



BEHAVIORAL AND SOCIAL  
SCIENCE VOLUNTEER  
PROGRAM

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AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION

# THE LINKAGE

NEWSLETTER OF THE BEHAVIORAL AND SOCIAL SCIENCE VOLUNTEER PROGRAM

## Stories From the Field: A Snapshot of BSSV Activities

By E. Duane Wilkerson, MPH, MDiv

The BSSV Program has grown tremendously in the past few years in its capacity to provide a wider variety of technical assistance (TA) to communities and health departments for HIV prevention planning and prevention efforts. The reason is simple: Great volunteers! We have increased the number of wonderful volunteer behavioral and social scientists (BSSVs) who make up the BSSV cadre of volunteers. There are now over 260 BSSVs in 45 states (including Hawaii and Alaska), the District of Columbia, Puerto Rico, and Guam. In recognition of the exceptional work they have done, and are currently doing, this edition of *The Linkage* highlights some of their work.

Making the decision about whom to ask to share their experiences was an impossible task. The ones selected were selected not because they were better than other volunteers. We tried to select a variety of TA experiences from a range of volunteers (geography, gender, discipline, ethnicity/race). We tried to choose a representative set that would give you a snapshot of the depth and breadth of the TA being done by all BSSVs across the country.

I am beginning my eighth year as the director of the BSSV Program. One of the major reasons I am still here is the tremendous satisfaction and joy I receive working with such incredible and committed scientists that make up the BSSV cadre. You will get a glimpse of this commitment in their stories.

Enjoy the stories that follow by BSSVs from Connecticut to California; stories of working with community-based organizations (CBOs) and community planning groups (CPGs). If you are a BSSV and you have not yet had an opportunity to experience a linkage, notice the insights shared in these stories, the lessons learned, how they are developed, and what the payback is for volunteers involved in linkages.

In 2005, and for the immediate future, the need for TA from behavioral and social scientists is greater than ever! CDC has strengthened its commitment to equip CBOs with the capacity to implement evidence-based interventions and to begin documenting the effectiveness of these interventions. These two goals are a major part of what BSSVs do with CBOs, CPGs, and health departments. It is part of our response to the challenge found in the 2001 Institute of Medicine report on HIV prevention efforts. (See corresponding box.)

I have a dream for the BSSV Program. That dream has to do with linking every single BSSV in our cadre with an agency in the next 18 months; every one of our 260 plus volunteers! It is not a deliverable in our contract. It is not a goal designed to impress our funders. It is simply a goal to honor the commitment of all BSSVs who make themselves available for a potential linkage, and subsequently to further strengthen the implementation of effective evidence-based HIV prevention programs across the country.

I hope you become inspired by these stories and contact me to say, "what can I do to help you link me with my community more?" ▼

**Institute of Medicine Report: No Time to Lose: Getting More from HIV Prevention**  
Excerpted from the Executive Summary pg. 7.

The Committee recommends that:

"Key Department of Health and Human Services agencies that fund HIV prevention research and interventions should invest in strengthening local-level capacity to develop, evaluate, implement, and support effective programs in the community."

# BSSV Advisory Board Continues To Be Productive Addition

## OFFICE ON AIDS

American Psychological Association  
750 First St., NE  
Washington, DC 20002-4242  
Phone: 202-336-6042  
Fax: 202-336-6198

**John R. Anderson, PhD**  
Director, Office on AIDS

## BSSV PROGRAM STAFF

**E. Duane Wilkerson, MPH, MDiv**  
Program Director

**Robin T. Kelley, PhD**  
Associate Director/  
Newsletter Editor

**Danielle N. Pope, BS**  
Administrative Coordinator/  
Newsletter Editor

## BSSV PROGRAM OFFICE

Phone: 202 218 3993  
E-mail: [bssv@apa.org](mailto:bssv@apa.org)  
Web address:  
[www.apa.org/pi/aids/bssv.html](http://www.apa.org/pi/aids/bssv.html)

*Each article reflects the perspective of the individual authors. The opinions expressed in the articles do not necessarily reflect the opinions of the Academy for Educational Development (AED), the Centers for Disease Control and Prevention (CDC), or the American Psychological Association.*



**Check Out Our Web Site at**  
[www.apa.org/pl/aids/bssv.html](http://www.apa.org/pl/aids/bssv.html)

**By David Baronov, PhD**  
*Rochester, NY*

A six-person advisory board was created in 2003 at the initiation of several BSSVs and the BSSV staff. The board convenes 4 times each year (both in person and via conference calls). We have convened as a board 8 times in the past 3 years (three times in person). Initially, our primary tasks concerned developing the structure and function of the advisory board.

The board is comprised of six volunteers. An effort is made, based on nominees, to be representative of the diversity of the BSSV cadre (e.g., geography, discipline, sociocultural characteristics, etc.). Ideally, board members will have taken at least one of the two BSSV trainings offered by the program and have a thorough understanding of the goals and objectives of the BSSV Program.

Board members are selected by program staff from the nominations that they receive (most are self-nominated). Board members are appointed for 2-year terms. The first board had three staggered cohorts to provide continuity. The first cohort served for 2 years. The second cohort will serve for 3 years, and the third cohort for 4. This ensures that as new members join the board, there will always be older members there as well.

Two standing committees were formed to focus on particular activities. These are the Evaluation Committee and the Conflict Resolution Committee. The Evaluation Committee considers issues pertaining to measuring the effectiveness of program delivery and impact. The committee advises on evaluation strategies and may help staff

design procedures pertaining to data collection and analysis. A readiness scale is being prepared and piloted to measure volunteer and agency readiness prior to creating a linkage. The position of chair was created for the purpose of coordinating activities and facilitating meetings. I was elected to the chair for a 2-year term. Now Dr. Nancy Brown serves as chair.

