PROVISIONAL
PROCEDURAL GUIDANCE FOR COMMUNITY-BASED ORGANIZATIONS

Revised April 2006
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NOTE: This document is provisional and will be updated as needed.

CDC is revising its HIV counseling and testing guidelines. Separate guidelines are being developed for HIV testing in health care settings and HIV counseling, testing, and referral in non-healthcare settings. The guidance provided in this document may change, depending on the results of the guideline revision process; however, until that time, the recommendations in this document should be adhered to.

Specifically, Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings will be published later in 2006. They will replace CDC's 1993 Recommendations for HIV Testing Services for Inpatients and Outpatients in Acute-Care Hospital Settings; and they will update aspects of CDC's 2001 Revised Guidelines for HIV Counseling, Testing, and Referral that apply to health care settings and the 2001 Revised Recommendations for HIV Screening of Pregnant Women. In addition, the process for updating recommendations for HIV testing in non-healthcare settings is under way, with publication expected in 2007.

Also, CDC is revising its guidelines for partner counseling and referral services. The revised guidelines will replace the Partner Counseling and Referral Services guidelines published in 1998. Publication of the revised guidelines is expected in 2007.

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INTRODUCTION

PROVISIONAL
PROCEDURAL GUIDANCE FOR COMMUNITY-BASED ORGANIZATIONS

REVISED APRIL 2006

ABOUT THE PROCEDURAL GUIDANCE

From the beginning of the HIV/AIDS epidemic, the Centers for Disease Control and Prevention (CDC) has worked with its partners to help stop the spread of HIV. Staff members have worked tirelessly on national, state, and local levels and have had much success. Today, HIV treatments can help improve the lives of those with the disease, and more information is available on how to help prevent the spread of HIV.

The number of new HIV diagnoses went down until the 1990s. Since then, the number has stayed at about 40,000 each year. Data from 33 states from 2001 through 2004 show that overall, except among men who have sex with men, the number of new HIV diagnoses is remaining stable. However, studies show that some people are putting themselves and others at risk by not taking steps to reduce their risk of getting HIV. In 2000 and 2001, the number of cases of syphilis went up, after 10 years of fewer cases.

In April 2003, CDC launched Advancing HIV Prevention: New Strategies for a Changing Epidemic (AHP). AHP supports HIV prevention work being done now, but also brings new tools (such as rapid HIV testing) and methods to meet the needs of persons living with HIV. The goals of AHP are to increase the number of persons living with HIV who know that they are infected and to give them and persons at high risk for HIV infection the best tools we have for staying healthy and reducing the chance of giving HIV to others or getting the disease.

AHP is designed to
- increase early diagnosis
- improve referral to prevention services, medical care, and treatment
- put programs in place to help persons living with HIV

The interventions and strategies in this guide give you information on programs that can help your community-based organization (CBO) provide services under the recommendations of AHP.

Why Was the Guidance Written?

The Procedural Guidance (the Guidance) gives information to help CBOs come up with a plan for delivering interventions.

It will help you design prevention programs and recruitment strategies to promote counseling and testing, health education and risk reduction, and other prevention services; counseling, testing, and referral strategies; and interventions to help prevent the spread of HIV to meet the needs of persons living with HIV, their partners, and other persons who are not HIV infected but are at very high risk for HIV.

The Guidance does not give all of the information you would need to design, deliver, and monitor the interventions. CDC will help you with more training and technical assistance. Information about the interventions is available at www.effectiveinterventions.org. Other information is being developed. If your CBO cannot handle an intervention by itself, you can ask another CBO to partner with you.

The Guidance and intervention kits produced by the Replicating Effective Programs (REP) project and distributed by the Diffusion of Effective Behavioral Interventions (DEBI) project are the best science we have today to improve HIV prevention efforts.

REP helps make HIV prevention interventions that have been shown to work more accessible. They use everyday language and are packaged in a user-friendly way.

DEBI is CDC's national project that provides training and technical assistance for health departments and CBO staff who are conducting evidence-based interventions to prevent HIV, viral hepatitis, and sexually transmitted diseases.

How is the Guidance Organized?

Each intervention is organized under the following subheadings:

- Description
- Core Elements, Key Characteristics, and Procedures
- Adapting
- Resource Requirements
- Recruitment
- Policies and Standards
- Quality Assurance
- Monitoring and Evaluation
- Key Articles and Resources
- References

MAKING THE INTERVENTIONS WORK FOR YOUR CBO (ADAPTING)

When HIV was first identified, ways in which the disease was spread were also identified. Since that time, much effort has been made to develop interventions to prevent others from getting the disease. These efforts led to the development of a number of evidence-based interventions for persons who do not have HIV or whose HIV serostatus is unknown. Interventions are now offered for a variety of populations and settings. Because of this, more persons who have HIV are receiving their diagnosis earlier in their infection. As a result of better treatments, these persons are living longer and healthier lives. This has increased the prevention needs of persons living with HIV and the attention given to these needs. A number of interventions that have been shown to work are available to address the strategies of AHP; others are being tested.

The interventions in the Guidance are based on theories of behavior change that can be applied to many behaviors and populations. Because of this, interventions can be adapted to meet the specific needs of groups that were not part of the studies done so far. Adapting these interventions will show success if changes made are based on the known needs and special conditions of the population with whom the work is to be done. When adapting, you can modify key characteristics (**but not core elements**) to meet the needs of your CBO or target population. Core elements and key characteristics are explained for each intervention.

About formative evaluation

Before adapting an intervention, you must first do what is called formative evaluation. This type of evaluation will help you know more about the group you are trying to reach, their culture, risk behaviors, and other factors that put them at risk for HIV infection.

Following the steps of a formative evaluation can help you find answers to questions about which population is most appropriate for the intervention, what location is best for the intervention, what message(s) you need to be giving, and how best to deliver the messages and time your intervention to have the best chance of reaching the target population.

You must find out whether risk determinants that were used in an intervention that has been shown to work apply to your new target population.

> **Example:** The SISTA intervention has shown that African American women must have open discussion with their male sex partners to get these partners to use condoms. To use SISTA to reach Hispanic women, you would have to assess whether this type of discussion with male sex partners makes sense in this population.

Steps of formative evaluation

1. Interview community gatekeepers and stakeholders.

a. Determine whether an intervention can be done successfully in the group you are trying to reach by talking with the community gatekeepers and stakeholders.

> **Example:** For Popular Opinion Leader (POL), an intervention with men who have sex with men, you might interview owners of gay bars to be sure that they agree with the intervention, will allow the intervention to take place in their bars, and will support their employees in helping to identify opinion leaders.
>
> **Example:** For SISTA, you might need to interview the managers and guards of county and city jails to make sure that they are comfortable with the intervention being done in their facility.

b. Check to be sure they believe the service is needed.

> **Example:** For Safety Counts, community leaders and those who have an interest in the program may ask, “We already have street outreach. Why do we need another intervention in our community for drug users?” Your staff could then explain, “Safety Counts is an intervention that works with injection drug and cocaine users to get them into prevention counseling, rapid testing, partner services, individual- and group-level interventions, medical services, and support-focused social events. Safety Counts is a specific outreach method with specific goals and is a new type of outreach and may not have been done before in your community.”

2. Conduct focus groups to learn what issues are most important to members of your new target population and their community. If what you find is similar to what was found in the original evidence-based intervention, then the intervention may be the one to choose for adapting. The focus groups must also discuss all the core elements of the original evidence-based intervention. Several focus groups may be needed in order to look at each core element.

> **Example:** MPowerment, an intervention for young gay men, has 9 core elements, of which 5 are listed below and could be explored using focus groups.
>
> - Recruit and maintain a core group of 12 to 20 young gay and bisexual men to design and carry out project activities.
> - Conduct formal outreach, including educational activities and social events.
> - Conduct informal outreach to influence behavior change.
> - Convene peer-led, 1-time discussion groups (M-groups).
> - Conduct a publicity campaign about the project within the community.

Focus groups should find out whether each of the core elements of the evidence-based program is doable and appropriate for the new target population and settings.

3. Develop a logic model, a plan (often shown in a flow chart or table) that shows a sequence of activities that will be used to address a problem statement. These activities are then linked to measurable outcomes that show reduced HIV risk.

Your logic model should fully describe the core elements of an intervention or strategy and how these activities work together to help prevent HIV. All intervention activities, based on the core elements of the intervention, should address the problem statement and be linked to clearly stated and planned results of the activities.

Your logic model also needs information for each of the core elements of the intervention. This means that you need to find all of the resources you need to do an evidence-based intervention. Resources include

- Enough people involved (employees, managers, and volunteers)
- Supplies
- Costs for site to be used
- Travel costs
- Incentives
- Ability to develop materials

When putting together your logic model, look at the changes in behavior that happened as a result of the original research done on the intervention. Be sure that the activities in your adapted program are designed to get the same or better results.

> **Example:** Street Smart was able to get more homeless and runaway adolescents to use condoms after 8 intervention sessions. To get similar outcomes in an adapted program, you must be willing and able to provide a similar number of sessions (8 sessions) to your new target population.

4. Pretest your intervention materials with a Community Advisory Board. Pretesting ensures that the materials are right for the population and meet the needs of the population. Explore things such as

- reading level of the target population
- community values and norms
- attractiveness of materials
- whether the messages and instructions are understood and can be remembered by the new target audience

5. Pilot test to check how the intervention works in a small subgroup of the population you will serve. Pilot testing shows the usefulness of the adapted intervention.

Individual- or group-level interventions can be divided into small pilot tests of each core element. Later, the entire intervention, including all core elements, can be pilot tested.

> **Example:** For SISTA, 1 group-level session addresses gender and ethnic pride for African American women. To adapt the

intervention for Hispanic women, you will need to test this session with a group of Hispanic women before carrying out the intervention on a larger scale.

Community-level interventions are hard to pilot test as a full intervention; however, core elements can be pilot tested.

> **Example:** For Community PROMISE, peer advocates hand out role model stories to members of the target audience. Before having all of these stories handed out in the community, you may want to pilot test them by having a small group of peer advocates hand out just 1 role model story. This will help you find out how best to do this activity on a larger scale.

Choosing an appropriate population is the first step to adapting an intervention. After that, messages and strategies can be changed to help persons change behaviors that put them at risk. Also**,** the setting for the intervention needs to be chosen. This will help you know how to deliver the intervention.

> **Example:** The Popular Opinion Leader intervention was first designed to reach gay men in bars. This intervention was changed successfully for use with African American women in an urban housing project.

> **Example:** VOICES/VOCES was first tested in sexually transmitted disease clinics but has been found to also work with persons in drug treatment settings.

ENSURING CULTURAL COMPETENCE

Individuals and groups can differ in ethnicity, gender, age, sexual orientation, and language. Their experiences may cause cultural variations that support these differences. It is important to look at the meaning of cultural variations when setting up and delivering your programs and services. Having an intervention delivered by a member of the target population does not mean it will be appropriate or successful. Reaching a population means understanding the culture of the population. Cultural competency is important for your intervention to be successful.

To make your intervention successful, you need to know the health needs of the persons you are trying to reach, as well as their cultural experience. This is a first step to a culturally competent program.

In 2001, the Office of Minority Health (OMH) in the Department of Health and Human Services published national standards for delivering services that reflect a group’s culture and language. This is referred to as culturally and linguistically appropriate services (CLAS).

To be culturally competent, a person must
- value the differences between persons and groups
- understand any negative feelings against a group
- be aware of what happens when different cultures come together
- make the knowledge of a culture a part of oneself
- make changes as necessary guided by what is needed to reach diverse groups.

The Office of Minority Health began by defining cultural competence as follows:
A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.
Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ***Competence*** implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

Office of Minority Health Standards for Measuring Cultural and Linguistic Competency

- Ensure that clients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural beliefs and practices and preferred language.

- Implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

- Ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically *appropriate* service delivery.

- Offer and provide language assistance services, including bilingual staff and interpreters, at no cost to each client/consumer with limited English proficiency at all points of contact in a timely manner during all hours of operation.

- Provide to clients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

- Ensure the competence of language assistance provided to limited English proficient clients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the client/consumer).

- Make available easily understood, client-related materials, and post signage in the languages of the commonly encountered groups and/or groups represented within the service area.

- Develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically *appropriate* services.

- Conduct initial and ongoing organizational self-assessments of CLAS-related activities. [Organizations] are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

- Ensure that data on the individual client's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

- Maintain a current demographic cultural and epidemiologic profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area (the HIV prevention community plan and other sources of relevant information).

- Develop participatory, collaborative partnerships with communities, and utilize a variety of formal and informal mechanisms to facilitate community and client/consumer involvement in designing and implementing CLAS-related activities.

- Ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by clients/consumers.

- Regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards, and provide public notice in (the organization's) communities about the availability of this information.

KEY ARTICLES AND RESOURCES

CDC. Advancing HIV prevention: new strategies for a changing epidemic. MMWR. 2003;52:329–332. Also available at: http://www.cdc.gov/hiv/partners/ahp.htm.

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Recruitment

DESCRIPTION

Recruitment is the means by which an organization brings members of a population into HIV prevention interventions, programs, and services. Populations recruited (target populations) can be persons living with HIV or persons whose HIV serostatus is negative or unknown and who are at high risk for HIV. Recruitment can take different forms–outreach, internal referrals, external referrals—depending on the target population and on the needs and abilities of the CBO doing the recruiting.

Outreach

Outreach is a common way to meet potential clients in their own environment. Outreach activities can be conducted at physical sites where persons at high risk congregate and where high-risk behaviors take place (e.g., shooting galleries, the street, parks, bars, bathhouses) or at virtual sites (e.g., the Internet or telephone hotlines). Outreach activities can also use contacts established through social networking techniques. CBOs can work with current clients to reach partners or friends who may also be at high risk.

Referrals

Referrals can be internal or external.

Internal Referrals

Often a CBO will refer clients to other services within the same organization. This strategy takes advantage of the client's existing trust in the organization. When a referral is made to another service within that organization, the client may be more likely to accept and access the services.

External Referrals

Another source for recruitment is referrals from outside organizations. Because persons at risk for transmission or acquisition of HIV often have competing needs that make HIV prevention a lower priority, they may seek services other than HIV prevention. They can be referred from these other services to HIV prevention interventions. To reach clients in need of prevention services, it is important to obtain a commitment from other service providers to assess their clients for risk of transmitting or acquiring HIV and to make referrals as needed.

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based; they are thought to be responsible for the intervention's effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.**

Recruitment has the following 5 core elements:

- Use information from multiple sources to describe common characteristics of the target population.
- Develop and deliver health messages (to be delivered by an outreach worker or by a referral source) that are appropriate for the setting.
- Recruit for specific services (e.g., counseling, testing, and referral services; prevention case management; other prevention interventions).
    - Link clients whose HIV serostatus is unknown to counseling, testing, and referral services.
    - Link persons living with HIV to care and prevention services.
- Track whether clients complete their referrals (to monitor the effectiveness of the referral strategy).
- Revise strategies or settings, as needed.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

Recruitment has the following key characteristics:

Outreach

- Go to places where potential clients congregate, and go at times when they are likely to be there.
- Conduct outreach in teams (for safety).
- Screen clients to determine their needs for specific prevention services such as counseling, testing, and referral; prevention case management; or other prevention interventions.
- Develop and deliver tailored and appropriate messages (health and prevention promotion).
- Provide tailored and appropriate materials (describing programs and services for potential clients).
- Use peers as outreach workers, when possible.

Internal Referrals

- Develop criteria that will help providers of other services within the CBO know who or when to refer.
- Assess all clients to find out whether they would benefit from prevention services delivered within the organization, and refer them as needed.
- Develop targeted and appropriate messages to be delivered by individual members of the CBO or by mass-messaging strategies (e.g., on posters hung throughout the organization).

External Referrals

- Establish linkages with those service providers that members of the target population are most likely to access, and provide them training related to prevention services.

- Develop formal agreements with appropriate service providers for ongoing screening and referrals to and from these providers.
- Give referral agents tailored and appropriate materials that advertise programs and services.
- Give potential clients tailored and appropriate materials that describe programs and services**.**

Procedures

Procedures are detailed descriptions of some of the above-listed elements and activities.

Procedures for Recruitment are as follows:

Creating a Profile

Regardless of the type of recruitment strategy used, a vital component is the profile of the population to be targeted. Information from many sources can be used to describe the common characteristics (the profile) of the population.

CBOs should consider reviewing
- epidemiologic profiles
- information from key informant interviews
- focus group data
- ethnographic data
- surveys and questionnaires
- program records
- other relevant population-based research findings

The target group must be specified at least in terms of
- gender
- age
- race and ethnicity
- risk behaviors
- indicators of risk (such as drug use)
- location

This information should be reviewed on a regular basis to ensure that it remains current.

