualitative Findings

Phase 1—Formative Evaluation

The collaborative team understood that community involvement would improve the chances that the intervention would be socially and contextually appropriate. The input of the young fathers—both participants in Phase 1 and employees of the CBO—who contributed to the intervention was fundamental and invaluable.

One of the objectives of Phase 1 was to gather information on potential approaches young Latino fathers thought would be effective for recruiting and retaining young parents in HIV prevention programs. The participants stated that receiving incentives such as money or transportation, as well as a program design that is peer-focused (facilitated by peers and encouraging peer support), would be ideal.

In addition, as mentioned earlier, several themes emerged from the focus groups and interviews that provided a picture of the young men's lives and were used to adapt and revise the intervention curriculum:

- All of the young fathers participating in the focus groups "described life experiences with poverty, oppression, violence in their communities, and substance abuse," as well as with domestic violence as either victim or witness. Their teachers and the school system as a whole had also failed them.[13]
- A number of the young men had joined a gang, and the gang played a significant role in their lives. Despite its many negative aspects, "gang membership emerges as a place to belong for young people whose options have been restricted and as a reaction to a childhood filled with discrimination, violence (community and family), and feeling alone."[6]

KEY RESULTS

Table 1 Phase 2 Participant Characteristics (N = 77)

	Experimental N = 35	Control N = 42
Sociodemographics		
Age (years)		
< 18	40.0%	42.9%
18–20	28.6%	40.5%
> 20	31.4%	16.7%
Ethnicity		
Latino	94.3%	90.5%
Caucasian	5.7%	4.8%
Other	–	4.8%
Pregnant (females only)		
Yes	22.2%	23.8%
No	77.8%	76.2%
Sexual history		
Positive STD diagnosis (ever)		
Yes	–	4.8%
No	100.0%	95.2%
Average age at first coitus	14.7	14.4
Average lifetime number of partners	3.8	4.7
Average episodes unprotected sex (past 3 months)	27.9	18.3
Condom use with last sex partner?		
Yes	23.9%	21.4%
No	77.1%	78.6%
Drug use history		
Methamphetamine	37.1%	26.2%
Cocaine	34.3%	16.7%
Marijuana	82.9%	57.1%
Heroin	5.7%	0%
Injected any illegal drug	2.9%	0%

Note: Not all respondents answered all questions.

Source: J. Lesser, R. L. Verdugo, D. Koniak-Griffin, J. Tello, B. Kappos, and W. G. Cumberland, "Respecting and Protecting Our Relationships: A Community Research HIV Prevention Program for Teen Fathers and Mothers," *AIDS Education and Prevention* 17, no. 4 (2005): 347–60.

Table 2 Intervention Participant Behavioral Intentions for Condom Use and AIDS Knowledge (N = 98 at baseline)

Mean Scores for Condom Use Intention (Possible Range 5–25)				
	Baseline	**Post-Test**	**3 Months**	**6 Months**
Experimental Group				
Males	16.0	19.1	17.3	18.8
Females	19.3	20.0	20.3	22.0
Control Group				
Males	17.2	18.5	17.5	16.1
Females	19.0	19.9	20.0	19.4
Mean Scores for AIDS Knowledge Scores (Possible Range 0–29)				
	Baseline	**Post-Test**	**3 Months**	**6 Months**
Experimental Group				
Males	23.3	25.6	24.9	26.8
Females	21.9	24.9	24.8	26.0
Control Group				
Males	21.8	22.4	23.7	24.9
Females	20.6	23.4	24.6	25.3

Note: Scores for AIDS knowledge had a range of 0–29, with one point given for each item answered correctly. Condom-use intention items were scored on a five-point Likert scale ranging from "Disagree Strongly" (1) to "Agree Strongly" (5). Higher scores on both of these measures were more favorable than lower scores.

Source: Final Report, UARP Grant PC99-LA-2011 (2002).

- Becoming a father brings profound changes for many young men. Many of the participants' narratives indicated a "growing understanding of the importance of developing relationships based on equality and balance." For some, fatherhood takes the place of the gang by fulfilling the same need for belonging and identity. For the sake of their children, young fathers begin to make different life choices: finishing their education, finding legitimate employment, changing relationships with their families, and developing empathy for others.[13]

"For young fathers, as for adolescent mothers, concern for the well-being of their children was found to be an important motivator for positive behavioral changes."[15]

The Phase 1 findings suggest, however, that HIV risk behaviors—in particular unprotected sex—are not affected in the same way as other behaviors. "Despite such major attitudinal and behavioral changes, these young men acknowledged that they were continuing to practice unsafe sex with infrequent condom use."[6] Many concerns about the consequences of risky sexual behavior were overshadowed by more immediate issues such as protecting themselves, their partners, and their children from violence; being a provider of financial support; and working through relationship conflicts.