The Conflict Resolution Committee considers practices and procedures for adjudicating conflicts tied to program delivery. This committee may also serve as a resource to help resolve particular conflicts. The advisory board is currently considering the development of an advisory/BSSV handbook that would explicitly address program goals, objectives, procedures, and protocols. The purpose of the handbook will be to provide volunteers with clear direction and a full understanding of their roles and expectations (and exciting opportunities!) as volunteers.

The primary function of the advisory board is to provide guidance to program staff regarding the recruitment,

## BSSV Advisory Board Members

### *End of Term 2005*

**Scott D. Rhodes, PhD**  
**Ann O'Connell, EdD**

### *End of Term 2006*

**Kimberly Coleman, PhD** (Psychology)  
Washington, DC  
**David Baronov, PhD** (Sociology)  
Rochester, NY

### *End of Term 2007*

**Nancy Brown, PhD** (Psychology)  
Palo Alto, CA  
**Javier Parga, PhD** (Psychology)  
Bayamon, Puerto Rico

### *End of Term 2008*

**Denise Travis, PhD** (Social Work)  
**David Whittier, PhD** (Sociology)



**BSSV Staff and Advisory Committee Members—First Row:** Kimberly Coleman, David Whittier, Danielle Pope (BSSV Staff), Ann O'Connell, Javier Parga. **Second Row:** Robin Kelley (BSSV Staff), Denise Travis, Nancy Brown, David Baronov. **Third Row:** Duane Wilkerson (BSSV Staff), John Anderson (BSSV Staff); missing in photo is Scott Rhodes.

training, retention, supervision of volunteers, and the assessment of program delivery and effectiveness. To date, for example, at the request of program staff, the advisory board members have reviewed data collection processes, evaluation processes, monthly tracking protocols, recruitment strategies, training materials, and mar-

BSSV and agency readiness prior to establishing a linkage.

Our face-to-face meetings have been particularly productive. The extended time together (2 days) allows the advisory board to consider issues in greater depth and to conduct more

keting materials, and we have begun to develop assessment instruments for the program as a whole. Based on this work, the advisory board has developed a number of recommendations for staff regarding program marketing, recruitment, tracking of volunteer activities, and measuring of

long-range and strategic planning regarding our responsibilities. The advisory board can serve as an effective feedback loop for program staff who might otherwise generally deal with volunteers on an ad hoc, individual basis. The advisory board provides an ongoing dialogue between staff and volunteers and between volunteers and volunteers that facilitates dynamic channels of communication contributing to program growth and development.

Participation on the advisory board has broadened our perspectives with respect to our own volunteer activities, strengthened our commitment to the BSSV Program, and given us the opportunity to reflect collectively on ways to strengthen and improve the program overall. We strongly encourage all volunteers to consider taking part on the advisory board at some point in the future! ▼

## **Improving and Expanding Prevention Services for People Living With HIV/AIDS**

**Melanie Spector, EdD, LPC, CADC, Tulsa, OK**

**A**s BSSVs we are often called upon to work with a variety of agencies, including local and state departments of health (DOH). Recently I assisted my state of Oklahoma's department of health to improve and expand prevention services for individuals living with HIV/AIDS. The DOH had initiated two prevention case management programs within its Ryan White Title II clinics. Central to the integrity of the programs was the importance of communicating to people living with AIDS the responsibility to not infect others without producing guilt or shame, acknowledging the need for intimacy through sexual interaction, and maintaining a nonjudgmental approach when working with injection drug users. As the BSSV, I assisted in developing the core indicators, which included the hypothesis that 50% of those individuals who complete a specified number of sessions will report a reduction in unsafe sexual and or drug-using risk behavior and maintain protective behaviors with partners. In conjunction with the Oklahoma state department's evaluation team, univer-

sity faculty members, and clinic staff, my assignment led me to assist them in using the principles of participatory evaluation to develop two instruments: a PCM screening tool and a PCM assessment tool designed as a pre- and postintervention measure.

A lesson learned is as BSSVs, when we work with our agencies, we should always seek to work collaboratively. In particular, when working with state and/or local health departments, as the external behavioral and social scientists, we are there to support, guide, and be part of their team. Through this strategy, the agency becomes empowered, and the agency owns the product because it played a significant role in producing it. Although it may take months or even longer to complete, it will be a capacity-building and enriching experience for you as well as for the agency. ▼



**Melanie Spector, EdD, LPC, CADC**

# The Natural History of a BSSV Volunteer

By Nancy Brown, PhD  
Palo Alto, CA

**Y**ou may know that the BSSV volunteers are a very demographically diverse group of professionals, including:

- 40% males and 60% females;
- 56% psychologists, 17% public health professionals, 7% sociologists, 7% anthropologists, and 13% other; and
- 19% African American, 5% Asian, 55% Caucasian, 15% Latino, 6% other.

But what may be more interesting than our demographic characteristics are the backgrounds or personal commitment to social change that motivates us to give back to our communities, and in the process, how we develop as professionals. I call the process of integrating our volunteer work into our professional lives, the natural history of a BSSV volunteer.

I suspect many of us came to the BSSV Program as newly minted, but uncirculated, professionals with something in our background driving us to “give back to our communities,” or volunteer. Introduced to the program by a colleague, or having seen a booth at a professional meeting, we contacted the program and found ourselves recruited into the BSSV Program and planning to attend a basic training session, with all of our expenses paid—what a treat.