Creating and Delivering Messages

To increase the likelihood that prevention services will be accepted and that referrals will be completed, consider the characteristics of the population when devising health and prevention promotion messages. The messages should be
- specific to the type of service for which the CBO is recruiting
- in the language of the target population
- tested with community members to be sure the messages are clear and appropriate

CBOs developing an outreach program should answer the following questions, in order:

1. **Who** is the target population?
2. **What** is the message or service that the agency should be delivering?
   The CBO may use outreach to remove barriers to accessing testing and prevention services or to deliver health education and risk reduction messages with the goal of getting the client into such services.
3. **Where** is the best place to approach clients?
   Outreach workers must go to places where they are most likely to find members of the target population (including places where high-risk behavior is taking place), where potential clients are most likely to accept the recruitment message, and where safety can be ensured.
4. **When** should the outreach service be provided?
   Outreach workers must choose the best times to find their target audience.
5. **How** should the message or service be delivered?
   Messages can be oral or written and can be in the form of pamphlets, flyers, or signs. It is important that information or materials be convenient and easy to carry (e.g., referral cards that are pocket-sized, printed information). Services can be delivered by referral or on site, if appropriate.
6. **Who** is the most appropriate person to provide the service to them?
   Messages or services coming from peers are more likely to be accepted.

Referring
CBOs may rely on referral networks instead of, or in addition to, outreach for recruiting clients. CBOs who rely on referral networks should

- formalize and nurture linkages to other CBOs and providers
- solicit memoranda of agreement
- ensure that referral sources are familiar with their services (perhaps by giving presentations or distributing pamphlets)
- keep all contact information for the organization current.

If the referral sources are unable to provide the expected referrals, the agency should attempt to find and solve the problem.

CBOs that are unable to provide extensive services beyond recruitment should partner with other organizations that provide HIV prevention services. CBOs that provide services but have limited or no capacity to conduct recruitment should consider partnering with organizations that can offer this expertise.

RESOURCE REQUIREMENTS

People

Staffing for Recruitment should be based on a needs assessment and the epidemiologic profile of the target population (e.g., the HIV prevention community plan, other sources of relevant information).

For Outreach

Recruitment requires at least 2 people (because they need to work in teams). More recruitment will require more outreach workers. Recruitment needs 1 supervisor for every 10 outreach workers.

For Referral

Recruitment needs 1 person to maintain the referral network (ensure that referral sources are active, track referrals made by recruitment program staff, assess client satisfaction with referrals provided). Depending on the size of the network, this person may also supervise recruitment program staff.

Space

Recruitment takes place where the target population congregates; this may or may not be where services are provided. Both places must ensure privacy and confidentiality for clients.

POLICIES AND STANDARDS

Before a CBO attempts to implement Recruitment, the following policies and standards should be in place to protect clients, the CBO, and the individual workers:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client or his or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated.

The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Linkage of Services

Recruitment must link clients whose HIV serostatus is unknown to counseling, testing, and referral services and must link persons living with HIV to care and prevention services. CBOs must develop ways to assess whether and how frequently the referrals made by their staff members were completed.

Personnel Policies

CBOs conducting outreach must establish a code of conduct. This code should include, but not be limited to, the following: do not use drugs or alcohol, do not loan or borrow money, and do use appropriate behavior with clients.

Safety

CBO policies must exist for maintaining safety of workers and clients. Plans for dealing with medical or psychological emergencies must be documented.

Selection of Target Populations

CBOs must establish criteria for, and justify the selection of, the target populations. Selection of target populations must be based on epidemiologic data, behavioral and clinical surveillance data, and the state or local HIV prevention plan created with input from state or local community planning groups. Persons living with HIV are expected to be the first priority population for community planning groups, and services for persons living with HIV should be addressed as such.

Volunteers

If the CBO uses volunteers to assist with or conduct Recruitment, then the CBO should know and disclose how their liability insurance and worker’s compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing Recruitment:

CBOs

CBOs should have in place a mechanism to ensure that all protocols for recruitment are followed. These protocols include

- the method for collecting information to select the target population
- records of formal or informal agreements with other CBOs
- training for outreach and referral staff
- procedures for tracking referrals, including the number completed and barriers for those not completed
- staff supervision

Quality assurance activities can include having key staff observe and review outreach workers and their interactions with clients. This review should focus on

- adherence to referral protocols
- service to clients (accessibility and responsiveness to expressed client needs)
- documentation of contact
- follow-up on referrals

Clients

When appropriate, clients' satisfaction should be assessed upon completion of referrals.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

CDC. Diffusion of Effective Behavioral Interventions project. Available at: http://www.effectiveinterventions.org.

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Interventions in the Diffusion of Effective Behavioral Interventions Project

COMMUNITY PROMISE

DESCRIPTION

Community PROMISE (Peers Reaching Out and Modeling Intervention Strategies) is a community-level intervention model that can be implemented with any high-risk population in which there are established social networks. Community PROMISE focuses on the influencing risk factors that put members of a specific population at risk for HIV. These are persons or groups who practice HIV risk behaviors (e.g., injection drug users and their sex partners, people living with HIV, sex workers, men who have sex with men but do not identify themselves as gay, youth.) The intervention will not be effective for use in a general population in which the risk behaviors are varied. For example, a population of heterosexual women would be too broad to work with compared with a population of African American women, 18 to 25 years of age, who are partners of injection drug users in Chelsea, Manhattan. In turn, men who have sex with men but do not identify themselves as gay will require a separate project than will men who do identify themselves as gay. For Community PROMISE to be effective, members of the target population must be able to identify with one another and openly communicate about risk factors. Trying to focus on 2 groups within 1 project may cause either group to become fearful of being identified with the other. The same consideration must be taken into account when targeting groups of HIV-infected persons versus groups of HIV-negative persons. Understanding how to identify populations, understanding their risk behaviors and influencing factors, and designing Community PROMISE accordingly points to the importance of gathering this type of information during the community identification (CID) process.

To conduct Community PROMISE, the CBO must have ties to the community and access to the target population. An existing outreach program will speed efforts to get this intervention up and running. In addition, experienced outreach workers who have earned trust from the community will save months of time up front in launching the program because they would be able to recruit peer and business advocates with ease.

Community PROMISE has been packaged by CDC’s Diffusion of Effective Behavioral Interventions project; information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

Goals

Community PROMISE aims to increase condom use, condom carrying, bleach use, and drug-related risk-reduction behaviors.

How It Works

Community PROMISE uses messages in role model stories to change behavior by influencing attitudes, beliefs, and norms throughout social networks. Peer advocates distribute role model stories containing messages that address the prevention needs of different populations. Besides reducing risk behaviors, the prevention messages can be used to encourage peers to seek HIV counseling and testing services, partner counseling and referral services, and other prevention and treatment services.

Theories behind the Intervention

Community PROMISE is grounded in several behavioral theories, including the stages of change model. Its effects extend beyond the persons who are involved in the intervention, thereby changing social norms and behavior within social networks in a community.

Research Findings

Results from a 3-year cross-sectional study in 5 cities across the United States showed Community PROMISE to be effective in promoting consistent HIV risk reduction throughout the involved communities. Specific results were increased consistent condom use with main and other partners and increased condom carrying among participants in the intervention compared with those in comparison communities. In addition, participants in the intervention group scored higher on the stages-of-change scale for use of condoms and bleach than did those in the comparison group.[1,2]

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based; they are thought to be responsible for the intervention's effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.**

Community PROMISE has the following 4 core elements:

- Conduct community identification.
- Write and distribute role model stories.
- Recruit and train peer advocates to reinforce the messages in the role model stories.
- Perform evaluation, to ensure integrity of intervention.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

Community PROMISE has the following key characteristics:

- Discuss with stakeholders the appropriateness of the intervention and necessary program resources.
- Network with other agencies and community organizations to avoid duplicating efforts, to elicit support and cooperation, and to find referral sources.
- Form a Community Advisory Board to foster community commitment to the project and to develop a plan for accessing community members who are at risk.
- Begin the community identification (CID) process.
    - to develop a clear understanding of the composition of the target population

    - to identify specific risk behaviors and the contexts in which they occur
    - to discover the meaning of risk practices to the target population
    - to learn what risk-reduction messages the members of the target population believe are appropriate and relevant
- Review recent epidemiologic data.
- Interview CBO staff and members of populations at risk.
- Begin creating a map of the community (streets and populations) and conducting focus groups specifically for CID.
- Identify the most prevalent stage(s) of change for various risk-reduction practices among populations at risk.
- Review the CID data and prepare a comprehensive report to document the CID process.
- Use CID information to decide on a specific risk-reduction behavior.
- Recruit members of the target population (e.g., current or former commercial sex workers) or credible outreach staff to be peer advocates.
- Train peer advocates for 1 to 3 hours with regard to program goals, HIV/AIDS, and use of role model stories.
- Establish a system for maintaining commitment from peer advocates.
- Recruit, screen, and interview members of the local target population who are performing behaviors to avoid HIV; use their decisions to have safer sex as the basis for role model stories.
- Write and pretest role model stories locally. Stories should be brief (400 words or less), should address the target population’s risk behavior, and can be based on examples available in the intervention kit. Stories should be relevant and realistic. They should include the person’s initial stage of change, motivator, action step, resolved challenge, and positive consequences of making the behavior change.
- Have peer advocates distribute stage-appropriate stories to their peers and reinforce the stories’ messages in conversation.
- Have peer advocates distribute condoms, lubricants, and bleach kits, as appropriate, along with the role model stories
- Have each peer advocate distribute these stories and supplies to 10 to 20 peers each week.
- Have program presence at community events (e.g., street fairs, Pridefests) to promote program recognition and community buy-in.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and activities.

Procedures for Community PROMISE are as follows:

Conducting Community Identification

CID, the formative evaluation stage of Community PROMISE, is designed to assist in identifying, prioritizing, accessing, and understanding target populations. CID means having project staff get to know the community being prioritized for the intervention. It is a process that is ongoing throughout the life of the project, as role model stories need to be continuously updated in order to have meaning for the target population. One main reason for doing the CID process is to identify the influencing factors and risk behaviors of the target population. For example, lack of self-efficacy is an influencing factor for unprotected sex, a risk behavior. Understanding influencing factors and risk behaviors through extensive interviews conducted during the CID process is essential to understanding the target population and writing role model stories that will affect individual behaviors and community norms.

Community identification helps to

- accurately define problems and identify solutions
- reveal community norms and the community's stage(s) of change
- develop trust
- provide information for intervention approaches
- identify peers who can be involved in outreach

Because Community PROMISE is based on stages of changes and other theoretical models, you have to identify which stage your population is in. We call this "staging" the population. Then you write role model stories that describe behavior in the next stage. For example, if you find that 75% of the target population is in the contemplation stage, then you would write role model stories in which the main character demonstrates behavior in the planning stage. See Evaluation below for more information on this process.

This first step of CID is identifying which formative evaluation methods to use and developing or adapting the necessary instruments, such as

- interviews
- community observation protocol
- focus group script and materials
- informed consent forms
- field safety guidelines

The next step of CID is hiring staff or training current staff members to conduct the formative evaluation. Staff members make decisions and develop an implementation plan according to the findings. Then outreach workers recruit members of the target population for in-depth interviews; identify possible role models to be used in role model stories; and act as liaisons between peer volunteers, members of the target population, and other CBO staff. The primary duty of these staff outreach workers is to train and supervise the peer volunteers.

A key component of CID is mobilizing the community to support and participate in the intervention. For example, local shops can make available prevention and other materials related to the intervention.

The time it takes to conduct CID depends on the CBO's access to the community. A CBO that is well trusted and established within a community may plan on spending from 3 to 6 months on this process; whereas, a new CBO may need more time. CID can be conducted by many methods, such as

- interviewing CBO staff
- mapping the intervention areas

- observing venues and locations where the target population congregates
- interviewing community leaders and business owners
- interviewing the members of the target population (key participants)

CBOs must plan on giving incentives to key participants who agree to be interviewed. This is a trust-building process that will introduce the project, its staff, and its mission to the community. During this process, outreach staff will be meeting many people who will later become key stakeholders in the intervention. These stakeholders may become part of the project's advisory board, role model interviews, models for program materials, or peer advocates.

Producing Role Model Stories

Role model stories are real-life descriptions of a positive behavior change described in the words of members of the target population. The stories are developed from interviews conducted by outreach workers with target population members, and they explain how and why the role models took steps to reduce risk for HIV and the positive effect that this behavior has had. This is the *message* that Community PROMISE is sending to your target population. The stories may be in the form of brochures, newsletters, comic strips or fotonovelas (a series of pictures with a story, often in comic book format). Candidates for role model stories will be identified through the CID process, outreach, referrals from other agencies, or HIV counseling and testing centers. The role model must have a shared risk behavior with your target population and must have made some positive changes to avoid that risk. An incentive deemed appropriate through the CID should be offered to those who agree to be interviewed. A structured role model interview form is recommended for documenting all of the influencing factors described by your role model (See Community PROMISE implementation manual). Tape-recording the interview is very helpful in terms of providing direct quotations for the stories. Several stories can be derived from 1 interview. For example, if you are interviewing someone with both sexual and drug-using risk, you may construct a story that talks about reducing sexual risk and another about reducing needle-sharing behavior. After a format and layout for the story are developed, the product is reviewed and edited by staff. Sample stories are included in the intervention kit and can be used as models. Once approved, the stories are printed and combined with prevention materials, if used.

Recruiting, Screening, and Training Peer Advocates

Peer advocates are recruited and trained to distribute role model stories. Peer advocates use conversation to reinforce the messages in the role model stories. They encourage other members of the target population to read and talk about the stories within their own social networks. By doing this, peer advocates help their peers relate more immediately to the content of the role model stories and encourage them to engage in risk-reduction or health-enhancing behaviors. For example, if the role model story demonstrates how the main character got tested for HIV, then the peer advocate encourages the member of the target population to think about getting tested. Peer advocates also distribute prevention materials such as condoms and bleach.

Once peer advocates are recruited, screened, and trained, they work with staff outreach workers and other staff to identify areas for distributing the role model stories and prevention materials. Peer advocates distribute materials to and interact with the target population at times and frequencies agreed upon with the outreach worker.

Enlisting members of your target population into a network of peer advocates is a core element of Community PROMISE. These people are the *messengers* of your program and will take the message to others in their social networks and encourage their peers to take risk-reduction measures. By using natural "change agents" from the community, your prevention efforts will reach a wide audience. These persons will be engaging in risk-reduction conversations and distributing the role model stories to people within their social networks who may never access other prevention programs. This is why Community PROMISE is an ideal intervention with "underground" or hard-to-reach populations. For example, a man who has sex with other men but for confidentiality reasons does not identify himself as gay or even bisexual may be reluctant to access prevention programs. However, this person is undoubtedly interacting socially with others who engage in the same risk behavior. If you are able to identify a peer advocate who socializes with this person, the peer advocate can deliver prevention messages and materials to him in a very natural and informal manner. It is recommended that you recruit peer advocates on a regular basis and have them meet at least monthly to pick up materials for distribution. Monetary and other incentives, such as t-shirts with the project logo, must be provided for the peer advocates.

ADAPTING

Because role model stories are based on experiences of the target population, Community PROMISE can be easily adapted to meet the needs of your target population. The ongoing CID formative evaluation process will ensure that you are always keeping your finger on the pulse of the community and its attitudes, behaviors, and beliefs regarding the transmission or acquisition of sexually transmitted diseases, HIV, and viral hepatitis. Because community members and businesses are recruited to be actively involved in the intervention, you are more likely to have a program that is culturally appropriate. This holds true for any target population. In addition, the role model stories can be written to include prevention messages about very specific behaviors, and these stories can be formatted to reflect cultural differences. A good example of this is the use of fotonovelas for Latino populations.

RESOURCE REQUIREMENTS

People

Community PROMISE needs at least

- a program manager (1/4 time to full time)
- 1 or more full-time outreach workers
- staff members (half-time) to write and produce role model stories
- a support staff member (half-time)
- volunteer peer advocates

Space

Community PROMISE needs space for

- CID (stores, bars, on the street, in CBO offices)
- interviews (in CBO offices or other private places in the community)
- distribution of role model stories (at whatever locations CID identifies as appropriate)

Supplies

Community PROMISE needs

- a computer that can do word processing, desktop publishing, and data analysis
- a printer
- telephones, fax machine, and copier
- a digital camera or a photographer (to take pictures for role model stories) and scanner
- transportation for outreach workers
- incentives for peer advocates (e.g., hats, hygiene kits)
- prevention supplies (e.g., condoms, bleach)

RECRUITMENT

Populations recruited for Community PROMISE are CID participants, role models, peer advocates, and recipients of the role model stories.

CID Participants

First, persons are recruited to participate in CID. These persons are invited to share their knowledge of the target population in focus groups, interviews, or surveys.

Role Models

Second, members of the target population are recruited by outreach workers to be interviewed for role model stories. These persons can be identified during CID or through referrals (by outreach workers, test site personnel, and other people who interact with members of the target population). Because you will be recruiting role models from the community you are targeting, they are sure to reflect the racial or ethnic make-up, age range, and identity of the target population.

Peer Advocates

Third, peer advocates are recruited either during CID (through interaction with target population and community members) or through street outreach (e.g., at local meeting places). Peer advocates who deliver the role model stories and reinforcing messages are also members of the target population.

Recipients of the Role Model Stories

Fourth, peers from the target population are recruited by peer advocates. Depending on the message in the role model story, peer advocates recruit peers into counseling, testing, and referral services and other prevention and treatment services. CID and the peer advocate’s familiarity with the target population environment will identify the proper settings and methods for interactions and distribution of role model stories and materials. Community PROMISE, developed and mobilized by the community for the community, creates a sense of project ownership which can result in an intervention that is well received and respected by the target population.