Phase 2—Intervention Study

Overall, the young parents responded positively to the enhanced HIV prevention education program. "They energetically engaged in the activities and discussions. At the end of the class series, they expressed recognition of the positive impact of various culturally based activities including the *Palabra* concept, the 'circle of relationships,' and storytelling."[6]

"Although most of the young men had at least some knowledge of the modes of transmission of HIV, most admitted that they did not use condoms."[6]

Although the sample size and rate of attrition in this study made it difficult to come to conclusions about the program's effectiveness, it is clear that the intervention was both well-accepted by the target population and feasible to implement in a community setting. Consequently, the intervention is being further tested through an NIH-funded longitudinal study with a larger sample of parenting couples. Additional changes to the study design have been incorporated as a result of this project (see the Lessons Learned sidebar).

Lessons Learned[6]

- Recruiting and retaining young mothers and fathers in longitudinal intervention studies is challenging and requires extensive resources.
- Pregnancy and childbirth effect temporary changes in sexual activity, so data collected from recent and expectant parents are less reliable.
- A community advisory board can assist with strategy development, lend their perspective to the project team, provide ethical and other oversight, collaborate in the interpretation and dissemination of findings, and help identify further opportunities for community collaboration.

COLLABORATION

The collaborative partnership at the center of this study drew on the research expertise of the UCLA School of Nursing and the extensive experience with Los Angeles' Latino community of Bienvenidos Family Services and the NLFFI. Because both researchers and agency personnel knew from the outset that they needed to understand what young people would respond to and welcome, involving the community in the collaboration was also seen as essential for ensuring that the intervention activities would be socially and contextually appropriate.

The partners and the process they followed in working together are described in the sections that follow.

Collaborative Partners

UCLA School of Nursing

The UCLA School of Nursing conducts and sponsors extensive bio-behavioral research. Faculty member Deborah Koniak-Griffin was one of the three principal investigators (PIs) on the project. She is the director of the Center for Vulnerable Populations Research at the School of Nursing and has conducted extensive research with adolescent mothers. A previous HIV prevention study with young mothers in Los Angeles County, on which she was PI, was the springboard for this study.[2]

Janna Lesser served as project director during the formative and implementation phases of the study. Evelyn Gonzalez-Figueroa succeeded her as project director in completion of the final phase.*

*Janna Lesser has since relocated to the School of Nursing, University of Texas Health Science Center at San Antonio. Evelyn Gonzalez-Figueroa is currently project director of HIV Prevention for Teen Parents, UCLA School of Nursing.

Bienvenidos Family Services and the National Latino Fatherhood and Family Institute

Bienvenidos Family Services, a division of Bienvenidos Children's Center, provides comprehensive services (including AIDS-related services) to a predominately Latino community. Families in the greater Los Angeles area are served through the organization's active participation in community-based collaboratives and its affiliation with hospitals, substance abuse treatment centers, homeless shelters, community health centers, and family welfare agencies. Bienvenidos Family Services operates centers in East Los Angeles, Altadena (San Gabriel Valley), and in Pomona.

NLFFI, a project of Bienvenidos Children's Center, brings together nationally recognized leaders in the fields of Latino health, education, social services, and community outreach. Its focus is on providing services that address the multifaceted needs of Latino males related to their positive involvement with their communities and families. Since 1995, the organization has been providing innovative services to young men aimed at helping them become nurturing and responsible fathers.

Barbara Kappos, director of Bienvenidos Family Services, was a PI for the study, as was Jerry Tello, NLFFI's director.

Processes and Key Components of Collaboration

The curriculum for the HIV prevention program was developed collaboratively by the researchers from the UCLA School of Nursing and staff from NLFFI and Bienvenidos Family Services. Some of the latter were teen parents.

> "This . . . project was successful because of the strength of the relationships between the partners and between the partners and program participants."[6]

During Phase 1, a female UCLA researcher and a male staff member from the CBO co-facilitated each of the focus groups. UCLA personnel conducted the individual interviews in this phase.

All of the Phase 2 measures were reviewed by the same collaborative team for cultural and language appropriateness, readability, and format.

The intervention and control group sessions in Phase 2 were led by pairs of facilitators from the CBO and UCLA, and data collection was performed by UCLA staff. UCLA team members compiled and analyzed the data, which was jointly interpreted.

CONCLUSION

This project demonstrates the potential effectiveness of community-academic collaborative research to promote health and prevent disease. The partnering organizations developed an HIV prevention program that was well-accepted by inner-city Latino teen parents and could realistically be implemented in a community setting. The study's results offer valuable data on young Latino fathers and mothers. Phase 1 of the study yielded important information on factors affecting young fathers' risk-taking behaviors and barriers to HIV prevention. For young fathers, as for adolescent mothers, concern for the well-being of their children was found to be an important motivator for positive behavioral changes. In Phase 2, the culturally sensitive HIV prevention program was implemented with parenting adolescents. For several outcome variables, positive trends were observed.[15] Although attrition issues remained a key factor in documenting intervention effectiveness data, they also highlight the challenges of developing appropriate research models for young, high-risk populations.