Feeling like we have arrived into the professional world, we attend a training session in which we learn how the BSSV Program works, who the customers are, and the types of technical assistance we may be asked to provide. In addition, we learn how to negotiate a Memorandum of Agreement (MOA) about a task, identify stakeholders, and help an organization with a task related to its community HIV service. Beyond the knowledge about completing a task with an organization, we also may learn about the community planning process, theories behind behavioral change, and how the CDC identifies programs for dissemination as “effective.”

Refreshed, invigorated, having learned quite a bit, and with a new network of like-minded professionals, we return to our new jobs, young families, partners, or communities, excited about the new line on our CV—BSSV Volunteer.

Our first task is assigned, Duane Wilkerson helps negotiate the MOA with a reasonable expectation, and we meet with the agency representative and begin our project, most likely helping an agency evaluate a service they provide. For most volunteers, this is a very positive experience, with the agency satisfied with the technical assistance that has been provided, and the BSSV feeling like he or she has made a difference.



Nancy Brown, PhD

For the majority of the BSSV volunteers, as our careers get under way, we may find we have less and less time to do volunteer work, but we remain with the program and continue to complete tasks while we develop professionally and become more active in the HIV-related research, service, or activism in our community. These roles and relationships may facilitate consultation jobs, funded research collaborations, and/or lifelong friendships.

We also may find that these roles in the community begin to generate volunteer work that comes directly to us from agencies we have worked with before, or that know us from community planning committee work, from our research or service provision roles, or as friends.

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**For most volunteers, this is a very positive experience, with the agency satisfied with the technical assistance that has been provided, and the BSSV feeling like he or she has made a difference.**

Examples of these types of activities that should be considered BSSV tasks include:

- Helping an organization develop an evaluation plan for a new proposal or program,
- Helping identify a data collection tool that can be used with a specific needs assessment or evaluation project,
- Creating a pre- or posttest form,
- Providing a talk or training about behavioral intervention theory or effective HIV interventions,
- Reviewing a training manual for staff about HIV-related programs or services,
- Serving on a community planning group, and
- Supervising or training volunteers in an agency.

If you are like me, when we get the quarterly reminders from Danielle Pope, we realize that we are doing volunteer work that should be a BSSV project and call Duane, who patiently listens to the facts about the project, collects infor-

## Who Are the BSSVs?

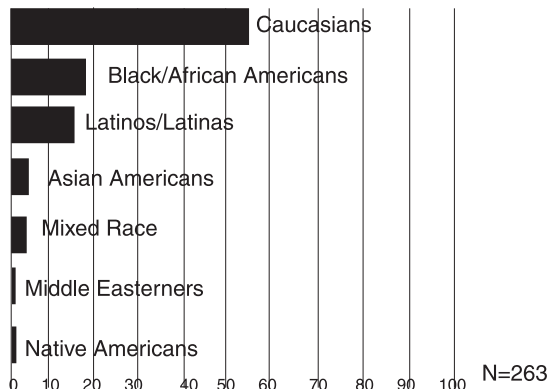
mation on the agency and contact person, and categorizes it as a task. Once the agency has been contacted, the project becomes a BSSV task. And, although there will not be an MOA, the task is official, and monthly record keeping takes place until the task is completed and Robin Kelley can call to complete the evaluation of the task with the agency and volunteer.

As our BSSV training recedes into the past, and we become more involved in our communities, it is increasingly important that all of us remember that the activities we may be completing as favors, (unpaid) consultation, or community service should be BSSV tasks. It is never too late to call Duane at 1 (877) 754-1404 and let him know what you are doing. He will determine the appropriateness of the task for BSSV Program.

I would like to share a personal reality at this point, which is that there is a huge benefit to having a project start as a BSSV task, and that benefit is the MOA process Duane facilitates. I have never had a task with an MOA negotiated by Duane get out of hand or develop into a larger project, but I have experienced some serious overwork when I naively say “sure, I can help” and get involved with an agency on my own.

After years of serving as a BSSV volunteer, you may want to consider a new type of involvement with the program, which includes serving as a member of the BSSV Advisory Committee. Our roles on this committee include providing feedback on the structure, purpose, and parameters for the BSSV Program. The first members of this group have had the privilege of working with the BSSV staff to provide feedback about:

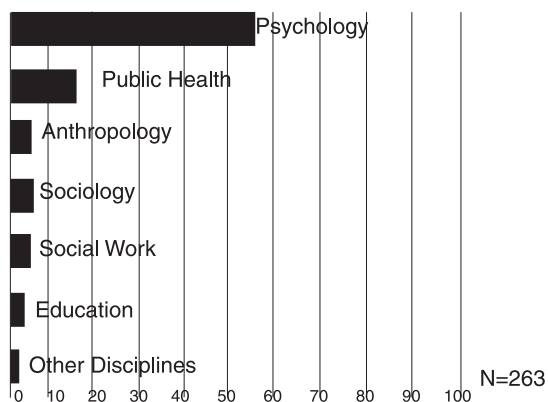
- Evaluating the BSSV Program,
- Procedures for tracking TA activities of BSSVs,



### GENDER AND RACE/ETHNICITY

There are 263 volunteers. Of these volunteers, 105 are males, and 158 are females.

- Caucasians— 55%
- Black/African Americans— 19% (These volunteers include three from Africa and two from Haiti.)
- Latinos/Latinas— 15%
- Asian Americans— 5%
- Mixed Race— 3%
- Middle Easterners— .3%
- Native Americans— .3%
- Missing Data— 3%



### DISCIPLINES

- Psychology— 56%
- Public Health— 17%
- Anthropology— 7%
- Sociology— 7%
- Social Work— 6%
- Education— 3%
- Other Disciplines— 2% (i.e., family studies, American studies)
- Missing Data— 2%

EDUCATION: The majority (91%) have doctoral degrees or are doctoral candidates, and the remaining (9%) are masters level.