POLICIES AND STANDARDS

Before a CBO attempts to implement Community PROMISE, the following policies and procedures should be in place to protect clients and the CBO:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client or his or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Linkage of Services

Recruitment and health education and risk reduction must link clients whose HIV status is unknown to counseling, testing, and referral services and persons living with HIV to care and prevention services. CBOs must develop ways to assess whether and how frequently the referrals made by their staff members were completed.

Personnel Policies

CBOs conducting outreach must establish a code of conduct. This code should include, but not be limited to, the following: do not use drugs or alcohol, do use appropriate behavior with clients, and do not loan or borrow money.

Safety

CBO policies must exist for maintaining safety of workers and clients. Plans for dealing with medical or psychological emergencies must be documented.

Selection of Target Populations

CBOs must establish criteria for, and justify the selection of, the target populations. Selection of target populations must be based on epidemiologic data, behavioral and clinical surveillance data, and the state or local HIV prevention plan created with input from state or local community planning groups.

Volunteers

The CBO should know and disclose how their liability insurance and worker's compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing Community PROMISE:

CBOs

Implementation Plan

A strong component of quality assurance is preparing a plan to implement Community PROMISE. A comprehensive implementation plan will facilitate understanding and buy-in from staff and increase the likelihood that the intervention will run smoothly.

Leadership and Guidance

Someone from the CBO should provide hands-on leadership and guidance for the intervention, from planning through implementation. In addition, a decision maker from the CBO should provide higher-level support, including securing resources and advocating for Community PROMISE.

Fidelity to Core Elements

The technical assistance manual contains a quality assurance tool to check fidelity to the core elements. In addition, training on the intervention and supporting materials (such as the implementation manual and technical assistance manual) provide CBOs with quality assurance tools to monitor implementation and measure fidelity. For example, the implementation manual contains a table detailing each task from the planning stage to the evaluation stage and listing the resources, skills, and knowledge needed for tasks.

Evaluation

Evaluation is an important tool for program management and quality assurance. Community PROMISE focuses on formative evaluation in the community identification process, process monitoring and evaluation to assess the implementation process, and outcome monitoring to identify changes in the target population. The implementation manual in the intervention kit provides guidance and instruments such as interview guides, surveys, and tracking forms that can be adapted and used.

Clients

It is necessary to ensure that the intervention is meeting the needs of CBO clients and staff. Staff who are implementing Community PROMISE can develop their own quality assurance checklist to help staff identify, discuss, and solve problems.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

For more information on technical assistance or training for this intervention or to get your name on a list for a future training, please go to www.effectiveinterventions.org.

REFERENCES

1. The CDC AIDS Community Demonstration Projects Research Group. Community-level HIV intervention in 5 cities: final outcome data from the CDC AIDS Community Demonstration Projects. American Journal of Public Health.1999;89:336–345.

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HEALTHY RELATIONSHIPS

DESCRIPTION

Healthy Relationships[1] is a 5-session, small-group intervention for men and women living with HIV/AIDS. It is not intended for persons who are not infected or living with HIV/AIDS, such as HIV-negative partners of persons living with HIV/AIDS. Healthy Relationships focuses on building skills related to problem solving, decision making, self-efficacy, and positive expectations.

Healthy Relationships has been packaged by CDC's Diffusion of Effective Behavioral Interventions project. An intervention package, training, and technical assistance are available from CDC. The intervention package will be provided only to participants of the 32-hour Healthy Relationships training conducted by CDC's training partners, the STD/HIV Prevention Training Centers. Planning and implementation information (including the starter kit, technical assistance guide) can be found at www.effectiveinterventions.org.

Goals

Healthy Relationships aims to build skills to reduce stress in the following 3 life areas:

- Disclosing HIV status to family and friends
- Disclosing HIV status to sex partners and needle-sharing partners
- Building healthier and safer relationships

How It Works

Healthy Relationships is intended to create a positive, engaging, and creative atmosphere that can be integrated into existing support groups or can be introduced as a new program. Conducted in 5 sessions, Healthy Relationships teaches clients decision-making and problem-solving skills to help them make informed and safe decisions about behaviors and HIV status disclosure. In each of the 3 life areas, a series of exercises is repeated to create and develop the skills. The primary exercise is viewing short clips from popular movies and then role-playing the scenarios.

Healthy Relationships is adaptable to different populations by varying the choice of movie clips and providing flexibility in role-playing to allow for cultural influences.

Theory behind the Intervention

Healthy Relationships is based on social cognitive theory. It focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills.

Research Findings

Compared with participants in a health maintenance control group, participants in the Healthy Relationships intervention group reported

- greater self-efficacy for suggesting condom use with new sex partners
- greater self-efficacy for being able to satisfy sex partners and themselves even when practicing safer sex
- intentions to consider the pros and cons of disclosing HIV status to partners
- intentions to engage in safer sex with partners of unknown HIV status

At 3-month and 6-month follow-up contacts, participants in the intervention group were significantly more likely than participants in the control group

- to have followed through on their earlier intentions
- to have considered the pros and cons of disclosing HIV status to sex partners
- to report less sexual intercourse
- to report less unprotected intercourse with partners who were not HIV infected

At the 6-month follow-up (but not the 3-month) contact, participants in the intervention group

- were significantly more likely to have refused to engage in unsafe sex (which was not true at the 3-month follow-up)
- reported
  - less unprotected intercourse
  - more protected intercourse
  - fewer sexual contacts

Research results show that this intervention is broadly applicable across subpopulations, including persons of different sexual orientations and persons with a history of incarceration, current or past drug use, or psychiatric problems or care. The results indicate a long-term effect (up to at least 6 months) on reported behaviors and perceived self-efficacy.

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based; they are thought to be responsible for the intervention's effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.**

Healthy Relationships has the following 5 core elements:

- Define stress and reinforce coping skills with HIV-infected people across 3 life areas.
  - Disclosing HIV status to family and friends
  - Disclosing HIV status to sex partners and needle-sharing partners
  - Building healthier and safer relationships
- Use modeling, role-playing, and feedback to teach and practice skills for coping with stress.

- Teach clients decision-making skills with regard to disclosing HIV status.
- Provide clients with personal feedback reports (PFRs) to motivate them to change risky behaviors and continue protective behaviors.
- Use movie-quality video clips to set up scenarios about HIV status disclosure and risk reduction to stimulate discussions and role-playing. (Note: The term *clip* is used, regardless whether the clip is short, long, or an entire movie.)

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

Healthy Relationships has the following key characteristics:

- Have clients meet in small groups (5 to 12 people), similar to support groups. New members cannot join once the series of sessions has begun.
- Have clients sit face to face in a circle.
- Have clients meet for at least 5 sessions, 2 hours each.
- Ensure that groups contain members of the same gender and sexual orientation.
- Have 2 facilitators per group.
- Ensure that facilitators have the following characteristics, which bring immediate credibility and rapport with clients:
  - One facilitator should be male and the other female.
  - At least 1 facilitator should be an experienced and skilled counselor, preferably a mental health professional. This facilitator may or may not be HIV infected.
  - At least 1 facilitator should be HIV infected.
  - At least 1 should be the same ethnicity as most clients.
  - Both should have the personal characteristics and group skills needed to be effective facilitators.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and characteristics.

Procedures for Healthy Relationships are as follows:

Making Sessions Interactive

Healthy Relationships is based on interactive sessions that educate and engage clients. They are not classes, lectures, or forums. These sessions create a context where people can interact, examine their risks, develop skills to reduce their risks, and receive feedback from others. Groups consist of 5 to 12 people of similar backgrounds. Clients sit in a circle so that they can easily see each other, share experiences, practice new skills, and receive feedback from their peers. Facilitators use easel chart guides to lead clients through the Healthy Relationships content.

Creating Personal Feedback Reports

Each client completes an initial assessment survey. From this survey, 3 PFR forms are created for each client. These PFR forms are designed to reinforce clients' motivation to change by helping them identify their behaviors, as well as determine which behaviors they want to change and which they want to maintain. The PFR forms are distributed in 3 different sessions, each tied to 1 of the life areas mentioned in the first core element.

Conducting Exercises

After each PFR is distributed and discussed, 3 risk continuum exercises are done. The continuum exercises use a long banner with a double-ended arrow labeled from high to low. Clients are given cards according to their personal evaluation of the stress or risk involved. The cards and the banner have corresponding pieces of Velcro on the back. Clients stick these cards along the appropriate place on the banner.

The continuum banner is used in 3 of the sessions, each time with a different set of cards. These exercises focus on how the clients view each of the following:

- **Exercise 1** Risk and stress of HIV status disclosure to family and friends
- **Exercise 2** Risk and stress of HIV status disclosure to sexual partners
- **Exercise 3** Risk of various sexual behaviors

Showing Videos

A variety of videos and movie clips are shown in the 5 sessions of Healthy Relationships.

- Personal statements
- HIV/AIDS information
- Condom demonstration
- Segments from popular movies (most important)

Describing Scenarios

Facilitators give brief descriptions or scenarios to introduce clips while tying them to the objectives of the session. Correctly setting up the scenarios facilitates both role-playing and discussion. These scenario descriptions are also used on many of the easel chart guides.

ADAPTING

Healthy Relationships is highly adaptable for many subgroups of persons living with HIV by varying the choice of movie clips and providing flexibility in role-playing to allow for cultural influences. CBOs are encouraged to select movie clips in which the race and ethnicity of the characters match that of most clients. CBOs are also encouraged to use a different set of a movie clips for each type of group conducted (e.g., movies clips for a Latina group, for an African American MSM group, or for a Latino heterosexual men’s group). CBOs should consult the Clip Essence tables found in Appendix VI of the Healthy Relationships implementation manual to obtain the purpose and the essential ingredients of the each movie clip. Healthy Relationships may be adapted for several settings and has been used successfully in clinical as well as community-based settings.

RESOURCE REQUIREMENTS

People

Healthy Relationships needs

- 1 full-time paid, experienced counselor or mental health professional
- 1 part-time (25% of time) HIV-infected peer group facilitator (volunteer or paid) for each group of clients (e.g., women, heterosexual men, men who have sex with men).
- 1 part-time (25% of time) program manager to do quality assurance and evaluation

The facilitators should meet the criteria described under Key Characteristics. Each group facilitator is strongly recommended to attend the 32-hour Healthy Relationships training conducted by CDC's training partners, the STD/HIV Prevention Training Centers. Program Coordinators/Managers, who oversee the intervention and supervise the group facilitators, are encouraged to attend the 32-hour Healthy Relationships training. Program Coordinators/Managers and those interested in learning more about the intervention are encouraged to read the Healthy Relationships starter kit found at www.effectiveinterventions.org.

A CBO will need from 40 to 60 hours to find and assemble 13 movie clips to use during the sessions. The 13 movie clips will not be provided by CDC or as part of the intervention package. The actual number of hours and costs for assembling the clips depends on

- staff knowledge of movies and appropriate clips
- equipment availability and staff skill for assembling clips on a VCR tape or DVD disk (or a contract for these services)
- the number of populations of clients who will be receiving the intervention (most of the selections are population specific)

Space

Healthy Relationships needs space that is

- private and secure, so that confidentiality of clients can be assured
- discrete (for clients who are uncomfortable with others knowing their HIV status)
- quiet and without interruptions (such as people entering and exiting the room or outside noise)

Supplies

The Healthy Relationships package comes with generic marketing tools, such as a video and printed promotional literature, which can modified for specific populations. Healthy Relationships will also require

- a TV and VCR or a DVD player with a remote control
- an easel, easel chart paper, and markers
- small incentives
- 1 small prize to give away through a random drawing at the end of each session

RECRUITMENT

CBOs are encouraged to screen potential clients to determine whether they are appropriate for the group-level intervention. The Healthy Relationships package (Appendix IV of the Healthy Relationships implementation manual) includes a list of questions that can be used to determine the appropriateness of potential clients.

The following recruitment strategies can be used to reach persons living with HIV:

- Recruit from existing programs and services for persons living with HIV, such as HIV support groups, comprehensive risk counseling and services, and HIV primary care settings.
- Use the generic marketing materials in the Healthy Relationships package.
- Send press releases to local radio and television stations.
- Advertise in local newspapers, including gay and alternative papers.
- Post announcements on the Internet.

Review Recruitment in this document to choose a recruitment strategy that will work in the setting in which the CBO plans to implement Healthy Relationships.

POLICIES AND STANDARDS

Before a CBO attempts to implement Healthy Relationships, the following policies and standards should be in place to protect clients, the CBO, and the Healthy Relationships intervention team:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client or his or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Informed Consent

CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO's responsibility and the clients' rights. Individual state laws apply to consent procedures for minors; but at a minimum, consent should be obtained from each client and, if appropriate, a legal guardian if the client is a minor or unable to give legal consent. Participation must always be voluntary, and documentation of this informed consent must be maintained in the client's record.

Legal and Ethical Policies

By virtue of participation in Healthy Relationships, clients will be disclosing their HIV status. CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners; CBOs are obligated to inform clients of the organization's responsibilities if a client receives a positive HIV test result and the organization's potential duty to warn. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Referrals

CBOs must be prepared to refer clients as needed. For clients who need additional assistance in decreasing risk behavior, providers must know about referral sources for prevention interventions and counseling, such as comprehensive risk counseling and services, partner counseling and referral services, and other health department and CBO prevention programs.

Volunteers

If the CBO uses volunteers to assist with or conduct this intervention, then the CBO should know and disclose how their liability insurance and worker's compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing Healthy Relationships:

Facilitators

Training

Facilitators should

- complete a training workshop, including review of the intervention theory and materials
- participate in practice sessions
- observe cofacilitation of groups, including practicing mock intervention sessions

Session Review

CBOs should have in place a mechanism to ensure that all session protocols are followed as written. Quality assurance activities can include observation and review of sessions by key staff and supervisors involved with the activity. This review should focus on

- adherence to session content
- use of appropriate videotapes with adequate facilitation of discussions
- accessibility and responsiveness to expressed client needs
- important process elements (e.g., time allocation, clarity)

Record Review

Selected intervention record reviews should focus on assuring that consent forms (signed either by the client, if older than 18 or emancipated, or by a legal guardian) are included for all participants and that session notes are of sufficient detail to assure that clients are participating actively.

Clients

Clients' satisfaction with the intervention and their comfort should be assessed at each session.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

CDC. Draft CDC Technical Assistance Guidelines for CBO HIV Prevention Program Performance Indicators. Atlanta, Ga: US Department of Health and Human Services, CDC; November 2003.

US Department of Health and Human Services, Office of Minority Health. National standards for culturally and linguistically appropriate services in health care. Washington, DC: US

Department of Health and Human Services; 2001. Available at: http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf.

An intervention package, training, and technical assistance on the Healthy Relationships intervention is available from CDC.

CDC would like to acknowledge and thank the faculty and staff of the Dallas STD/HIV Prevention Training Center for their assistance in compiling this Procedural Guidance for Implementation of Healthy Relationships.

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1. Kalichman SC, Rompa D, Cage M, et al. Effectiveness of an intervention to reduce HIV transmission risks in HIV-infected people. American Journal of Preventive Medicine. 2001;21(2):84–92.

HOLISTIC HEALTH RECOVERY PROGRAM

DESCRIPTION

The Holistic Health Recovery Program (HHRP), formerly Holistic Harm Reduction Program,[1] is a 12-session, manual-guided, group-level program for HIV-infected and HIV-negative injection drug users.

HHRP has been packaged by CDC's Diffusion of Effective Behavioral Interventions project; information on obtaining the intervention training and materials is available at www.effectiveinterventions.org. Two manuals, 1 for HIV-infected and 1 for HIV-negative injection drug users, are available at www.3-s.us/.

Goals

The primary goals of HHRP are harm reduction, health promotion, and improved quality of life. More specific goals are abstinence from illicit drug use or from sexual risk behaviors; reduced drug use; reduced risk for HIV transmission; and improved medical, psychological, and social functioning.

Theories behind the Intervention

HHRP is based on the information-motivation-behavioral skills (IMB) model of HIV prevention behavioral change. According to this model, there are 3 steps to changing behavior: receipt of HIV prevention information, motivation to engage in HIV prevention, and opportunities to practice behavior skills for HIV prevention.

How It Works

HHRP takes a harm-reduction approach to behavior change, in which abstinence from drug use or sexual risk-taking behavior is 1 goal along a continuum of risk-reduction strategies. Clients are not assumed to be abstinent from either drug use or sexual risk behaviors. Risk behaviors are viewed as being sustained by hopelessness in the face of a life-threatening illness (for those who are HIV infected) and high levels of stress, psychiatric disorders, and medical and social problems for those who are HIV infected or HIV negative. The ability to acquire and retain the skills needed for change may be impeded by the effect of HIV status, drug-related cognitive deficits, or both. HHRP enables clients to meet their own harm-reduction goals by presenting materials in a way to minimize the effects of cognitive difficulties and by providing clients with an empathic, directive, nonconfrontational setting in which structure and consistency are emphasized.

Research Findings

Clients in both an Enhanced Methadone Maintenance Program (which includes a 6-session HIV risk-reduction component) and HHRP exhibited significant improvements on measures of addiction severity, harm-reduction behaviors, harm-reduction knowledge, motivation, behavioral skills, and quality of life. HHRP clients had significantly greater improvement in behavioral skills and showed continued decreases in addiction severity and risk behavior after 3 months;

members of the control group did not maintain improvements. In later stages of the project, the HHRP manual for HIV-negative persons was developed as a variation of the HHRP manual for HIV-infected persons to generalize the intervention beyond HIV-infected drug users. It was tested and found to be efficacious in a randomized clinical trial among injection drug users who were either HIV negative or whose status was unknown.