This research project contributed to the team's receipt of a National Institutes of Health (NIH) grant to conduct an outcome evaluation of the experimental intervention.[6] This longitudinal study is following a larger sample of young parenting couples for one year post-intervention. The investigators' goal is to gather data needed to establish the program as an effective intervention for reducing risk of HIV infection among young adults.

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Appendices

A. Phase 1 Focus Group Questions
B. Research Protocol Manual
C. Recruitment Flyer
D. Consent Forms
E. Screening Form
F. Locator Guide
G. Baseline Questionnaire
H. Post-Test and Three-Month Follow-Up Questionnaire
I. Six-Month Follow-Up Questionnaire
J. Experimental Curriculum

ABOUT THE MODULE 7 APPENDICES

These appendices contain tools that can be used to:

- Verify that potential subjects meet study requirements and obtain informed consent for participation
- Track research participants' likely whereabouts in order to maintain contact for follow-up activities over the term of a longitudinal study
- Collect data on demographics and culture, health knowledge, behavioral intentions, condom use beliefs, sexual history, history of drug and alcohol use
- Guide focus group discussions to gather information to be used in developing an intervention design

Sample materials in the appendices include:

- Flyer used in recruiting young Latino parents for the study
- Protocol manual outlining study requirements and procedures
- Curriculum for a culturally appropriate six-session experimental HIV prevention workshop for young parents

Each of the appendices is described briefly below.

Appendix A. Phase 1 Focus Group Questions

This list of questions was used to direct the focus group discussions in Phase 1. The questions were designed to gather information to help the researchers devise both a contextually appropriate curriculum and approaches to participant recruitment and retention that would be effective with young Latino men.

Appendix B. Research Protocol Manual

This document outlines the overall structure of the research study and includes the procedures for recruitment, screening, obtaining informed consent, data collection, telephoning participants, and emergency procedures.

Appendix C. Recruitment Flyer

Flyers such as this one were posted at recruitment locations, including several community-based organizations and alternative schools with pregnant-minor and parenting programs.

Appendix D. Consent Forms

This appendix contains the forms used to record the informed consent given by participants in signing on for the experimental HIV prevention intervention. Different forms were used for males and females, although the content is virtually identical. Recruiters carefully reviewed the forms with potential participants, describing the purpose and structure of the study, the workshop content, risks and benefits of participation (including incentives), the study's confidentiality measures, and their rights as participants.

Appendix E. Screening Form

This one-page form was used to verify that participants met the eligibility criteria for the study.

Appendix F. Locator Guide

The Locator form was used to collect contact information for participants, including address, phone numbers, and three alternate contact persons.

Appendix G. Baseline Questionnaire

The baseline instrument was completed at program enrollment by all participants in both the intervention and control groups, in English or Spanish. A research assistant read the questions aloud to separate small groups of men and women, and the participants recorded their responses. Sections include questions on demographics and culture, self-image, parenting, health knowledge, behavioral intentions, condom use beliefs, sexual history, history of drug and alcohol use, and romantic relationships.

Note: Although different versions of the questionnaires were used for male and female subjects, the differences are slight. Therefore, only the male versions are reproduced in this module. Both English- and Spanish-language instruments were also used. The printed version of this module includes only the English questionnaires. However, the Spanish version of the baseline instrument is available for download from the UARP web site as a Microsoft Word file; go to **http://uarp.ucop.edu/ca_collaborations/modules/module7a_app.html.** That document contains all of the questions administered later in the study.

Appendix H. Post-Test and Three-Month Follow-Up Questionnaire

This instrument was used (1) at the conclusion of the control group's HIV prevention session, (2) after the final workshop of the six-week experimental intervention program, and (3) at the three-month follow-up point for all participants. It was used to collect much of the same data as at baseline, for purposes of comparison over time.

Appendix I. Six-Month Follow-Up Questionnaire

This follow-up questionnaire was administered at the final data collection session, six months after either (1) the control group's single HIV prevention session or (2) the final workshop of the experimental intervention. It includes most of the same questions from the baseline questionnaire, except for demographic and cultural questions.

Appendix J. Experimental Curriculum

This appendix contains an overview of the curriculum for the six-week experimental HIV prevention intervention, as well as a session-by-session outline of workshop content and activities.

Use of Materials

All the resources presented in the appendices for Module 7 are derived from materials developed and used as part of the project listed below. These materials may be freely used for HIV/AIDS prevention intervention evaluation programs. Publications that use any of the forms, surveys, and so forth, or that are based on any of the materials included in these appendices, should provide a citation of the original project and principal investigators:

HIV Prevention for Teen Fathers and Mothers: A Collaborative Approach

UARP Grant PC99-LA-2011

Principal investigators:

Deborah Koniak-Griffin, School of Nursing, UCLA

Barbara Kappos, Bienvenidos Family Services, Bienvenidos Children's Center

Jerry Tello, National Latino Fatherhood and Family Institute, Bienvenidos Children's Center

Janna Lesser, School of Nursing, UCLA