LOCATION: BSSVs reside in every state except Nebraska, South Dakota, Vermont, West Virginia, and Wyoming. BSSVs also provide technical assistance in U.S. territories, such as Guam and Puerto Rico.

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- Promoting and marketing the BSSV Program,
- Ways in which the BSSV Program staff could better support the BSSVs,
- How to prepare BSSVs for emerging TA roles,
- How to better perform targeted recruitment for BSSVs,
- How to identify resources that would be helpful to BSSVs, and

Beyond the knowledge about completing a task with an organization, we also may learn about the community planning process, theories behind behavioral change, and how the CDC identifies programs for dissemination as “effective.”

- How to network with existing researchers/ community collaborations.

Since 1996 I have served as a BSSV volunteer in California and

truly believe that my involvement with this program has contributed to my career development and has also provided me with a tremendous number of opportunities to “make a difference” in the field of HIV prevention. If you haven’t already recruited a volunteer—why not do it today! Identify young professionals and encourage them to call the BSSV Program—they will thank you! ▼

# ***BSSV Linkages: Sometimes You Have To Put Your Passion Aside***

**By Denise Travis, PhD, LCSW  
Gary, IN**

**T**he role of a Behavioral Social Science Volunteer (BSSV) conjures up several feelings in me: dedication, the importance of ethical behavior, and the importance of building capacity at a community level. In my desire to complete my BSSV linkage assignment, I allowed my passion to help the agency, i.e., do work for them, to overshadow, or take precedence over, building the agency's capacity so that it, the agency, could continue its growth in behavioral science and thus, self-sustainability.

I was excited when I received my first request from Duane Wilkerson, program director of the BSSVs, to provide consultation to Brothers Uplifting Brothers (BUB), a community-based organization (CBO) located in Gary, IN.

One of the basic tenets of generalist social work practice is to "meet the clients where they are." Although it is clear to me that the then-director of this agency was not a client, it remained important that I assess the agency staff's current skill set as I formulated the plan to assist them with the required tasks. There were three surveys for which the organization had gathered data that needed analyzing: Knowledge of HIV, attitudes toward condom use, and street outreach.

As policy dictates, a conference call was held that included Duane, the executive director of BUB, and me.

The request was discussed, and the parameters for the linkage set. Even with this, the following problem occurred. As an undergraduate student, I was part of the generation whose anxiety grew when it was time to take the statistics class that called for one to manually calculate formulas. By the time I returned to school to work on my doctoral degree, computers had begun to become a part of our furniture and the Statistical Program for Social Science (SPSS) was available. For me it was the window to a new world, and I embraced the opportunity to relieve my anxiety and conquer a skill that evaded me.

Herein lies the tactical error. After several additional conversations with the BUB executive director, arrangements were made for me to receive the results of the three surveys. I was committed to the task as I had perceived it: setting up the databases for each individual survey. As I reflect back on entering the data, I can recall how I enjoyed the sound of my fingers hitting the keys, knowing



**Denise Travis, PhD, LCSW with staff member of BUB**

that at any minute, I would click the mouse and the statistical analysis would be complete.

Following the analysis, the executive summaries were completed and submitted, and I had my assignment exit interview with Duane. During the discussion, we talked about the initial assignment, tasks performed, and the results. In the midst of the conversation, I found myself becoming very pensive as I realized that I had not fulfilled one of the goals of the BSSV Program, that is, I had not taught BUB how to be self-sufficient in analyzing their own data. It was an eye opener!

What was interesting about the exchange between Duane and me was that he may have come to this conclusion before I did. It was a very sobering experience as we discussed how the process could have been done differently.

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**The role of a Behavioral Social Science Volunteer (BSSV) conjures up several feelings in me: dedication, the importance of ethical behavior, and the importance of building capacity at a community level.**

## **Lesson Learned**

I clearly learned more from this experience than the agency I served did. Did they receive the results of the data needed for future grants? Yes, but I had not facilitated their learning to increase their skill set that would

allow them to replicate the assignment in the future. It was a lesson learned. With my next assignment, ever cognizant of this lesson, I was careful to teach the receiving agency how to empower itself to analyze its own data.

I have continued to work with Brothers Uplifting Brothers. The current executive director and one of the original founders, Tony Gillespie, and I have engaged in conversations about what I can provide as a BSSV, particularly in relationship to advancing their research skill set. It is a relationship that is beneficial to me, the agency, and the community at large. ▼

## ***Bridging the Gap***

**By Scott E. Clair, PhD**  
**Ames, IA**

**W**hen I first joined the BSSV Program about 4 years ago in Connecticut, I decided that in order to best be of service to the HIV providers in my area, I had to sit at the same table they were sitting at literally and figuratively. As a result, I started attending Connecticut's community planning group (CPG) meetings. By being present at the meetings, I was able to offer assistance when needed to various requests, and my role on the CPG gradually grew over time, including chairing the Needs Assessment Committee. A little over a year ago, I moved from Connecticut to Iowa and followed the same model. Immediately upon moving to Iowa, I contacted the director of the HIV program at the state Department of Public Health (DPH), Pat Young, and she asked if I wanted to be a member. I accepted, and I currently serve as the chair of the Interventions Committee.

I recognize that not all BSSVs may be able to take such an active role in their local CPGs for a variety of reasons. However, I would encourage each of you to do three things:

1. Introduce yourself to the CPG DPH cochair and/or the director of the HIV program in your area,
2. Introduce yourself to the CPG community cochair, and
3. Attend your local CPG meeting at least once per year.