In 2005, HHRP training was field tested by CDC in collaboration with 4 states—New Jersey, Connecticut, Pennsylvania, New York—and the Academy for Educational Development. The findings have been applied to the revisions of this document.

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based; they are thought to be responsible for the intervention's effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.**

HHRP has the following 8 core elements:

- Teach skills to reduce harm of injection drug use and unprotected sexual activities.
- Teach negotiation skills to reduce unsafe sexual behaviors with sex partners, and teach skills to heal social relationships.
- Teach decision-making and problem-solving skills using cognitive remediation strategies.
- Teach goal-setting skills and develop action plans to achieve goals.
- Teach skills to manage stress, including relaxation exercises, and help clients understand which aspects of a stressful situation can and cannot be controlled.
- Teach skills to improve health, health care participation, and adherence to medical treatments.
- Teach skills to increase clients' access to their own self-defined spiritual beliefs, in order to increase motivation to engage in harm-reduction behaviors.
- Teach skills to increase awareness of how different senses of self can affect self-efficacy and hopelessness.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

HHRP has the following key characteristics:

- **Group sessions.** Hold group sessions at the same time and place each week, and follow the same structured format.
- **Group size.** Have 3 to 15 clients in each group.
- **Facilitators**

  - Have the groups cofacilitated by 2 substance abuse counselors who have experience working with HIV-infected substance abusers and who are comfortable with the concepts of harm reduction in this population.
  - Include 1 male counselor and 1 female counselor, if possible, on the facilitation team.
  - Ensure that at least 1 of the counselors cofacilitating the interventions has a master's degree in a counseling discipline.
- **Group gender or sexual orientation.** Select groups to accommodate the CBO's clientele (e.g., all male, mixed-gender, all gay or lesbian, mixed sexual orientation). During the adaptation process, HHRP may be modified to make sure all relevant issues are addressed for group makeup.
- **Group Structure and Duration.** Schedule HHRP in 1 of several ways.
  - 1 weekly 2-hour session for 12 weeks (e.g., 9:30-11:30 every Wednesday)
  - 2 weekly 1-hour sessions for 12 weeks (e.g., 9:30-10:30 every Tuesday and Thursday)
  - One session (2 hours) alternating with discussion groups weekly for 24 weeks (e.g., Week 1=Group 1, Wednesday, 9:30-11:30; Week 2=Group 1 Discussion, Wednesday, 9:30-11:30)
- **Enrollment.** Choose from 2 enrollment options, each of which has pros and cons. Each organization will decide which enrollment option best meets their requirements.
  - **Open enrollment.** New clients start in any week (this option can be used only if HHRP is offered on an ongoing basis).
  - **Cohort enrollment:** Clients start together and proceed through all 12 groups as a group. If using the cohort recruitment method, to allow for attrition it is recommended that you start with at least 12 clients.
- **Threshold for Discontinuation.** Membership in HHRP requires clients to make a commitment. HHRP members are to attend all group and individual sessions without fail. Members are to be discontinued if they miss 6 sessions. They may start over if the CBO is offering other sessions and if they indicate that they want to participate.
- **Eligibility requirements.** Ensure that clients
  - are of the appropriate HIV status for their HHRP intervention (e.g., HIV infected and HIV negative or unknown HIV status)
  - have recently (within the last 30 days) used or are actively using drugs
  - are either enrolled in a drug treatment program or have expressed a desire to enroll

  Eligibility requirements may be adapted to be made more appropriate for other populations.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and characteristics.

Procedures for HHRP are as follows:

Conducting Sessions

The HHRP manual describes 12 group sessions, each 2 hours long, which can be presented in 1 of the following formats:

- 1 weekly 2-hour session for 12 weeks (recommended)
- 2 weekly 1-hour sessions for 12 weeks
- 1 session (2 hours) alternating weekly with discussion groups for 24 weeks

An individual treatment orientation session can be provided before the client attends group sessions.

Providing Content

Session 1	Setting and Reaching Goals
Session 2	Reducing the Harm of Injection Drug Use
Session 3	Harm Reduction with Latex
Session 4	Negotiating Harm Reduction with Partners
Session 5	Preventing Relapse to Risky Behavior
Session 6	Health Care Participation
Session 7	Healthy Lifestyle Choices
Session 8	Introduction to the 12-Step Program
Session 9	Overcoming Stigma
Session 10	Motivation for Change: Overcoming Helplessness
Session 11	Moving Beyond Grief
Session 12	Healthy Social Relationships

Determining Format

To address the psychiatric and neuropsychological needs that are often present in clients who are dealing with substance abuse issues, the sessions of HHRP use multiple teaching strategies so all persons can learn, regardless of learning style. These strategies are as follows:

- **Multimodal presentation of materials,** including oral (lectures and discussion), visual (slides, videos, charts, and written material), and skill-building (games, practice, role-playing) modalities
  - PowerPoint slide sets are available at www.3-s.us/. They are used to demonstrate a number of harm-reduction skills. To engage all clients (regardless of sex, sexual orientation, or race and ethnicity) in the process of rethinking risk behaviors, images used in HHRP slides should be
    - visually engaging
    - neutral in terms of gender
    - neutral in terms of race and ethnicity
  - Movie clips are used to teach skills and enhance the learning process.
  - Experiential activities provide a nonthreatening context in which HHRP members can practice skills. Immediate feedback during games, role-playing, and exercises can reinforce appropriate behavior and increase self-esteem and self-confidence.
- **Frequent reviews** to facilitate learning and retention
- **Reduction of fatigue and distraction**
  - These factors impede learning and may be particularly problematic for cognitively impaired clients.

  - Frequent breaks, multimodal presentations, and reduction of outside noise and distractions help improve concentration and achieve this goal.
- **Consistency** in meeting times and places, provision of an agenda, and following of the same structured format
- **Assessment and feedback** of knowledge and skills gained
  - This allows members to evaluate the different teaching strategies.
  - This also provides a chance for additional practice of new skills.
- **Generalizability** of information to the life situations of group members
  - **Memory book system** to improve memory for session material and for organizing and remembering activities required for living a healthy lifestyle
  - **Learning by doing** through activities that are appropriate to the group topic and aid in skills acquisition, retention, and self-confidence
  - **Providing immediate feedback** during games, to reinforce appropriate behaviors, discourage less helpful behaviors, and increase self-esteem and self-confidence
  - **Managing stress**
    - Use visualization strategies focused on relaxation and health promotion.
    - Stress can impair concentration, increase cognitive dysfunction (such as memory difficulties or impulsivity), and potentially lead to relapse.
  - **Group treatment**
    - Enable clients to practice and strengthen generalizable social behaviors.
    - Use group treatment to reduce feelings of isolation and provide a sense of interpersonal support from persons with similar life circumstances.

Facilitating

The 2 counselors work as a team to facilitate all aspects of the groups. One is primarily responsible for ensuring that all material is presented in accordance with the manual, and the other is primarily responsible for the experiences had by members of the group. Counselors must establish group structure, provide a consistent model of behavior and behavior change, and use a consistent and nonjudgmental therapeutic style to help each client reach his or her own harm-reduction goals. HHRP counselors should receive ongoing supervision from a clinically trained professional with experience in harm reduction.

Understanding Mechanisms of Behavior Change

HHRP takes a harm-reduction approach to behavior change; abstinence from drug use or sexual risk-taking behavior is 1 goal along a continuum of risk-reduction strategies. Clients are not assumed to be abstinent from either drug use or sexual risk behaviors. Risk behaviors are viewed as being sustained by hopelessness in the face of a life-threatening illness, high levels of stress, psychiatric disorders, and medical and social problems. In addition, the ability to acquire and retain the skills needed for change is impeded by HIV- and drug-related cognitive deficits. By presenting materials in such a way as to minimize the effects of cognitive difficulties and by providing clients with an empathic, directive, nonconfrontational setting in which structure and consistency are emphasized, the HHRP intervention allows clients to meet their own harm reduction goals.

ADAPTING

HHRP's risk-reduction approach is sufficiently broad that the intervention could be adapted for those who use noninjection drugs. HHRP can also be translated (e.g., into Spanish) or have some of the language paraphrased for clients who have literacy challenges or to make it appropriate for those who use noninjection drugs.

RESOURCE REQUIREMENTS

People

HHRP needs a project coordinator and 2 substance abuse counselors, at least 1 of whom should be a masters' level clinician with experience. It is recommended that each counselor team have 1 man and 1 woman.

Space

HHRP is best done at a facility that treats clients with substance abuse or dependence issues; for example, a methadone maintenance clinic, other drug treatment facility, or CBO serving a high number of HIV-infected clients who use drugs. The sessions must be done in a space that is private and secure so that confidentiality can be assured. It is crucial that the sessions not be interrupted by people coming and going and by outside noise.

Supplies

HHRP needs

- access to audiovisual equipment
    - a slide projector or computer projector and screen
    - a TV and VCR with remote control
    - an easel, easel chart paper, and markers
- money for incentives (food or small prizes) to give out at each group session

The HHRP counselor manual was designed to be highly user-friendly and contains relevant background and theoretical material. This manual minimizes the need for extensive prior training. The manual includes all the other materials needed to run the program, such as

- detailed scripts for each group session
- all necessary visual aids (slides or PowerPoint format)
- learning activities
- quizzes

Resources (e.g., sample implementation plan, CBO readiness checklist) for CBOs considering implementing HHRP are available at www.effectiveinterventions.org.
Intervention materials (including background and research information manuals, and instructional materials for individual and group sessions) are available at www.3-s.us/.

Other

For the program to be effectively and safely implemented, CBOs must

- maintain 2 group facilitators

- maintain a program manager/director
- maintain an administrative manager/interviewer
- provide individual sessions (Orientation and Closing)
- provide and adhere to all 12 of the manual-guided group sessions of HHRP
- have preexisting counseling and referral capabilities

RECRUITMENT

Although the original HHRP intervention was offered to clients in a methadone maintenance clinic, it can be adapted to reach clients in any drug treatment program or in a CBO serving a high percentage of persons living with HIV who have substance abuse and dependence issues.

Review Recruitment in this document to choose a recruitment strategy that will work in the setting in which the CBO plans to implement HHRP.

POLICIES AND STANDARDS

Before a CBO attempts to implement HHRP, the following policies and standards should be in place to protect clients, the CBO, and the HHRP program team:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client or his or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Informed Consent

CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO's responsibility and the clients' rights. Individual state laws apply to consent procedures for minors; but at a minimum, consent should be obtained from each client and, if appropriate, a legal guardian if the client is a minor or unable to give legal consent. Participation must always be voluntary, and documentation of this informed consent must be maintained in the client's record.

Legal and Ethical Policies

By virtue of participation in HHRP, clients will be disclosing their HIV status. CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners; CBOs are obligated to inform clients of the organization's responsibilities and the organization's potential duty to warn. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Referrals

CBOs must be prepared to refer clients as needed. For clients who need additional assistance in decreasing risk behavior, poviders must know about referral sources for prevention interventions and counseling, such as comprehensive risk counseling and services, partner counseling and referral services, and other health department and CBO prevention programs.

Volunteers

If the CBO uses volunteers to assist with or conduct this intervention, then the CBO should know and disclose how their liability insurance and worker's compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing HHRP:

Facilitators

Training

The HHRP manual is comprehensive and contains detailed scripts for each session. Additional training required for facilitators will depend upon the facilitator's level of expertise but could include

- completion of a training workshop, including review of the intervention theory and materials
- participation in practice sessions
- observed cofacilitation of groups, including practice with mock intervention sessions

Session Review

CBOs should have in place a mechanism to ensure that all session protocols are followed as written. Quality assurance activities can include observation and review of sessions by key staff and supervisors involved with the activity. This review should focus on

- adherence to session content
- multimodal presentation of material
- use of role-playing
- use of behavioral games as teaching aids
- comfort with the nonjudgmental, nonconfrontational approach to treatment

Weekly supervision should ensure that treatment is provided in accordance with the HHRP manual, that ways to adapt the manual are discussed, and that counselor concerns are shared.

Record Review

Selected intervention record reviews should focus on assuring that consent forms (signed either by the client, if older than 18 or emancipated, or by a legal guardian) are included for all participants and that session notes are of sufficient detail to ensure that clients are participating actively.

Clients

Clients' satisfaction with the intervention and their comfort should be assessed at each session.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

Avants SK, Margolin A, DePhilippis D, Kosten TR .A comprehensive pharmacologic-psychosocial treatment program for HIV-seropositive cocaine-and opioid-dependent patients: preliminary findings. Journal of Substance Abuse Treatment. 1998;15(3):261–266.

Avants SK, Margolin A, Usubiaga MH, Doebrick C. Targeting HIV-related outcomes with intravenous drug users maintained on methadone: a randomized clinical trial of a harm reduction group therapy. Journal of Substance Abuse Treatment. 2004;26(2):67–78.

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US Department of Health and Human Services, Office of Minority Health. National standards for culturally and linguistically appropriate services in health care. Washington, DC: US Department of Health and Human Services; 2001. Available at: http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf.

Intervention materials including background information, and research, as well as manuals and instructional materials, for individual and group sessions are available at www.3-s.us.

CDC would like to acknowledge and thank the faculty and staff of the Harm Reduction Unit, Division of Substance Abuse, Department of Psychiatry, Yale University School of Medicine for their assistance in compiling this Procedural Guidance for Implementation of HHRP.

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1. Margolin A, Avants SK, Warburton LA, Hawkins KA, Shi J. A randomized clinical trial of a manual-guided risk reduction intervention for HIV-positive injection drug users. Health Psychology. 2003;22:223–228.

MANY MEN, MANY VOICES

DESCRIPTION

Many Men, Many Voices (3MV) is a 7-session group-level intervention program to prevent HIV and sexually transmitted diseases among black men who have sex with men (MSM) who may or may not identify themselves as gay. The intervention addresses factors that influence the behavior of black MSM: cultural, social, and religious norms; interactions between HIV and other sexually transmitted diseases; sexual relationship dynamics; and the social influences that racism and homophobia have on HIV risk behaviors

3MV has been packaged by CDC's Diffusion of Effective Behavioral Interventions project; information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

Goals

3MV sessions aim to foster positive self-identity, educate clients about their risk for HIV and sexually transmitted diseases, and teach assertiveness skills.

How It Works

3MV consists of distributing educational materials, (which may be used to recruit persons at risk into the group), conducting outreach (by project staff) for recruitment, and holding the intervention sessions. The intervention addresses factors that influence the behavior of black MSM, such as values, perceived risk, cultural and social norms, and sexual relationship dynamics. It is delivered in 7 highly interactive group sessions, 2 to 3 hours each. The sessions are facilitated by a peer and contain 6 to 12 clients. Clients who are unaware of their HIV status are told the benefits of knowing their status and are referred for counseling and testing, if appropriate. 3MV uses behavioral skills practice, group exercises, facilitated discussions, role-playing, and lectures.

Theory behind the Intervention

3MV was adapted from the Behavioral Self-Management and Assertion Skills intervention[1] (now called Partners in Prevention), developed by the Center for AIDS Intervention Research in the Department of Psychiatry and Behavioral Medicine at the Medical College of Wisconsin.

Research Findings

In the original intervention, gay men who participated reduced their frequency of unprotected anal intercourse and increased their use of condoms significantly more than those who did not participate. The original intervention contained 12 sessions lasting 1.5 hours each; the intervention has been condensed to 7 sessions lasting 2.5 to 3 hours each. It has been adapted to address the factors that influence behavior of black MSM. The adaptation and implementation of this intervention were done through a partnership of Men of Color Health Awareness, Inc.; People of Color in Crisis, Inc.; and the Center for Health and Behavioral Training of the University of Rochester.

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based; they are thought to be responsible for the intervention's effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.**

3MV has the following 9 core elements:

- Enhance self-esteem related to racial identity and sexual behavior.
- Educate clients about HIV risk and sensitize to personal risk.
- Educate clients about interactions between HIV and other sexually transmitted diseases and sensitize to personal risk.
- Develop risk-reduction strategies.
- Build a menu of behavioral options for HIV and other sexually transmitted diseases risk reduction, including those that one can act on individually and those that require partner involvement.
- Train in risk-reduction behavioral skills.
- Enhance self-efficacy related to behavioral skills.
- Train in partner communication and negotiation.
- Provide social support and relapse prevention.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

3MV has the following key characteristics:

- Foster positive identity development and self-esteem for black MSM by
    - exploring the dual identity culture of black MSM
    - addressing social influences and family, religious, and cultural norms within the black community
    - exploring the concept of internalized racism and homophobia
- Discuss sexual relationship roles and risks, addressing knowledge of interactions between HIV and other sexually transmitted diseases and transmission risk, and exploring beliefs about those risks.
- Address perceived personal risk and personal susceptibility for infection with HIV and other sexually transmitted diseases as well as perceived barriers to remaining HIV negative.
- Increase skills, self-efficacy, and intentions with regard to protective behaviors.
- Explore the dynamics of sexual relationships, including the dynamics of power and the concept of "tops" and "bottoms" for black MSM.
- Address the importance of peer support and social influence on maintaining healthy behaviors.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and characteristics.