Most of the linkages we receive require the community-based organizations (CBOs), CPGs, or DPH to call Duane Wilkerson, who then checks in with us about our availability for a specific project. This process works well, so we as vol-

unteers are not put on the spot, and so Duane and the rest of the BSSV staff can help "triage" the requests. However, I think that the need for assistance is much greater than what is represented by the number of requests we currently address. I believe one of the main reasons for this is the barriers to asking for outside assistance. By introducing yourself to some of the key stakeholders in HIV prevention in your area and attending a CPG meeting, those barriers will be lessened.

Taking the initiative and attending the CPG meetings accomplishes a number of things for me personally. First, it helps me learn the lay of the land of the HIV community that I want to work with, which agencies are doing what types of programs with which populations, etc. Second, I am able to offer my assistance for various tasks as they come up. This has included chairing committees, helping with grant reviews, and offering suggestions about priority setting and evaluation among other things. Third, I think that by our being a part of the CPG, the barriers between BSSVs and the various groups that we work with (CBOs, CPGs, and DPH) are minimized. I think we can all relate to the fact that it is easier to ask a friend or colleague for assistance than to make a request of someone we have never met. Why would we expect it to be any different for those working in the field of HIV prevention? Finally, by being on the CPGs in both Connecticut and Iowa, I have been lucky enough to work with a number of dedicated and truly amazing people, many of whom I consider close friends. ▼



**Scott E. Clair, PhD**

## ***Conference Updates***

### **October 15, 2005**

National Latino AIDS Awareness Day: Sponsored by U.S. Office of Minority Health

### **December 1, 2005**

World AIDS Day: Sponsored by U.S. Office of Minority Health

### **December 5-9, 2005**

National Viral Hepatitis Prevention Conference, Washington, DC: Sponsored by the CDC Division of Viral Hepatitis and other sponsors.

### **December 10-12, 2005**

American Public Health Association 133rd Annual Meeting, Philadelphia, PA: For more information, visit the American Public Health Association Web site: [www.apha.org](http://www.apha.org) and click on the link in the Annual Meeting Update box.

# **The Growth of an ASO–BSSV Partnership: Humble Beginnings, Long-Term Progress BSSV Since 1999**

**By Scott D. Rhodes, PhD, MPH, CHES  
Winston-Salem, NC**

## **Partnership Background**

Our work as Behavioral and Social Science Volunteers (BSSV) encompasses more than providing technical assistance. It is a process of building trust and gaining an emic or insider's perspective of HIV/AIDS prevention and support within our own communities; sharing knowledge and resources; increasing capacity of our community partners as well as our own capacity; and working together as partners with various strengths to prevent HIV/AIDS and support those living with and affected by HIV/AIDS. My first official linkage just after moving to North Carolina (NC) was with the Triad Health Project (THP). Located in Greensboro, NC, THP is the area's leading provider of comprehensive case management, support services, prevention education, and direct financial assistance to individuals living with HIV/AIDS and their families in a North Carolina statistical metropolitan area of nearly 1.5 million residents.

## **The Primary Linkage**

A health educator whose primary responsibility included HIV primary prevention with the self-identifying gay and the non-self-identifying MSM communities wanted support in developing an evaluation protocol for the multiple session primary prevention case management intervention with adult men at increased risk for HIV infection. The health educator contacted the NC HIV Prevention and Care Branch at the state level, which in turn contacted the BSSV Program. After introductory calls and a conference call that included a representative from the BSSV Program, a representative from the NC HIV/AIDS Prevention and Care Branch, the health educator from THP, and me as the BSSV, the scope of work was agreed upon and a site visit to THP was arranged.

## **Challenges of Working in Partnership**

Using an iterative approach through the exchange of



**Scott D. Rhodes, PhD, MPH, CHES with his parents**

drafts, the health educator and I developed four session-specific evaluation instruments that included open-ended questions as well as modified scales that were selected to measure session content. The health educator and I were engaged in a process that was collaborative but also characterized by a community-based participatory research (CBPR) approach. The health educator and I were co-learners; I provided my training and experiences in sound science, and he provided an emic perspective to what was true to the lived experience of those individuals with whom THP works. He offered a picture of reality.

In the early stages of our work together, I winced as the health educator suggested that scales be shortened. He continued to remind me that he preferred limited accurate data as opposed to inaccurate data resulting from longer instruments that frustrated and discouraged the men. The health educator wanted to ensure that the men, with whom he worked, completed the evaluation tool honestly, not lose

their trust in him, and returned for their next prevention case management session.

Although I've worked closely with ASOs (AIDS Service Organizations) in the past, this experience reminded me of the importance of coming into the partnership fresh and unassuming. Each situation is unique and requires an initial step for trust and relationship building. The health educator and I worked for several weeks, communicated by e-mail, and finalized the evaluation protocol. Then suddenly I heard nothing more from him. My e-mails were not replied to; my telephone calls were not returned. Robin Kelley of the BSSV Program called to evaluate the linkage. I reported how well it seemed to have gone from my perspective and I confided my concern that I had not heard from the health educator for awhile. Her insight into what had hap-

pened would be appreciated. Had I done something wrong? Had I not been sufficiently collaborative? Was THP even using the evaluation protocol? I had gone into the linkage as informally as possible. I had asked the THP staff to call me “Scott” rather than “Dr. Rhodes.” I had been impressed with THP, and I had tried to communicate that. I had used all of my tools to make the linkage as easy, useful, and insightful as possible. I thought we had “clicked” as partners. I see my role as a scientist to contribute to the accumulation of knowledge for the sake of effecting health through improved practice. The health educator was doing the “real” work, innovatively and effectively, and I wanted to offer my help.

I had entered the scene talking about evaluation from a perspective that would have made my mentors proud. Dr. Laura Leviton, who had introduced me to the BSSV Program and got me to my first training in 1999, taught me the importance of entering each situation with an open mind, learning from the community, prioritizing context and culture, and being flexible. It was she who said that in terms of evaluation, “We really need to have the questions drive the methods we use, and not vice versa.” I also had applied principles of community partnership, co-learning, and participation that I was developing as a WK Kellogg Foundation Postdoctoral Fellow at UNC working with Dr. Eugenia Eng.

Finally, Robin made contact. The health educator reported being satisfied and was implementing the evaluation protocol. The delay in responding to my outreach efforts was caused by outside of their control. THP had experienced an office flood that had required it to quickly find and move into new office space. The health educator also had transitioned into developing other projects while prevention case management was running smoothly.

### Long-Term Partnership Outcomes

Because of the BSSV Program, the health educator and I established an ongoing relationship. Since that early experience working in partnership, we have applied and received funding from the UNC Center for AIDS Research (CFAR) to standardize and systematically implement and evaluate a lay health advisor intervention within local chat rooms used by MSM for social and sexual networking. The CyBER M4M (chat room-based education and referral) is a chat room HIV prevention intervention that representatives from THP and researchers and practitioners from Wake Forest University Health Sciences and UNC have developed and are evaluating through analysis of chat room dialogue, available demographic data abstracted from online bio lines and profiles, quantitative data collected from a password protected questionnaire, and HIV testing data. This study is an example of BSSV and an ASO blending talents to better inform the practice of health edu-

cation through co-learning. The health educator and I work collaboratively; each of us brings his ideas, talents, experiences, training, and perspectives to the table to create something better than could happen each working alone or without the perspective of the other.

As a researcher, I want to know more, collect more data. As a practitioner, the health educator wants to protect participants from burdensome “research subject” questioning and increase the accuracy of the data collected. Because of our online work, a CyBER educator and I presented our previous work with online intervention research and our current project to a University of Pittsburgh Department of Infectious Diseases and Microbiology.

Finally, this partnership has led to the placement of three physician assistant (PA) students working closely with THP. One is assisting in CyBER M4M with evaluation; two other students are completing a photovoice research project with participants in the day program at THP.

A colleague at UNC/Greensboro once commented to me that working in partnership with community members is a privilege. I view my work as a BSSV as a privilege. It is a privilege that I am able to leave the confines of my

office and learn about what is going on in the community to effect HIV/AIDS. It is a privilege that THP opens its doors to me and wants to work in partnership. It is humbling because I am not the expert; I have access to certain knowledge, certain resources, and certain perspectives, but the real experts are those in the field, our partners, the community-based organizations and AIDS service organizations that face the daily challenges of HIV/AIDS. They do not have time to sit back and wait; HIV is happening now, and our job is to assist them any way we can. The health educator and the other staff members and volunteers at THP have become partners as well as friends. It has been noted that partnerships between scientists and community members are like marriages: It is not always smooth, it is a constant negotiation, it cannot be taken for granted, requires constant nurturing, but is worth the effort.

The process of partnership building and trust gaining has proven to be worth the initial investment for me as a BSSV and an ASO partner. ▼

# Renewing HIV Prevention Programming for MSM in the Mid-Hudson Valley

By David Lounsbury, PhD  
New York, NY

**A**IDS Related Community Services (ARCS), a community-based organization that provides prevention education and case management services in New York State, initiated a plan this past summer to enhance HIV prevention programming for men who have sex with men (MSM). Their efforts were prompted by a recommendation from their primary funding source, the New York State Department of Health AIDS Institute, which has reaffirmed the need for intensive outreach to MSM, particularly young MSM, citing a resurgence of new HIV infections in this population in the New York City Metropolitan area.

Since the beginning of the epidemic, the percentage of ARCS clients that present as gay or bisexual has declined. Currently, 17% of clients are MSM. The remaining 83% are intravenous drug users, their partners, and persons who have been infected from heterosexual contact. Moreover, there are now nearly as many women as men among ARCS client population (46% vs. 54%, respectively). In response, ARCS has developed a variety of harm reduction programs and outreach initiatives designed to reinforce the fundamentals of HIV prevention and to promote HIV testing for these populations. These programs by definition are not MSM-focused.

## Getting Started With BSSV

ARCS was interested in designing a program that would best meet the prevention needs of MSM. Trina Hiemcke, ARCS' director of education and prevention, contacted the BSSV Program (BSSVP) for technical assistance, which then asked me to work with her to design a needs-assessment project for the agency. During our first phone calls, Trina and I discussed the work at hand. A number of important issues surfaced. Although nearly all staff had some training in program evaluation, they wanted support from a more experienced source. She also noted that those on staff who were best equipped for this type of project were already fully allocated to other work.

Trina also explained that ARCS served a geographically large, culturally diverse region of New York State. In addition to their home office in Westchester, ARCS has offices in Dutchess, Orange, Putnam, Rockland, Sullivan, and Ulster counties. Systematically surveying the entire area felt like an overwhelming task. Moreover, the rural character of many communities in these counties compelled much of the MSM population to be on the "down low" and/or "closeted" about their relationships, a factor that would make outreach particularly challenging.

## Reaching Out to the LGBT Community

Reflecting on these issues, we felt that an essential first step was to reach out to a variety of community stakeholders, such as local advocacy groups, business establishments, and other health services agencies that were LGBT-friendly. Trina was well acquainted with the communities ARCS served and had longstanding relationships with organizations in the region, so it was easy for her to put together a list of contacts from these settings.