Procedures for 3MV are as follows:

Holding the Sessions

The 7 sessions address specific influencing factors in a purposeful sequence.

Session 1	The Dual Identity Culture of black MSM
Session 2	HIV Prevention for black MSM: Sexual Roles and Risks
Session 3	HIV Risk Assessment and Prevention Options
Session 4	Intentions to Act and Capacity to Change
Session 5	Partner Selection, Communication, and Negotiation
Session 6	Social Support and Problem Solving to Maintain Change
Session 7	Building Bridges and Community. This session links clients to • other prevention services within the CBO (e.g., behavioral counseling, HIV counseling and testing, screening for sexually transmitted diseases) • related services within the community (e.g., mental health and substance abuse treatment) • community building activities for black MSM

Information on the specific content of the sessions is provided during facilitator training sessions. Sessions are more interactive (i.e., allowing clients to learn through experience, such as educational games and exercises) and less didactic (i.e., containing very little presentation of information).

Determining Duration of Sessions

CBOs that have adapted the intervention found that the African American gay and bisexual men that they served were more inclined to attend 7 sessions of 2 to 3 hours each than 12 shorter sessions of 1.5 hours each. A CBO may conduct its own formative evaluation to determine the optimum number and length of sessions according to client needs and convenience. For example, the intervention may be condensed into a weekend retreat, covering the 18 to 21 hours of intervention materials in a single weekend.

ADAPTING

Adapting means modifying the intervention to appropriately fit the local context in a way that does not violate the core elements of the intervention. Although 3MV was not specifically designed for members of other racial and ethnic groups who may identify themselves as being “of color,” (e.g., Asians/Pacific Islanders, Latinos, and Native Americans), the intervention could be adapted for these special populations.

RESOURCE REQUIREMENTS

People

3MV needs

- 1 or 2 facilitators
    - The facilitators are responsible for coordinating all activities and organizing all aspects of the intervention.
    - At least 1 must work full time.
    - At least 1 must be a gay or bisexual black man.
    - Both must be skilled in leading groups.
    - Both must be trained in the specific content of each group session (2 training sessions, 3 days each).
    - Facilitators are encouraged to satisfactorily complete trainings offered by their regional STD/HIV Prevention Training Center: “Group Facilitation,” and “Bridging Theory and Practice,” and “STD Overview for Community Providers.”
    - Neither should run more than 2 concurrent groups.
- an administrative employee of the CBO (to supervise the facilitators)
- project staff (to recruit black MSM at risk into the intervention)

Space

3MV needs meeting space, which can usually be found at the CBO. It must be

- large enough for 6 to 14 people
- safe, with comfortable seating
- easy to get to using public transportation and near where black MSM live, work, and socialize
- private and secure, so that confidentiality can be maintained
- quiet and without interruptions (such as people entering and exiting the room or outside noise)

Supplies

3MV needs

- VCR, TV, overhead projector
- markers, easels and paper, masking tape, poster boards, clothespins
- Outreach materials (poster, flyers)

RECRUITMENT

The population recruited for 3MV is black men who are gay, bisexual, or same-gender–loving and black men who may not identify themselves as gay or bisexual but who do have sexual or emotional attraction to other men (men on the down-low). 3MV is not appropriate for other MSM such as inmates who have “situational sex,” those who have sex for money or drugs who do not have sexual or emotional attraction for other men, or heterosexual men.

Note: In relation to 3MV, *black* refers to black race, including African American, African, Caribbean/West Indian, and black Latino or Hispanic.

Clients are usually recruited by the group facilitators. If potential clients are referred from other programs, the facilitators should interview them to be sure they are appropriate for the group. Printed materials may be distributed to help with recruiting.

POLICIES AND STANDARDS

Before a CBO attempts to implement 3MV, the following policies and standards should be in place to protect clients, the CBO, and the 3MV program team:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client or his or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Informed Consent

CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO’s responsibility and the clients’ rights. Individual state laws apply to consent procedures for minors; but at a minimum, consent should be obtained from each client and, if appropriate, a legal guardian if the client is a minor or unable to give legal consent. Participation must always be voluntary, and documentation of this informed consent must be maintained in the client’s record.

Legal and Ethical Policies

CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners; CBOs are obligated to inform clients of the organization's responsibilities if a client receives a positive HIV test result and the organization's potential duty to warn. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Linkage of Services

Recruitment and health education and risk reduction must link clients whose HIV status is unknown to counseling, testing, and referral services and persons living with HIV to care and prevention services. CBOs must develop ways to assess whether and how frequently the referrals made by their staff members were completed.

Personnel Policies

CBOs conducting recruitment, outreach, and health education and risk reduction must establish a code of conduct. This code should include, but not be limited to, the following: do not use drugs or alcohol, do use appropriate behavior with clients, and do not loan or borrow money.

Referrals

CBOs must be prepared to refer clients as needed. For clients who need additional assistance in decreasing risk behavior, providers must know about referral sources for prevention interventions and counseling, such as partner counseling and referral services and other health department and CBO prevention programs.

Safety

CBO policies must exist for maintaining safety of workers and clients. Plans for dealing with medical or psychological emergencies must be documented.

Selection of Target Populations

CBOs must establish criteria for, and justify the selection of, the target populations. Selection of target populations must be based on epidemiologic data, behavioral and clinical surveillance data, and the state or local HIV prevention plan created with input from state or local community planning groups.

Volunteers

If the CBO uses volunteers to assist with or conduct this intervention, then the CBO should know and disclose how their liability insurance and worker's compensation applies to volunteers. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing 3MV:

Facilitators

Training for facilitators should address

- completion of a training workshop, including review of the intervention theory and materials
- participation in practice sessions
- observed cofacilitation of groups, including practice of mock intervention sessions

CBOs implementing 3MV are encouraged to complete and use the Many Men, Many Voices implementation planning tool to plan, document, and guide their project. This tool is available at www.effectiveinterventions.org/interventions/tools/3mv_planningtool.pdf.

CBOs should have in place a mechanism to ensure that all session protocols are followed as written. For quality assurance, key staff can observe and rate the sessions in terms of adherence to session content and group facilitation skills.

Selected intervention record reviews should focus on assuring that consent forms (signed either by the client, if older than 18 or emancipated, or by a legal guardian) are included for all participants when required and that session notes are of sufficient detail to assure that clients are participating actively. The entire content of the sessions constitutes the core elements of this intervention, so the entire content must be covered to implement the intervention with fidelity.

Clients

Clients' satisfaction with the intervention and their comfort should be assessed at the end of the 7th session. Process monitoring systems should also track the number of sessions each client attends as well as reasons for not attending.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

REFERENCES

1. Kelly JA, St. Lawrence JS, Hood HV, Brasfield TL. Behavioral intervention to reduce AIDS risk activities. Journal of Consulting and Clinical Psychology. 1989;57:60–67.

MPOWERMENT

DESCRIPTION

The Mpowerment Project[1] is a community-level HIV prevention program that is run by a core group of 12 to 20 young gay and bisexual men from the community and paid staff coordinators. The core group members, along with other volunteers, design and carry out all project activities.

Mpowerment has been packaged by CDC's Diffusion of Effective Behavioral Interventions project; information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

Goals

The objective of Mpowerment is to establish a community organizing process for diffusion of risk-reduction norms, those supportive of safer-sex behavior.

How It Works

Participants bring about communitywide change by carrying out a set of 4 integrated activities that convey safer sex as the norm.

Formal Outreach

Teams of young gay and bisexual men go to locations frequented by other young gay and bisexual men to discuss and promote safer sex, deliver literature on HIV risk reduction, and distribute condoms. Additionally, teams create their own informational events (e.g., discussion groups) to educate young gay and bisexual men and promote safer sex.

M-groups

At these peer-led, 1-time, 3-hour meetings, groups of 8 to10 young gay and bisexual men discuss factors contributing to unsafe sex (e.g., misconceptions about safer sex, poor sexual communication skills). Through skill-building exercises and role-playing, the men practice safer-sex negotiation and correct condom use. The men receive free condoms and lubricant. They are trained and motivated to conduct informal outreach.

Informal Outreach

Informal outreach consists of young men having casual conversations with their friends in a relaxed, informal manner that promotes healthy community norms. They discuss the desirability of

- adopting safer-sex behaviors
- knowing one's HIV status
- seeking HIV testing
- disclosing HIV status to sex partners
- seeking medical care if HIV infected

Ongoing Publicity Campaign
The campaign attracts men to the project by word of mouth and through articles and advertisements in newspapers (gay, alternative, university).

Theories behind the Intervention

Mpowerment embodies many principles of community psychology, including the following:

- social diffusion theory
- social motivations for behavior
- importance of a community-level approach and multiple levels of approach
- community building and support
- peer influence
- empowerment philosophy

Research Findings

In the communities in which it has been implemented, the Mpowerment Project has been shown to reduce rates of unprotected anal intercourse among young gay and bisexual men.[1,2]

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based; they are thought to be responsible for the intervention’s effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.**

Mpowerment has the following 9 core elements:

- Recruit and maintain a core group of 12 to 20 young gay and bisexual men to design and carry out project activities.
- Recruit volunteers to help deliver services and to make important decisions about the program.
- Use project coordinators to oversee project activities.
- Establish a dedicated project space where many of the project activities can be held.
- Conduct formal outreach, including educational activities and social events.
- Conduct informal outreach to influence behavior change.
- Convene peer-led, 1-time discussion groups (M-groups).
- Conduct a publicity campaign about the project within the community.
- Convene a Community Advisory Board.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

Mpowerment has the following key characteristics:

- **Use Coordinators who will**
  - understand HIV prevention and community building
  - know about the local young gay and bisexual men's community
  - have leadership skills
  - oversee all project activities
  - promote racial, ethnic, and socioeconomic diversity
  - support and empower core group members and volunteers in developing and implementing activities
  - begin the process of spreading messages about safer sex
  - review and evaluate all parts of the project, their role in the project, and issues facing young gay and bisexual men

- **Maintain Core Group Members who will**
  - base decisions on the project's guiding principles
  - make important decisions (e.g., naming the local project, planning intervention activities, developing materials, choosing and furnishing the project space)
  - represent racial, ethnic, and socioeconomic diversity
  - change over time as new men join and others leave
  - support and encourage each other and other friends with regard to safer sex
  - schedule regular meetings that are fun, social, productive
  - review and evaluate all parts of the project, their own roles in the project, and issues facing young gay and bisexual men

- **Recruit Volunteers who will**
  - represent racial, ethnic, and socioeconomic diversity
  - make important decisions
  - learn new skills and conduct meaningful and interesting work (usually devoting less time than core group members)
  - support each other and stress the importance of safer sex and of HIV testing
  - create a warm, appreciative, social, and welcoming atmosphere

- **Conduct Formal Outreach that**
  - promotes safer sex, HIV antibody testing, HIV status disclosure
  - sponsors appealing events and engaging performances
  - helps build community
  - provides social opportunities
  - creates opportunities for positive peer influence
  - recruits for M-groups and other project activities
  - empowers project volunteers
  - schedules activities regularly

- **Conduct Informal Outreach that**
  - spreads a norm of safer sex and HIV antibody testing
  - uses peer influence to change behavior

  - is achieved through nonjudgmental and supportive peer interactions
  - is reinforced through other project activities

- **Hold M-groups that**
  - are led by well-trained and skilled project staff, volunteers, or both
  - address issues important to young gay and bisexual men
  - create social opportunities
  - teach safer sex, sexual negotiation skills, and how to do informal outreach
  - encourage project involvement and volunteerism
  - are scheduled regularly

- **Conduct a Publicity Campaign that**
  - creates attractive informative materials
  - reminds young gay and bisexual men of the importance of safer sex and encourages HIV testing and seeking of medical care if HIV infected
  - reaches all young gay and bisexual men in the community
  - focuses on young gay and bisexual men, not the general community

- **Form a Community Advisory Board that**
  - includes 5 to 10 persons (typically older than 30 years), who are knowledgeable about
    - the target population
    - public health in their state and community
    - prior HIV prevention efforts
    - other community institutions that reach the target population
  - serves as a resource to the core group and coordinators (meets monthly to offer advice on intervention activities)
  - links the project to a range of community CBOs
  - does not have day-to-day decision-making power

Guiding Principles

- **Social focus.** Address young gay or bisexual men's social needs; link HIV prevention to fulfillment of these needs; infuse HIV prevention into all activities.
- **Empowerment philosophy.** Empower young gay or bisexual men. Behavior change is most lasting when persons are actively involved in creating and implementing solutions to their own problems; young gay or bisexual men are the decision makers of the project; it is their own project.
- **Peer-based.** Mobilize peers to act as agents of change within their social networks; peer influence is very powerful.
- **Multilevel and multicomponent.** Address multiple predictors of risk, and operate at many levels. Young gay or bisexual men engage in high-risk sex for a variety of reasons: individual factors (e.g., perception that safer sex is dull), interpersonal factors (e.g., inability to negotiate safer sex with partner), and environmental factors (e.g., risky venues, no targeted programs for young gay or bisexual men).
- **Gay positive and sex positive.** Enrich and strengthen young gay or bisexual men's sexual identity and pride in being gay or bisexual; make safer sex methods more

attractive (not just focused on condoms); use images that reflect diversity of the community.
- **Community building.** Create healthy community; promote supportive friendship networks; disseminate a norm of safer sex throughout the community.
- **Diffusion of innovations.** Have young gay or bisexual men talk and encourage their friends to be safe; they spread this message throughout the community, and a norm of safer sex is established and reinforced.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and activities.

Procedures for Mpowerment are as follows:

Locating Coordinators

First, CBOs locate coordinators by writing letters to agencies and advertising in local newspapers. Coordinators are then hired and trained to organize all aspects of the intervention, including managing volunteers and all activities.

Assessing the Community

Next, CBOs conduct a community assessment to identify
- the different groups of young gay and bisexual men throughout the community (including what social settings exist and where the different groups congregate)
- resources (e.g., spaces in which to hold outreach events, especially those that attract young gay and bisexual men)
- people in the community who are relevant to the project (e.g., potential members of the Community Advisory Board, organizations that might support the project, places to advertise and recruit young gay and bisexual men)

After the community assessment, CBO representatives must contact community leaders and inform them of the project.

Assembling the Core Group

Coordinators must identify and invite potential members from the different segments of the young gay and bisexual men’s community to join the core group.

Recruiting Volunteers

Volunteers are recruited from the young gay and bisexual men’s community to carry out most activities.

Conducting Formal Outreach

Formal outreach includes outreach teams and outreach events.

- **Outreach teams** of young men go to specific settings for very brief activities that attract attention and promote safer sex. The teams sponsor a variety of large and small outreach events designed to appeal to each segment of the young gay and bisexual men's community.

- **Outreach events** promote safer sex and referral to HIV counseling, testing, and referral services. They also encourage the young men to learn their HIV status and to adopt and maintain safer behaviors over time. Safer-sex and HIV testing messages are infused into every project activity in an appealing and fun way. Materials (e.g., safer-sex information with motivational messages, condoms, water-based lubricants, invitations to intervention activities) are handed out at events. Examples of activities include
  - weekly video presentations
  - social gatherings
  - discussion groups
  - community forums

Young men who attend the outreach events can be invited to join the core group and participate in M-groups. Young men who want to join the core group or volunteer are encouraged to attend an M-group to learn about the project's goals and activities. The project should strive to recruit 15% to 20% of the estimated number of young gay and bisexual men in the community to attend an M-group.

Conducting Informal Outreach

Informal outreach consists of young gay and bisexual men communicating with friends in casual conversations about the need to

- engage in safer sex
- know their HIV antibody status
- disclose their HIV status to potential sex partners
- seek medical care if HIV infected

Young men learn how to conduct informal outreach while attending the M-groups. They are asked to make a commitment to speak with several of their friends, give them safer-sex packages, and invite them to an M-group. The goal of informal outreach is to develop a process of communication that promotes safer sex throughout the entire community.

Conducting a Publicity Campaign

An ongoing publicity campaign communicates project goals, health messages, and activities. The campaign uses articles and advertisements in alternative newpapers; posters and fliers; internet Web pages, chat rooms, and e-mail distribution lists; and word-of-mouth publicity within social networks. The campaign's goals are to establish awareness of the intervention, invite young men to become involved, and provide a continual reminder of safer-sex norms.

ADAPTING

Adapting means modifying the intervention to appropriately fit the local context in a way that does not violate the core elements of the intervention. Mpowerment contains preimplementation (start-up) steps to fit the intervention locally. Community assessment is a major part of the start-up work. The information obtained is used to adapt Mpowerment to make it appropriate for the location. For example, all promotional materials for Mpowerment are developed locally and are appropriate for the area. Knowledge of and skill with research methods are important to adaptation.