We decided to organize a series of focus groups, which would be publicized as community forums. This approach was appealing because it built upon ARCS' ongoing relationship with the LGBT community and, at the same time, served as a means to collect qualitative data about HIV prevention and MSM. To keep things as practical as possible, Trina suggested that we arrange two groups: one for rural communities in the Mid-Hudson Valley (Orange County), and one for more suburban communities in the Lower Hudson Valley (Westchester County).

To help carry out the project, ARCS approved a small budget for a consultant who would facilitate the community forums. After interviewing a number of candidates who responded to a position announcement, ARCS offered the position to Dr. Jo Sotheran. Dr. Sotheran had extensive experience in the HIV community and the LGBT community and was a skilled sociologist.

The project took shape quickly once Dr. Sotheran was on board. The groups were advertised via mailings and word of mouth by ARCS as an open discussion about HIV prevention for MSM. Both groups were held during early evening hours in June 2004; both were facilitated by Dr. Sotheran and observed by Trina and me. The following questions were discussed by participants: (1) Who are the MSM of the Hudson Valley? (2) How do the MSM here relate to New York City? (3) How is access to services and information affected by the geography of the region? (4) What prevention services would be most effective for MSM in the communities served by ARCS? (5) What sources of information do MSM use and prefer? (6) How do the MSM of the Hudson Valley manage the stigma of homosexuality and HIV? Five MSM participated in the Mid-Hudson Valley group; seven MSM participated in the Lower Hudson Valley group.

## Diverse MSM Clientele → Different Prevention Needs

With respect to understanding the HIV prevention needs of MSM in the Hudson Valley, four major challenges to HIV prevention were identified. These included: (1) ARCS' geographically large service region, (2) growing complacency about practicing safer sex, (3) a high level of stigma associated with homosexuality in most communities, and (4) ARCS' diverse MSM clientele.

Arguably, our biggest finding was that a one-size-fits-all approach to HIV prevention for MSM in a service region as large as ARCS' would not be effective. First, our data indicated that MSM who self-identified as gay communicated very different needs than MSM who did not. For example, gay men expressed a need for social support and networking opportunities. In contrast, MSM who did not identify as gay were concerned about having access to programs and services that would ensure their privacy. Second, participants affirmed that there was no clear choice of place for MSM-focused prevention programs in the area served by ARCS. Newburgh, NY, was pointed out as the most gay-friendly town that ARCS served, but it would not be easily accessible to all MSM. The more common experience for an MSM in the Hudson Valley was isolation. Isolation, due mainly to the rural character of many communities in the area, was associated with casual hookups, which were often arranged via the Internet or sought after at various public cruising locations. Some participants noted that public cruising venues were associated with a greater likelihood of high-risk sexual activities, because of either an apparent lack of knowledge about HIV transmission (among MSM who do not identify as gay, particularly young MSM) or safer sex fatigue (among MSM who did identify as gay). Third, participants noted that social networks among MSM tended to be organized on the basis of age, race/ethnicity, and type of relationship (committed/coupled vs. casual/friendly), as well as by proximity to New York City's gay communities.

Trina reported that these results validated much of ARCS' own thinking about why designing and offering services for MSM has been so difficult to sustain in recent years. She said that agency staff also pointed to improvements in medical treatment (e.g., HAART) as contributing to a diminished sense of urgency about prevention for MSM. She also noted that ARCS' greatest challenge would likely be balancing the needs of MSM who identify as gay with the needs of those who do not. As an observer of the groups, she was struck by how much the behaviors and attitudes differed, even among our small number of participating MSM.

### **Building Collaborative Capacity Through Partnership**

Collectively, these findings suggest that agencies like ARCS may need to step up and take on a new role, one that goes beyond the delivery of evidenced-based behavior-change programs for narrowly defined, at-risk populations. To be effective, ARCS will need to explore ways of developing multiple types of interventions in multiple settings. For example, psychoeducational programs that are linked, or integrated, with services, such as HIV testing and clinical care, are being considered.

To start, HIV-related messages, publicized via local electronic mailing lists, Web sites, and other media, could be used to build awareness about the cultural and social diversity represented in the Hudson Valley and the need for a collaborative approach to address the problem of HIV infection among MSM. Creating messages that constructively engage

the community at large as well as the MSM population will be a challenge. However, the real challenge will be helping agencies like ARCS take on the function of community program coordination. A single agency such as ARCS does not have sufficient in-house resources to launch and successfully sustain a seven-county HIV prevention program for such a dispersed, diverse MSM clientele. However, it does have a geographical infrastructure that could foster a coordinated approach to setting HIV prevention priorities and implementing action plans that address the needs of its MSM population.

This winter, ARCS will begin to test its own skill at community program planning for its MSM population. To properly develop this new role, ARCS will need the backing, as well as increased funding, from sources such as the state department of health. It will also need additional technical support. The Community Collaboration Core (CCC) of the HIV Center for Clinical and Behavioral Studies (New York State Psychiatric Institute/Columbia University), funded by the National Institute of Mental Health, is one place where the science of initiating and sustaining successful partnerships for HIV prevention is being conducted. Community partnerships are not a new concept and have received greater attention in prevention research circles in recent years. However, understanding how partnerships succeed or fail is not enough. We, as members of the BSSVP, can help ARCS and other agencies with the same need by (1) actively disseminating our best models of community partnership through our own network of behavioral and social researchers; (2) linking them with expert consulting scientists, such as Dr. Sotheran; and by (3) making the knowledge and resources available through applied research groups like the CCC more accessible.

In conclusion, our two, simple community forums generated a lot of insight. ARCS' situation is not uncommon, but it is complex. Meeting the prevention needs of ARCS' diverse MSM clientele shows how hard the fight against HIV has become, and how important it is that today, more than ever before, we learn to work together to end it. ▼



**David Lounsbury, PhD**



**Trina Hiemcke**

## Teaching the Transtheoretical Model to Staff

By Andrew S. London, PhD  
Syracuse, NY

In 2003 I did my linkage with the staff of the FACES (Fighting AIDS/HIV Thru Case Management, Education, and Support) program, operated by the Syracuse Model Neighborhood Facility, Inc., at the Southwest Community Center. The FACES program aims primarily at providing culturally sensitive case management, education, prevention, outreach, and support services in the African American and Latino communities of Syracuse. In consultation with members of the BSSV Program and staff from the New York State Department of Health AIDS Institute, we agreed that the priority for this first linkage between the BSSV and FACES programs would entail training staff to use the Transtheoretical Model of Behavior Change to stage clients who were receiving services in the program.

In order to achieve this objective, I did two trainings with program staff using materials that I developed from resources obtained from other members of the BSSV network. Duane Wilkerson put out a request on my behalf for materials others had used for conducting trainings on the Transtheoretical Model. The materials I received from several other volunteers were invaluable to me as I prepared the materials that I thought would be most effective for the trainings I was planning. I am very grateful to those who shared their materials with me, as they greatly facilitated my ability to meet the objectives of the linkage we had established. From my perspective, the ability to provide the infrastructure for such networking and information sharing is one of the great strengths of the BSSV Program.

For the first training, which I conducted at a staff retreat in the summer of 2003, I prepared a written overview of the major concepts and principles of the Transtheoretical Model, which I distributed and went over carefully at the training. This eight-page document provided some background information related to the development of the model, the critical assumptions on which the model is based, and the advantages of following the stages of change model relative to other kinds of behavioral intervention strategies. The remainder of the document focused on providing an overview of the model, definitions of each term and construct that is needed to understand the basic structure and functioning of the model, and a description of how the stages of change and processes of change map onto one another.

At the retreat, I began by introducing myself and asking each of the staff members to do the same. Then, we



Andrew S. London, PhD

had a fairly open-ended conversation about what the staff perceived their own needs to be, what they knew about the Transtheoretical Model, how they thought training in how to stage clients might help them meet their professional and agency objectives, and what they hoped to get out of the training. I then provided an overview of the training I had planned and discussed with them my decision to break the training into two or more parts, one focused on learning the model, which we would do that day, and at least one more session where we would learn and practice how to apply the model. I told them that I thought it was too much to try to learn the model and how to apply it all in one session. I spent the next couple of hours teaching the fundamentals of the model to the staff, using the materials I had prepared to anchor the discussion. At the end of the session, I reminded the staff that we could meet one or more times to do additional training on how to apply the model if they wanted to do so. In the interim, I encouraged them to give some thought individually and collectively to the specific arenas in which they thought that the model would be useful in their practices and agency.

I was invited to return to do a second training with the staff at FACES in the fall of 2003. For this training, I developed a second set of materials, which in this case included some guidelines for staging clients using an algorithm, a detailed example of how the model can be used to identify the stage a person is in with respect to a particular aspect of behavior, and how, once the person was staged, it was possible to identify processes of change that are appropriate for someone at that stage of readiness for changing or maintaining that specific behavior. I also included some guidelines for developing role model stories, which I suggested could be useful modeling the dynamics of success and connecting abstract ideas about behavior change with someone's lived experience. At the training, we did a brief review of the major concepts and guiding principles of the Transtheoretical Model and then proceeded to work through the guidelines and examples that were included in the materials I provided. At the end of the 2-1/2-hour session, we talked about some of

the specific behaviors that the staff thought they might prioritize as targets for their program and how they might integrate the staging of clients into their ongoing and developing programmatic initiatives. I suggested that the staff would need to spend some time working on the staging algorithms that they thought would be beneficial for their program and offered to return to go over those with the staff if they felt it was necessary.

I thoroughly enjoyed working with the staff at FACES and found the process of putting these materials together and thinking about how to teach this model to others to be both challenging and rewarding. As is always the case when I work out how to teach something to others, I found the process of putting these training materials together and conducting these trainings to be constructive and instructive. I thought about the model and its applications in new ways as a consequence of having done the work needed to try to teach it to others. Partially as a result of my participation in this linkage, I have integrated the Transtheoretical Model as the theoretical foundation for a grant proposal that I and several collaborators have submitted for review. This proposed experiment aims to evaluate the extent to which a computer-based, interactive, multimedia HIV prevention intervention is more successful than comparable traditional counseling and educational materials at moving probationers to the contemplation phase on selected behavioral outcomes on which they are screened to be precontemplative at the outset of the study.

In closing, I would like to note that I was gratified to learn that the work I had done locally had a broader, even international impact as a result of the networking accomplished by the BSSV Program. I learned from Duane Wilkerson that he had passed along the curriculum materials I developed to a volunteer in Southern California who was thinking of doing a staff training at the Gay and Lesbian Community Center of Greater Long Beach. Similarly, I learned from Robin Kelly that she had shared with someone in South Africa the overview of the major concepts and principles of the Transtheoretical Model that I developed for the first training session with the staff at FACES. In writing to express her appreciation for receiving those materials, this South African woman wrote that she had “forwarded it to others, including my brother, a clinical psychologist and OD professional, who is sharing it with his own colleagues in the state health system, and wrote glowingly about it (which is rare for him, given that he is very critical and quite the perfectionist).” Given that materials I received from others in the program helped me meet my goals at FACES, I was very happy to learn that I was able to give something back to the larger, global network of people working to prevent the spread of HIV, who are in part connected through this program. ▼