RESOURCE REQUIREMENTS

People

Mpowerment needs the following people:

- **Core group members**. These 12 to 20 volunteers are a diverse group of young gay or bisexual men.
- **Volunteers**. Young gay or bisexual male volunteers are needed in addition to the core group.
- **M-group facilitators.** Two facilitators are needed.
- **Project coordinators.** The number of coordinators will depend on the program and the community, but MPowerment will need at least 1.5 full-time coordinators.
- **Administrative staff member** (e.g., HIV prevention manager). This person may be from the CBO and supervises the coordinator(s).
- **Community Advisory Board members**

Space

Mpowerment must have a dedicated space for meetings (events, M-groups, volunteer trainings, staff meeting) and for young gay and bisexual men to drop in (during certain hours) to socialize, get information about community organizations and services, obtain referrals, and pick up risk-reduction resources and materials. If the CBO has enough money, a separate building is best; if not, other community agencies may help pay for a space for Mpowerment. The meeting space should

- be safe and have comfortable chairs
- be furnished and decorated
- be easy to get to, near public transportation routes, near where young gay/bisexual men live, work, and socialize
- provide a private and confidential environment if rapid HIV testing is offered
- have a TV and a VCR

Supplies

Mpowerment needs

- posters and handouts about safer sex
- condoms and lubricant to hand out
- information about referrals

RECRUITMENT

The population recruited for Mpowerment is young gay and bisexual men. Methods used to recruit people for M-groups, the core group, and the Community Advisory Board are

- formal outreach
- informal outreach
- publicity campaign

Review Recruitment in this document to choose a recruitment strategy that will work in the setting in which the CBO plans to implement Mpowerment.

POLICIES AND STANDARDS

Before a CBO attempts to implement Mpowerment, the following policies and standards should be in place to protect clients, the CBO, and the Mpowerment project intervention team:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

All process and outcome data collected from or associated with clients (e.g., worksheets, progress reports, attendance records) must be kept in a locked, secure location with only designated program staff able to access it.

Informed Consent

CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO's responsibility and the clients' rights. Individual state laws apply to consent procedures for minors; but at a minimum, consent should be obtained from each client and, if appropriate, a legal guardian if the client is a minor or unable to give legal consent. Participation either as a volunteer, a core group member, or an M-group member must always be voluntary, and documentation of this informed consent must be maintained in the client's record.

Legal and Ethical Policies

Mpowerment is an intervention that may deal with disclosure of HIV status. CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners; CBOs are obligated to inform clients of the organization's responsibilities if the client receives a positive HIV test result and the potential duty to warn. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Referrals

CBOs must be prepared to supply appropriate referrals to clients as necessary. If clients need additional assistance in decreasing risk behavior, providers must know about referral sources for prevention interventions and counseling, such as comprehensive risk counseling and services, partner counseling and referral services, and health department and CBO prevention programs for persons living with HIV.

Volunteers

Mpowerment uses volunteers to conduct the intervention; therefore, the CBO should know and disclose how their liability insurance and worker's compensation applies to volunteers. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing the Mpowerment Project:

Coordinators

Training

Coordinators should complete a training workshop that includes

- review of the intervention theory and materials
- participation in practice sessions.
- observation while cofacilitating groups, including practice of mock core groups and M-groups

Supervisors of coordinators should also (but are not required to) attend a training workshop that includes review of the intervention theory and materials.

Protocol Review

CBOs should have in place a mechanism to assure that all session protocols are followed as written. For quality assurance, key staff can review the sessions (by direct observation or videotape). They should look for

- adherence to session content
- use of appropriate videotapes and adequate facilitation of discussions
- accessibility and responsiveness to expressed client needs
- important process elements (e.g., time allocation, clarity)

Record Review

Selected intervention record reviews should focus on ensuring that consent forms (signed either by the client, if older than 18 or emancipated, or by a legal guardian) are included for all clients when required, and session notes are of sufficient detail to assure that clients are actively involved.

Clients

Clients' satisfaction with the intervention and their comfort should be assessed after each M-group.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

Hays RB, Kegeles SM, Rebchook GM. The Mpowerment Project: community-building with young gay and bisexual men to prevent HIV. American Journal of Community Psychology. 2003;31:301–312.

The University of California San Francisco's Center for AIDS Prevention Studies offers low-cost trainings for project coordinators and program supervisors and free help to some organizations. You can get training manuals and videotapes by sending an e-mail to mpowerment@psg.ucsf.edu or by going to www.mpowerment.org.

REFERENCES

1. Kegeles SM, Hays RB, Coates TJ. The Mpowerment Project: a community-level HIV prevention intervention for young gay men. American Journal of Public Health. 1996;86(8): 1129–1136.

2. Kegeles SM, Hays RB, Pollack LM, Coates TJ. Mobilizing young gay/bisexual men for HIV prevention: a two-community study. AIDS. 1999;13(13):1753–1762.

POPULAR OPINION LEADER

DESCRIPTION

Popular Opinion Leader (POL) is an HIV/AIDS risk-reduction program in which groups of trusted, well-liked people are recruited and trained to conduct a novel and particular type of outreach. This outreach focuses on a specific risk-influencing factor, a community norm, such as endorsement of safer-sex behaviors. Opinion leaders endorse targeted risk-reduction behaviors by having casual, 1-on-1 conversations with their friends and acquaintances (peers) in their own social network (friendship group).[1] Only specific peers in social networks are opinion leaders, those who are the most popular, credible, and trusted in their social network. The settings are those in which social networks can be counted or estimated and shared attitudes about HIV risk can be described. Gay bars and community centers used by women in low-income housing have been successful settings. Although originally for men who have sex with men, the POL intervention techniques have been successfully adapted to a variety of risk populations and settings.

POL has been packaged by CDC’s Diffusion of Effective Behavioral Interventions project; information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

Goals

POL aims to spread messages about a variety of health behaviors (e.g., adopting safer-sex behaviors, seeking HIV antibody testing, disclosing HIV status to sex partners, seeking prevention and medical services) throughout a community. Usually, 1 risk influencing factor, or community norm, is targeted.

How It Works

The community changes the way it thinks about protecting itself from HIV as a result of efforts of community members. During peer-to-peer conversations, opinion leaders correct misperceptions, discuss the importance of HIV prevention, and describe strategies they use to reduce risk (e.g., keeping condoms nearby, avoiding sex when intoxicated, resisting coercion for unsafe sex). They communicate their personal approval of the targeted risk-reduction behavior, using “I” statements to emphasize personal endorsement. For example, if the targeted risk-reduction norm is routine testing, the opinion leader may say, “I think that routine testing is best; routine testing is what I intend to do. I think it is possible for me to test routinely, and I think it is possible for you to test routinely too.” Effective behavior change communication is that which targets risk-reduction attitudes, norms, intentions, and self-efficacy. Factual information is limited to that which directly promotes the targeted risk-reduction norm.

Each opinion leader may recruit new opinion leaders, thereby increasing opinion leaders and conversations. The CBO does the preparatory work, including identification and recruitment of opinion leaders, and teaches vital communications skills; as the number of trained opinion leaders increases, the number of conversations in the community that endorse HIV prevention and care also increases.

Theories behind the Intervention

POL is based on the social diffusion theory. The premise is that behavior change in a population can be initiated and will then diffuse to others if enough opinion leaders within the population are known to adopt, endorse, and support the behavior. For POL, this opinion leaders shape changes in safer-sex norms to make it easier for others to start and maintain risk-reduction behavior changes.

Research Findings

POL was initially shown to increase condom use by men who have sex with men (MSM).

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based; they are thought to be responsible for the intervention's effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.**

POL has the following 9 core elements:

- Direct the intervention to an identifiable target population in well-defined community venues and where the population's size can be estimated.
- Use ethnographic techniques systematically to identify segments of the target population and to identify in each population segment those persons who are most popular, well-liked, and trusted by others (i.e., conduct community identification).
- Over the life of the program, train 15% of the target population size found in intervention venues as opinion leaders.
- Teach opinion leaders skills for initiating HIV risk-reduction messages to friends and acquaintances during everyday conversations.
- Teach opinion leaders the characteristics of effective behavior change communication targeting risk-reduction attitudes, norms, intentions, and self efficacy. Have opinion leaders endorse, in conversations, the benefits of safer behavior and recommend practical steps needed to implement change.
- Hold weekly meetings of groups of opinion leaders in sessions that use instruction, facilitator modeling, and extensive role-playing exercises to help opinion leaders refine their skills and gain confidence in delivering effective HIV prevention messages to others. Groups should be small enough to provide extensive practice opportunities for all opinion leaders to shape their communication skills and create comfort in delivering conversational messages.

- Have opinion leaders set goals to engage in risk-reduction conversations with friends and acquaintances in the target population between weekly sessions.
- Review, discuss, and reinforce, at subsequent training sessions, the outcomes of the opinion leaders' conversations.
- Use logos, symbols, or other devices as conversation starters between the opinion leaders and others.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

POL has the following key characteristics:

- Elicit the involvement, support, and cooperation of community gatekeepers.
- Identify and characterize the various social networks within the target population.
- Use key informants to identify opinion leaders from each social network in the population. The number of opinion leaders should equal at least 15% of each social network (e.g., 15 opinion leaders per 100 in the network). This percentage has been documented as the point at which social norms begin to shift.
- Train opinion leaders with regard to
  - theory and philosophy of the intervention
  - accurate information about HIV risk reduction
  - practical advice on how to implement HIV risk-reduction behavior changes
  - communication skills (e.g., modeling and role-playing) for imparting HIV risk-reduction information to others
  - initiation of effective peer risk-reduction conversations
- Seek the agreement of each opinion leader to have a specified number of conversations (e.g., 14) within a specified period with peers who are at risk.
- Place posters at intervention settings, and give opinion leaders items with logo (buttons, caps, jackets, t-shirts, key chains, or temporary tattoos) to wear while at the settings.
- Recruit additional opinion leaders by asking each current opinion leader to bring friends to participate in the next wave of the intervention.
- Train a new wave of opinion leaders, to maintain program momentum.
- Organize reunion meetings with all opinion leaders (first and successive waves) and community gatekeepers to discuss maintenance of POL.

Procedures

Procedures are detailed descriptions of how to do some of the above-listed elements and activities.

Some of the procedures for POL are as follows:

Training Opinion Leaders

An important aspect of POL training sessions is building the communication skills of the opinion leaders to help them effectively communicate HIV risk-reduction information to others in spontaneously initiated conversations. Newly recruited opinion leaders attend 4 training sessions, during which they learn communication skills and factual information. They model the conversations during training and then providing opportunities for clients to role-play and receive feedback on their conversations. Because risk-reduction topics do not typically arise in casual conversations, training must focus on how each opinion leader will initiate these conversations. This is done through group problem solving and by allowing each person ample time to discuss issues particularly relevant to him or her.

Communication skills include how to

- give practical advice for changing behaviors and seeking HIV antibody testing
- reinforce safer-sex norms through risk-reduction conversations with their peers
- endorse HIV antibody testing
- emphasize the desirability of knowing one's HIV antibody status
- describe their experiences in getting tested for HIV
- encourage peers who are HIV infected to participate in partner counseling and referral services, disclose their HIV status to future sex partners, and seek medical care

Factual information includes

- HIV/AIDS facts and myths
- HIV risk reduction
- antibody testing technologies, including rapid testing
- the importance of partner counseling and referral services as a prevention strategy
- the importance of disclosing HIV status to sex partners
- the importance of seeking medical care if a person learns he or she is HIV infected

Maintaining Opinion Leaders

At the end of the POL training sessions, each opinion leader is asked to invite 2 or more friends to attend the next training cycle. A second group of opinion leaders begins the training as the first group finishes. When the second group completes the training, it helps recruit a third group of opinion leaders. In this way, each group of opinion leaders invites the next, and the intervention continues to diffuse health norms. Reunions are held to support opinion leaders.

ADAPTING

Adapting means modifying the intervention to appropriately fit the local context in a way that does not violate the core elements of the intervention. The adapting of POL is done during the background or formative research preimplementation phase. The formative research for POL is like mapping (or drawing a map of) the target community and culture. It is similar to the community identification process used in the DEBI intervention named Community PROMISE.

POL has been successfully implemented and evaluated with risk populations other than men who have sex with men. POL has wide potential for adaptation to risk populations defined by the need for promotion of a risk-reduction supportive norm in the context of shared social networks clustered around popular, credible, and trusted individuals (opinion leaders).

Detailed information for POL is collected and analyzed for

- the target population in the targeted community setting or context
- the subgroups (social networks) therein
- the popular and credible opinion leaders in these subgroups
- the HIV risk-reduction opinion or norm in need of promotion
- an appealing and relevant intervention marketing strategy, including materials

A variety of methods can be used, depending on the task. Abbreviated and expeditious use of a variety of methods to establish social health promotion programs is called rapid ethnographic assessment. Methods that are appropriate for the formative work to establish a POL intervention program include

- sociometric surveys or community member ratings of other members in terms of popularity
- observational studies of community venues, social networks, popular individuals in networks, and HIV risk attitudes and opinions
- interviews of and support from gatekeepers and key informants
- focus groups to develop social marketing devices
- community surveys of members' knowledge, attitudes, and behaviors
- secondary analysis of existing reports and data sets (e.g., existing needs assessments, risk assessments, market studies, and census studies)

RESOURCE REQUIREMENTS

People

POL needs paid staff members and volunteers.

Paid Staff Members

Estimates of the amount of time needed by paid staff members depends on the number of opinion leaders. An example of staff time needed for 43 opinion leaders can be found at www.effectiveinterventions.org/interventions/tools/polbudget.pdf.

- senior staff (project coordinators), 4.6 hours per opinion leader
- junior staff (program workers), 4.7 hours per opinion leader
- administrative assistant 0.4 hours per opinion leader

Paid staff members will

- satisfactorily complete trainings offered by their regional STD/HIV Prevention Training Center: "Bridging Theory and Practice" and "Group Facilitation"
- possess skills in group facilitation and social science related to community-level HIV prevention interventions
- find out where the target population meets
- identify social networks and potential opinion leaders

- collect information about the target population, setting, and risk norms
- recruit and train each wave of opinion leaders
- provide materials with the logo
- hold reunion meetings for opinion leaders and gatekeepers
- be sure the intervention meets quality assurance standards
- conduct background research and ongoing creative efforts to market POL

Opinion Leaders
Opinion leaders are volunteers, but they may be paid stipends to help compensate them for costs they may incur.

Gatekeepers
These people are also volunteers.

Space

POL needs space for trainings and staff meetings (may be the CBO's office space) and the opinion leaders' conversations with peers (where the target population lives, works, and congregates). Training and meeting space should

- have comfortable seating for having discussions and watching videos
- be in the same place for each session (e.g., meeting at a business during the hour before it opens)
- be convenient to where opinion leaders live, work, and socialize
- be easy to get to using public transportation

Supplies

- Video equipment
- Incentives (e.g., transportation passes, snacks)
- Copies of prevention materials

RECRUITMENT

The original target population for POL was gay men in mid-size cities, but the intervention can be adapted to reach a broad range of populations and groups at risk. Initial recruitment of opinion leaders is based on the preimplementation, background research, or formative phase mapping and identification of opinion leaders in their social networks to ensure representation across and within social networks at the required level of 15% in each network. Initial recruitment of opinion leaders is supplemented by referrals of new opinion leaders by existing opinion leaders.

Review Recruitment in this document to choose a recruitment strategy that will work in the setting in which the CBO plans to implement POL.

POLICIES AND STANDARDS

Before a CBO attempts to implement POL, the following policies and standards should be in place to protect clients, the CBO, and opinion leaders:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client or his or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Personnel Policies

CBOs conducting outreach must establish a code of conduct. This code should include, but not be limited to, the following: do not use drugs or alcohol, do use appropriate behavior with clients, and do not loan or borrow money.

Safety

CBO policies must exist for maintaining safety of workers and clients. Plans for dealing with medical or psychological emergencies must be documented.

Selection of Target Populations

CBOs must establish criteria for, and justify the selection of, the target populations. Selection of target populations must be based on epidemiologic data, behavioral and clinical surveillance data, and the state or local HIV prevention plan created with input from state or local community planning groups.

Volunteers

CBO should know and disclose how their liability insurance and worker's compensation applies to volunteers. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing POL:

CBOs

Implementation Plan

Have an implementation plan to ensure that all of POL's core elements and key characteristics are included and followed. CBOs conducting POL are encouraged to complete and use the POL Implementation Planning and Program Objectives tool, available at www.effectiveinterventions.org/interventions/POL_tools.cfm.

Leadership and Guidance

Provide hands-on guidance to improve opinion leaders' skill and comfort in initiating and having risk-reduction conversations with peers within their social networks.

Training

Train staff to ensure that they

- thoroughly understand the intervention and its underlying theory
- know correct risk-reduction information
- identify social networks and their opinion leaders
- have group facilitation skills
- recruit and train successive waves of opinion leaders
- maintain and evaluate the intervention

Fidelity to Core Elements and Key Characteristics

Ensure fidelity to core elements to ensure program effectiveness. Have a quality assurance fidelity checklist to track whether all of POL's key characteristics were followed.

Clients

Feedback loops should be used to improve delivery of the intervention. Information should be shared with opinion leaders, whenever possible, to encourage their continued involvement.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

Kelly JA. Popular opinion leaders and HIV prevention peer education: resolving discrepant findings and implications for the development of effective community programmes. AIDS CARE. 2004;16(2):139–150.

Kelly JA, Murphy DA, Sikkema KJ, et al. Randomized controlled community-level HIV-prevention intervention for sexual risk behavior among homosexual men in US cities. The Lancet. 1997;350:1500–1505.

Kelly JA, St. Lawrence JS, Stevenson Y, et al. Community AIDS/HIV risk reduction: The effects of endorsement by popular people in three cities. American Journal of Public Health. 1992;82(11):1483–1489.

Miller RL, Klotz D, Eckholdt HM. HIV prevention with male prostitutes and patrons of hustler bars: replication of an HIV prevention intervention. American Journal of Community Psychology. 1998; 26(1):97–131.

For more information on technical assistance and training for this intervention or to get your name on a list for a future training, please go to www.effectiveinterventions.org.

Implementation materials and training and technical assistance for POL are available through the Dissemination of Effective Behavioral Interventions (DEBI) program and are also available at www.effectiveinterventions.org.

REFERENCES

1. Kelly JA, St. Lawrence JS, Diaz YE, et al. HIV risk behavior reduction following intervention with key opinion leaders of population: an experimental analysis. American Journal of Public Health. 1991;81(2):168–171.

REAL AIDS PREVENTION PROJECT

DESCRIPTION

The Real AIDS Prevention Project (RAPP) is a community-level HIV prevention intervention designed to help sexually active women and their male partners reduce their risk for HIV infection.

RAPP has been packaged by CDC's Diffusion of Effective Behavioral Interventions project; information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

Goals

The objectives of RAPP are to
- increase consistent condom use by women and their partners
- change community norms so that practicing safer sex is the acceptable norm
- involve as many people in the community as possible

How It Works

The program has 3 phases: community assessment, mobilization, and maintenance.
- **Community assessment** is finding out about the community and how to talk to women and their partners about their risk for HIV infection.
- **Community mobilization** involves the community in a combination of risk-reduction activities for the women and their partners.
- **Maintenance** occurs when project activities are running and evaluation is being conducted.

Theories behind the Intervention

RAPP is based on 3 theories.
- **The transtheoretical model of behavior change** is commonly called stages of change.[1,2] This theory says that people do not change behavior all at once but go through a series of stages.
- **The diffusion of innovation theory** says that people are more likely to adopt new behaviors when influential members of the community have already adopted them.[3]
- **The social cognitive theory** says that people learn new behaviors best when trusted sources such as their peers practice the behavior and when people have the opportunity to increase both knowledge and skills related to the behavior.[4]

Research Findings

RAPP has been demonstrated to be effective in helping women change their behavior. Women in the original study were helped to move toward consistent condom use by being given condoms and messages adapted to their stage of change. After participating in the RAPP intervention, women living in high-risk intervention communities were more likely than women living in comparison communities to have initiated condom use with their steady partners and to have negotiated condom use with steady and casual partners. Women at very high risk (e.g., sex workers) were more likely to use condoms consistently with both steady and casual partners.[5–9]

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based; they are thought to be responsible for the intervention's effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.**

RAPP has the following 5 core elements:

- **Peer Network.** Recruit people from the community to become part of the peer network to talk to women and men about HIV prevention and related issues, distribute role model stories and educational materials, and provide referrals.
    - Depending on resources and target populations being served, a CBO can have more than 1 peer network. For example, if the target population is both African American and Latina women, a CBO can have 2 peer networks to meet the needs of these 2 target populations.
    - Additionally, male and youth networks can be established. It is important for CBOs to obtain information during their community assessment about how many networks should be established. The peer networks serve not only as a mechanism to increase HIV/AIDS awareness in a community but may serve also as a support mechanism for the members (via ongoing trainings, social events, informal gatherings, etc.).
- **Staged-based Encounters.** To find out the person's stage of change, conduct encounters that are 1-on-1 conversations led by trained outreach specialists and peer volunteers who ask questions about attitudes and condom use. Then, on the basis of the response, the outreach specialists or peer volunteers give women a message aimed at encouraging them to begin or continue condom use.
    - Staged-based encounters occur over time and are not necessarily conducted during the first encounter with a community member. It may be important for outreach specialists and trained peer volunteers to first establish a rapport with their community prior to conducting staged-based encounters.
    - Only trained staff should conduct this type of outreach as it requires a certain set of skills and an in-depth understanding of the stages of change model.
- **Role Model Stories.** Develop and distribute printed role model stories that are based on interviews with community members about their decisions to change their behavior.
    - The role model stories are based on real-life experiences of people in the community. In each role model story, a certain risk behavior is highlighted along with the role model's stage of readiness to change the behavior and the influencing factors that will facilitate those changes.

    - The stories should capture only movement from 1 stage to another. However, CBOs can develop a set of role model stories based on 1 character that illustrates behavioral change through all 5 stages along with their appropriate influencing factors.
- **Community Network.** Recruit local businesses, organizations, and agencies to become part of the community network to support the project's goals. Ask them to display and distribute role model stories and other educational materials and to sponsor activities.
    - For recruitment and retention purposes, it is important for CBOs to conduct meetings for their community network members. These meetings provide an opportunity for network members to learn about RAPP, provide input, and volunteer resources to the project.
    - CBOs are strongly encouraged to conduct a yearly gathering to show appreciation for their community network members. This provides an opportunity for the community network members to renew their commitment to the project and provide recommendations for future RAPP activities.
- **Small-Group Activities.** Conduct small-group activities to promote safer sex, and host HIV/AIDS presentations. Recruitment for participation in the small-group activities is central to the outreach activities of RAPP.
    - The safer-sex gathering is a 1-session skills-building activity that allows women to learn to use male and female condoms correctly and teaches them how to negotiate safe-sex practices with their partners. However, depending on the needs of their target population, agencies can choose to have more than 1 session or gathering.
    - "Basic HIV 101" is provided during this session to increase women's knowledge about HIV transmission and associated risk behaviors.
    - Culturally based role-playing activities and condom practice are emphasized during this session to empower women to use condoms correctly and consistently with their partners. Additional sessions can emphasize self-esteem building and issues like domestic violence.
    - This type of gathering also allows for women to learn of other programs or services being delivered in their community. Referrals are made to HIV testing and counseling centers as well as to other social service providers.
    - Participants in the safer-sex gatherings should be of the same sex and age group. Men-only gatherings can be conducted. Additionally, couple gatherings can be conducted, if requested by the women.
    - The HIV/AIDS presentations are delivered in various settings to increase awareness of how HIV affects the community and to increase HIV testing and counseling among community members. These presentations are delivered in places such as schools, churches, recreation centers, businesses, and health clinics.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

RAPP has the following key characteristics:

- Hire a recognized leader in the community to be an outreach specialist. This outreach specialist coordinates the project activities, conducts outreach, and manages the peer network and community network. The outreach specialist should match the target population in race, gender, and age. It is also important that the outreach specialist have the ability to communicate to the target population in a clear, concise manner (i.e., speak the same language).
- Gather community permission from key community officials to gain support and enthusiasm for the project.
- Conduct focus groups and key informant interviews to further gather more knowledge of community needs related to HIV prevention and other pertinent information about the community.
- Train peer volunteers to have 1-on-1 conversations with members of the target population. Peer volunteers can also assess individuals' general level of knowledge related to HIV/AIDS and other sexually transmitted diseases and provide them with accurate information.
- Write short role model stories, based on the interviews, about people in different situations and stages of change regarding condom use or abstinence.
- Provide monetary incentives or stipends to peer volunteers and hold appreciation events.
- Debrief peer volunteers regularly and provide short refresher trainings.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and activities.

Procedures for RAPP are as follows:

Getting Started (Preimplementation)

The preimplementation activities can vary for different organizations and is heavily dependent upon the community needs, capacity, and resources.

Community mobilization is part of the preimplementation and implementation phases of RAPP. Having the community mobilized and excited about RAPP will work toward the success of the project. This effort is necessary to enable community members to direct and own the intervention through their continual input and personal participation in the project. Community mobilization is grounded in the diffusion of innovation theory and the social learning theory.

The purpose of community mobilization is to

- use existing networks to support behavior change
- draw attention to the role model stories and media message
- create opportunities for community involvement
- create project name and logo
- use the power of the community to initiate and maintain behavior change

Preimplementation activities usually take 9 to 12 months and include

- doing the community needs assessment
- recruiting persons for focus groups and key participant interviews
- finding volunteers for the peer network and community network
- arranging for materials to hand out

Step 1. Identify key community members and solicit community involvement. A promotional video designed to give an overview of the project and to get people excited about RAPP can be used.

Step 2. Get to know the community. This involves not only identifying physical boundaries and who lives in the community but also finding out what community members think about HIV prevention, what they see as the issues related to HIV, what the barriers are to changing their beliefs and attitudes, and what their ideas are about overcoming these barriers.

Step 3. Conduct focus groups and interview key participants. Gather information about what people want to know about HIV prevention, what messages they want to hear, and how they want to hear them. Invite people who know a lot about the community and can provide information about community attitudes and perceptions. Their insights can help CBOs plan ways to adapt RAPP to meet the needs of the community in a way that is acceptable to the people who live there. Key participant interviews can be done during the same time period as the focus groups. CBOs should plan to complete both in 6 to 8 weeks.

Focus groups are discussion groups among people who are invited because of their knowledge about a specific topic.[10–11] Conduct at least 4 focus groups, with 8 to 10 people from the community in each. Focus groups can point out some obstacles that CBOs may face in implementing RAPP as well as strategies to overcome them. A key component to successful focus group outcomes is having a trained group leader. Inexperienced group leaders will need training.

To get the widest range of opinions, the focus groups should be conducted with the following people:

- community leaders and other influential people who can “make or break” the project
- adult women who can share issues specific to women
- adult men who can provide insights from the male perspective
- teenagers

Key participant interviews are 1-on-1 interviews conducted with people who know about the community and about the people who will be affected by the project’s activities. Recognized community leaders, residents of the community, and people with alternative lifestyles (e.g., sex workers) should be interviewed. They should be asked about attitudes, beliefs, and perceptions related to HIV prevention.

Running the Project (Implementation)

This phase involves

- doing outreach
- scheduling and tracking peer network activities
- training volunteers, getting feedback from them, and adjusting according to the feedback
- writing new role model stories
- doing community networking
- leading safer-sex presentations
- keeping records

In the third or fourth month of the project, CBOs should begin recruiting community network members and having peer network volunteers distribute role model stories.

In the fourth or fifth month, CBOs should begin to conduct stage-based encounters, develop new role model stories, and recruit hosts for safer-sex programs and sponsors for HIV presentations.

Outreach is a major part of RAPP. It can take on several forms, as described below.

Peer Network

Having a peer network is 1 of the 5 core elements of RAPP. It is a group of 6 to 8 community members who volunteer 2 or 3 times a week to go out in the community; talk to people about safer sex; and hand out role model stories, educational materials, and condoms.

To create a peer network, CBOs will need to recruit members of the community; orient them to the project; and give them training for street outreach, stage-based encounters, and other activities. Initially peer network volunteers may be hesitant to talk to people in the community, and it is suggested that role-playing activities be encouraged to allow volunteers to practice their skills.

The peer network guide should be given to every peer volunteer during the peer network training. The guide is to be used as a resource for peer network members to familiarize themselves with the roles and responsibilities of being a peer network member. Active recruiting and training for the peer network should be conducted at least twice a year because dropouts may occur.

CBOs should use the following strategies for maintaining their peer network:

- Identify responsibilities early.
- Provide incentives such as gift certificates.
- Give volunteers a special bag for carrying materials.
- Present certificates for completed trainings.
- Provide ongoing support.

Stage-based Encounters

Stage-based encounters are specific kinds of outreach activities based on the stages of change theory. A stage-based encounter is a 1-on-1, face-to-face, brief interview aimed at helping women think about changing a risky behavior (such as having unprotected sex) or maintaining a healthy behavior (like using condoms all the time).

In a stage-based encounter, a trained interviewer (a peer volunteer or outreach specialist) asks a few questions to determine readiness for behavior change. On the basis of the answers, the interviewer responds in a way that will help the person change a behavior or continue doing the new behavior. This process is called staging.

Stage-based outreach involves 5 things.

- Making contacts where people in the community live, work, and play
- Asking a few simple questions to find out whether the person is using condoms
- Determining the person's stage of change
- Responding in a way that gives information, encouragement, and positive feedback specific to the person's stage of change
- Handing out role model stories and condoms

Peer volunteers and the outreach specialist should carry role model stories and condoms every time they go out to do street outreach. During the stage-based encounter, they should offer the person to whom they are talking a story, a condom, and information on where to get counseling and testing for HIV or help with other problems. This type of encounter should take 5 to 10 minutes.

CBOs implementing RAPP should conduct a 2-day training on stage-based encounters for everyone in the peer network. This training should cover the stages of change, influencing factors, strategies for staging, and instructions for reporting the activity.

Role Model Stories

These stories are a very important part of RAPP outreach. They are printed stories based on interviews with people about their decision to change their behavior. In these stories, people in different situations and stages of change tell about real-life experiences that made them think about, start, or continue using condoms. Because role model stories are based on the experiences of community members, they deal with issues to which other residents can relate. This makes role model stories culturally sensitive and culturally appropriate.

Role model stories are framed using the stages of change theory. Each story relates to changing 1 behavior, is written for 1 of the 5 stages of change, and uses 1 or more of the influencing factors. The purpose of the stories is to help people move toward consistent condom use. CBOs should develop stories that show how people move from not using condoms or using them only sometimes to using them all the time. The role model stories should be developed into a colorful pamphlet or flyer that would fit into a pocket or purse.

CBOs developing their own role model stories or adapting existing ones should create an annual story plan. This plan outlines the number of stories a CBO should put out every month, the stages and topics that will be dealt with, and when each story will be distributed. Ideally, CBOs should develop 2 new stories each month (i.e., 24 stories a year). If resources are limited, CBOs should use existing stories that are available in the intervention package. CBOs can use them in their original form or adapt them so that they better fit the community.

Community Network

The community network is a group of businesses, agencies, and organizations in the community. The primary function of the community network is to provide a place where role model stories are easily and widely available for clients and customers. By making stories available to a large number of people, the community network provides an opportunity for community members to get HIV prevention messages.

The more businesses, agencies, and organizations that are involved, the more the awareness in the community of HIV and AIDS. Community networks should have at least 25 members. Examples include nail and hair salons, barbershops, welfare offices, restaurants, banks, drug stores, newsstands, convenience stores, record stores, clothing shops, health care agencies, and schools.

Invitations to be involved in RAPP should be done in person and should include a brief description of the project, expectations, and a determination of the members' level of support for the project. Members of the community network should be sent at least 2 letters each year to thank them for their support of RAPP and to report on the project's activities and accomplishments. Information about community networking activities should be recorded on the RAPP activity reporting form (supplied in the RAPP implementation package).

Small-Group Activities

These activities give people an opportunity to learn about HIV prevention. The outreach specialist and the peer volunteers should organize 2 kinds of small group activities: safer-sex gatherings and HIV informational presentations.

Safer-sex gatherings are usually hosted in homes, but they can also take place in other settings where people feel comfortable, such as community centers. The outreach specialist or peer volunteers should recruit residents from the community to host the gatherings and to invite 6 or 8 of their friends over to play educational games, win prizes, and learn about HIV prevention. The outreach specialist directs the activities. Peer volunteers may also host, help with, and lead safer-sex presentations, which should last about 1.5 hours. The host should privately be given an incentive such as a gift certificate. Information about the gathering should be recorded on the RAPP activity reporting form.

HIV informational presentations take place in more formal group settings where people can learn about how HIV is spread and about prevention strategies. The outreach specialist should conduct these presentations for members and nonmembers of the community network. The presentations should last about 1 hour, with an optional follow-up session.

ADAPTING

RAPP can be adjusted to meet the needs of populations other than African American and Latino women. The adapted intervention must be culturally competent. When RAPP is adapted to fit the needs of a population, it is important to adapt the objectives, educational activities, recruitment strategies, and peer and community network member roles. In addition, adapting must be approached systematically to ensure that

- the needs of the target population(s) and community are met
- the balance between fidelity and local implementation needs are met
- consistent and effective implementation is achieved and maintained

Examples of adapting RAPP include

- using RAPP with male and female migrant farm workers
- conducting stage-based encounters in a community center where members of the immigrant communities congregate

The RAPP model lends itself well to supporting CDC’s new Advancing HIV Prevention initiative. The initiative is aimed at reducing barriers to early diagnosis of HIV infection and increasing access to and use of quality medical care, treatment, and ongoing prevention services for persons living with HIV. RAPP can be adapted to support the 4 priority AHP strategies in the following ways:

AHP Strategy 1. Make voluntary HIV testing a routine part of medical care.
RAPP can integrate the APH initiative into the activities that are associated with each of its 5 core elements. As a communitywide, community-level intervention, RAPP supports the distribution of information and referrals to testing through peer-based outreach, through discussions of testing and its importance in small-group gatherings and presentations, through providing information and stories about testing in project-based literature, and by making this literature available in a network of community businesses and organizations. These activities, along with encouraging voluntary testing and making it 1 of the foci of desired behavior change in the stage-based encounters and role model stories, also may help make this behavior a community norm.

AHP Strategy 2. Implement new models for diagnosing HIV infections outside medical settings.
All activities described above can also be used to promote and provide information on programs or sites that offer special programs or opportunities for testing. CBOs that implement RAPP can offer testing, including rapid testing, or refer people to organizations or programs that can provide testing. In forming the community network, CBOs that implement RAPP can pay special attention to including AIDS service organizations and other agencies offering programs for diagnosing HIV infections outside of medical settings.

AHP Strategy 3. Prevent new infections by working with persons diagnosed with HIV and their partners.

Consistent condom use—the initial RAPP behavior change objective—will help prevent new infections. In addition, staff and volunteers from the CBOs conducting RAPP can refer, to case management or other services, any persons living with HIV that they encounter. They can provide information about the importance of partner notification. With the exception of information that may be provided in the course of a stage-based encounter, it is unlikely that RAPP personnel will know whether they are talking to someone who has a diagnosis of HIV. However, other RAPP activities can be used to provide sources for additional referrals or referral information. Use of a well-developed referral network is critical.

AHP Strategy 4. Further decrease mother-to-child HIV transmission

Pregnant women encountered in any of the activities conducted by RAPP staff and volunteers can be given information about the importance of prenatal care as well as testing and can be given referrals. (Voluntary testing is an integral part of standard prenatal care.) Encouragement provided through stage-based encounters, role model stories, or peer street outreach may be influential in a pregnant woman’s decision to be tested.

RESOURCE REQUIREMENTS

People

- RAPP needs a project coordinator.
- RAPP needs 1 or more paid outreach specialists. The number will depend on the size of the community to be served, epidemiologic data on HIV incidence rates and AIDS cases, and services available in the community. Outreach specialists should be hired as early as possible because their duties span the preimplementation and the implementation phases.
- RAPP also needs 10 to 30 peer network members.

Space

RAPP needs a place to hold trainings and staff meetings. It should

- have comfortable seating for 6 to 12 people
- be near public transportation
- be near where the target population lives, works, and congregates

Supplies

RAPP needs

- a TV and VCR
- a computer and printer
- condoms
- incentives

RECRUITMENT

The populations recruited for RAPP are women at risk for HIV, peer volunteers, role models, and members of the community network. Women at risk for HIV include women who have multiple sex partners, have a partner who injects drugs, trade sex for drugs, or are injection drug users.

Peer Volunteers

Peer volunteers should like to talk to people on the street and be comfortable discussing HIV and other sensitive topics. They should vary in age, gender, and race to match the population being recruited.

Recruit peer volunteers through

- the outreach specialist
- volunteers of the network
- flyers and formal (mailed) invitations
- referrals from other agencies

Role Models

Role models should use condoms all the time or be in the process of making changes toward using condoms all the time. They can talk about their experiences with trying to use condoms and can explain how and why they have changed their behavior.

Recruit role models by

- talking with peer volunteers
- placing ads on the back of the role model stories
- handing out flyers
- talking to people at safer-sex gatherings
- getting referrals from other agencies (e.g., CBOs, health care providers, homeless shelters, religious institutions, schools)

Community Network

Peer volunteers and the outreach specialist can recruit community network members from businesses and agencies that they use and from places where their friends and family visit. Community network members should be recruited in person.

Review Recruitment in this document to choose a recruitment strategy that will work in the setting in which the CBO plans to implement RAPP.

POLICIES AND STANDARDS

Before a CBO attempts to implement RAPP, the following policies and standards should be in place to protect clients, the CBO, and staff:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client or his or her legal guardian must be obtained. All documents and forms containing clients' information should be locked away in file cabinets. The outreach specialist, peer network volunteers, and any persons involved in the project should be strongly cautioned about the confidentiality of any information disclosed during any RAPP activities. Special trainings dedicated to this topic may be required.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Linkage of Services

Recruitment and health education and risk reduction must link clients whose HIV status is unknown to counseling, testing, and referral services and persons living with HIV to care and prevention services. CBOs must develop ways to assess whether and how frequently the referrals made by their staff members were completed.

Personnel Policies

CBOs conducting outreach must establish a code of conduct. This code should include, but not be limited to, the following: do not use drugs or alcohol, do use appropriate behavior with clients, and do not loan or borrow money.

Safety

CBO policies must exist for maintaining safety of workers and clients. Plans for dealing with medical or psychological emergencies must be documented.

Selection of Target Populations

CBOs must establish criteria for, and justify the selection of, the target populations. Selection of target populations must be based on epidemiologic data, behavioral and clinical surveillance data, and the state or local HIV prevention plan created with input from state or local community planning groups.

Volunteers

If the CBO is using volunteers to assist in or conduct RAPP, the CBO should know and disclose how their liability insurance and worker’s compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing RAPP:

RAPP Outreach Specialists

RAPP outreach specialists should have extensive knowledge of HIV transmission and of local and national statistics. Outreach specialists should reflect the target population in race, gender, and age and should deliver the information in a nonthreatening and culturally relevant manner.

Peer Network Training (1 day)

During the beginning of the RAPP intervention, the outreach specialist and peer volunteers should be trained by a professional who is very familiar with the curriculum. Later, the trained outreach specialist can conduct training sessions, using the materials in the RAPP training manual. Volunteers should have this training, followed by experience in doing peer networking, before they participate in the stage-based encounter training. Additional trainings and retrainings should be conducted on an as-needed basis, including when new information needs to be shared.

Role Model Stories Training

This training should first be conducted by a trainer who is familiar with using the stages of change theory and who has experience conducting interviews. Subsequent training sessions can be conducted by the outreach specialist or CBO staff. Additional 1-on-1 training may be needed.

Staged-Based Encounters Training (2 days)

This 2-day training should be conducted by the outreach specialist or CBO staff. Participants in this training should have attended the 1-day peer network training. The first day of this training should focus on identifying stages of change, and the second day should concentrate on identifying and using influencing factors. The 2 sessions should not be held more than 1 week apart. The training should be conducted with small groups of 6 to 8 trainees. Frequent review and periodic retraining sessions with peer volunteers may be necessary. This training should be conducted by a trainer who is familiar with the application of stages of change theory.

All RAPP Training

Quality assurance activities can include direct observation and review of training conducted by the outreach specialist. The review could focus on the quality (or adherence to the fidelity) of the training delivered and responsiveness and openness of the volunteers to the outreach facilitator. Outreach specialists should collect all evaluation forms after the training and ensure confidentiality of the peer volunteers. In addition, outreach specialists should ensure that all clients are actively involved in the training activities. Monthly meetings with supervisors to discuss progress and opportunities for change are encouraged.

RAPP Outreach Activities

All RAPP outreach activities should be recorded on the RAPP activity reporting form to ensure that the intervention is being implemented as intended by the original researchers. Keeping these records will help CBOs monitor and assess how each RAPP core element is being implemented in the community.

The RAPP activity reporting form monitors the following:

- Who has been contacted, when, where, and what was the outcome
- The number and types of activities being conducted
- The type of persons being reached (gender, age, risks)
- The number and types of referrals being made
- The supply of role model stories at drop sites
- The number of safer-sex gatherings and HIV presentations conducted

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

For more information on technical assistance or training for this intervention, please go to www.effectiveinterventions.org.

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SAFETY COUNTS

DESCRIPTION

Safety Counts is an intervention to prevent HIV and viral hepatitis, designed specifically for persons who are using illicit (not prescribed) drugs and who are not ready or not willing to enroll in drug treatment programs or otherwise stop their drug use. It helps clients understand how their drug-use behaviors are related to important influencing risk factors that put them at risk for HIV infection and design a plan to reduce these risks. Using structured group and individual activities conducted over a period of 4 months, the intervention helps clients develop personal risk-reduction goals and define specific steps for achieving them. An important component of Safety Counts is recruitment, which links clients to counseling, testing, and referral; prevention and treatment services; care; and other support services.

Safety Counts uses a client-centered approach, which helps create a partnership based on trust and understanding between staff and clients. Safety Counts is appropriate for HIV-infected as well as HIV-negative clients who have used illicit drugs in the past 90 days. Clients may be either injection drug users (IDUs) or drug users who do not inject. Examples of specific drugs that individuals may be using, either by injection or by smoking, sniffing, or consuming, are heroin; cocaine; speedball; marijuana; methadone not prescribed by a treatment program; methamphetamine; club drugs such as ketamine, MDMA, 2CB, and benzodiazepine; and pharmaceutical drugs such as Xanax, Vicodin, Demerol, and Percodan.

Safety Counts has been packaged by CDC’s Diffusion of Effective Behavioral Interventions project; information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

Goals

The primary objective of Safety Counts is to reduce HIV transmission among drug users. It also strives to increase understanding of drug-use patterns in relation to HIV infection risk and to monitor HIV seroprevalence among drug users. The program consists of 7 sessions held over 4 months.

How It Works

Clients identify the behaviors that put them at risk, identify and take ownership of personal risk-reduction goals, and develop steps for achieving these goals.

Theories behind the Intervention

Safety Counts uses social modeling, social support, and behavioral contracting (goal setting). Under the guidance of counselors and outreach staff, clients design and manage a personal HIV risk-reduction plan. Clients recognize how their own behaviors may put them at risk for HIV, hepatitis C, and other bloodborne and sexually transmitted diseases; figure out what they can reasonably do to reduce their risk for HIV and hepatitis C; take ownership of their personal risk-reduction goals; and develop and manage plans for achieving those goals. This client-centered approach helps clients reduce HIV risk behaviors and HIV infection and helps clients and their peers reduce drug use and increase entry into drug treatment. By engaging the client in group and individual sessions, Safety Counts helps form a partnership between clients and CBO staff.

Research Findings

Research showed that participants in the intervention group were more likely than those in the comparison group to report behavior changes at follow-up (5–9 months after enrollment).

- Increased condom use
- Cessation of crack use
- Cessation of drug injection
- Reduced injection drug use

Also, at follow-up fewer crack cocaine users in the intervention group had positive test results for cocaine.[1]

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based; they are thought to be responsible for the intervention's effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.**

Safety Counts has the following 5 core elements:

- Conduct 2 group sessions to have clients
    - identify their HIV risks and current stage of change
    - hear risk-reduction success stories
    - set a personal goal
    - identify a first step to reduce HIV risk
- Conduct 1 (or more) individual counseling session to
    - discuss and refine the client's risk-reduction goal
    - assess the client's needs and refer, if needed, to HIV counseling and testing services and to medical and social services
- Hold 2 (or more) group social events to have clients
    - share a meal and socialize
    - participate in planned HIV-related risk-reduction activities
    - receive reinforcement for personal risk reduction
- Conduct 2 (or more) follow-up contacts to
    - review the client's progress in achieving risk-reduction goal
    - discuss barriers encountered
    - identify a next step and possible barriers and solutions
    - refer clients, if needed, to HIV counseling and testing services and to medical and social services
- Conduct or refer to counseling and testing for HIV and hepatitis C.

Each core element of Safety Counts must be implemented as prescribed in the Safety Counts program manual to ensure fidelity to the original intervention. The sessions are to be provided in the order and manner indicated in the program manual, in accordance with the 4-month timeline of the intervention. This required sequence of events is the most efficient way to conduct the Safety Counts intervention. Any deviation from the order outlined in the program manual may result in clients' failure to achieve or adhere to their chosen risk-reduction goal and may ultimately compromise the effectiveness of the Safety Counts intervention.

It is strongly recommended that prior to conducting any of the Safety Counts core sessions, CBOs conduct a program enrollment session to establish a new client's willingness to participate in the intervention, assess the client's specific risks, gather demographic information, and establish the client's eligibility for the intervention. The agenda of this session should also include acquiring contact information (mail or e-mail address, telephone number, name of a friend or relative, hangouts) that can be used to communicate with the client to remind him or her of upcoming sessions and to locate the client for follow-up.

Group Sessions

To maintain the integrity of the intervention, CBOs must not add additional content to either of the group sessions. In particular, additional HIV/AIDS educational information beyond what is already included should not be added to these sessions. Also, additional sessions or workshops should not be added to the 2 existing group sessions of Safety Counts. CBOs that wish to continue their existing HIV/AIDS or viral hepatitis educational presentations must offer them under a different program name not associated with Safety Counts; attendance should be optional for Safety Counts clients. Although "HIV/AIDS and Hepatitis 101" informational classes can have a number of benefits (e.g., providing an opportunity to make referrals for medical care, mental health care, or other services), they are not a part of Safety Counts and should not be incorporated into the program.

In group sessions 1 and 2, personal risk-reduction success stories are used to empower clients to take steps to reduce their own risks for HIV and hepatitis through experiencing the personal stories of peers who have successfully made such changes in their lives. These stories should reflect the experiences of drug users in your local community and may be in the form of videos, audiotapes, or printed flyers. Each story must conform to a prescribed format and address certain specific topics and questions. Step-by-step guidelines for constructing risk-reduction success stories are contained in Appendix C of the Safety Counts program manual, and these should be followed exactly.

Incentives may be provided to persons whose personal risk-reduction success stories are being developed for use in the intervention. A signed release must be obtained from each person whose personal story will be used (a sample release form is included in the program manual).

Written stories are the easiest to develop, but although quite acceptable, they are not as powerful as video stories. Video stories, on the other hand, are more difficult to develop. However, today's technology can ease the burden considerably. One agency in New York purchased a Sony digital camcorder and, using the editing software supplied with it, produced the required risk-reduction success stories on DVD disks. Total cost for the camera and software was around $700. (Access to a laptop or other computer with a DVD burner and room to load the editing software was also necessary.) It took staff about a week to become familiar with the camera and learn how to use the editing software. They were able to produce their first risk-reduction success stories for presentation in the group sessions within 2 weeks of purchasing the camera.

If your CBO decides to produce video stories, they must be edited to produce effective stories for use in the intervention. It will not work to shoot raw footage and show it without editing. We recommend that prior to a video recording session, the role model be guided in developing and rehearsing the answers to the questions provided in guidelines (program manual, Appendix C). This ensures that the client understands what is expected and can respond appropriately; it also relieves some of the stress associated with the actual recording of the story. An interviewer then asks these questions of the role model during the recording session, and they are edited out, along with any extraneous comments and digressions on the part of the role-model, after the conclusion of all recording. (This same general approach is also useful in developing audio-recorded stories.)

Individual Counseling Sessions

The 1-on-1, private counseling session should be conducted by someone who has experience with and knows how to talk with drug users. The counselor does not need to be licensed. It is suggested that more than 1 individual counseling session be conducted to ensure that the client fully understands his or her goal and the steps needed to reach that chosen goal. It is also suggested that a final individual counseling session be scheduled so the last risk-reduction checklist can be conducted when the client will be staged for progress in his or her behavior change. This will allow staff an opportunity to congratulate the client for completing Safety Counts and for successfully (or not) changing a risk behavior. In addition, this session will provide time to assess clients' needs for referrals to other prevention services or medical care.

Group Social Events

A key objective of the Safety Counts social events is to provide validation, problem solving, and skills building focused on the specific risk-reduction goals that clients have chosen. Social events require at least 1 staff member to serve as master of ceremonies and small-group facilitator and another staff member to handle food service and general logistics.

A "planned HIV/hepatitis-related risk-reduction activity," following the guidelines set forth in the program manual, must be included as part of every Safety Counts social event. It must be a structured activity that is focused on a particular aspect of supporting and facilitating clients' achievement of their individual risk-reduction goals. Activities that seek to provide only general information about HIV or hepatitis transmission or prevention without engaging clients regarding their personal Safety Counts goals do *not* qualify as planned risk-reduction activities for the purposes of Safety Counts.

Examples of planned risk-reduction activities include working in small groups to share social support stories, discussing personal triggers for positive behavior change, and sharing successes and challenges in working toward personal risk-reduction goals. Other examples are described in the Safety Counts program manual. CBOs are encouraged to design their own risk-reduction activities rather than limiting themselves to ones suggested in the program manual. Again, all of these activities must meet the specific criteria outlined above for planned risk-reduction activities.

An entertainment activity is also a part of each social event. This is an opportunity for CBO staff members to express their creativity. Entertainment activities may be oriented around aspects of the Safety Counts program or around factual information about HIV and hepatitis. Clients may be entertained with a humorous skit poking fun at some aspect of the Safety Counts program or HIV and hepatitis prevention Some CBOs have used television game show formats like “Jeopardy” and “Family Feud” to encourage participants to learn more about HIV and hepatitis transmission and prevention. CDC is also pilot testing “Who Wants to Be a Millionaire” for the Safety Counts program.

To maximize involvement and retention of Safety Counts clients, social events should be held no less often than once a month during the 4-month period of the intervention, and clients should be encouraged to attend as many events as possible (a minimum of two are required). This will allow clients maximum opportunity to benefit from social support provided by their peers as well as to develop and strengthen positive social relationships with other Safety Counts participants.

The timing of social events is critical to their success; therefore, it is important for CBOs to determine the best time to hold social events. One CBO in New York has found that mornings, as opposed to evenings or late afternoons, are better in terms of attendance and that the end of the month is best for clients.

To make optimum use of budgeted funds, CBOs are advised to buy food and supplies in bulk for social events. When possible, CBOs should involve clients in organizing and preparing for social events.

Follow-up Contacts

Outreach is 1 of the strong program components of Safety Counts, and the 2 follow-up contacts are core elements and, therefore, must be conducted in order. Outreach workers conduct at least 2 follow-up contacts with clients in the community, on their turf. This contact serves to support clients’ behavior change when they are in a setting outside the CBO. During the follow-up contact, the client might need to be reminded of his or her goal, be commended for completing the first step, or create new steps to reach the goal. After the follow-up contact, the client can be referred back to the CBO to attend a social event or have another individual counseling session intended to resolve any misunderstandings or confusion pertaining the steps needed to obtaining the chosen goal.

Outreach workers will have been introduced to clients during the course of the preceding Safety Counts events. Outreach workers will also have been informed of appropriate places and times for contacting clients in the field, this information having been gathered during the enrollment session.

HIV and Hepatitis C Counseling and Testing

Making active referrals for HIV and hepatitis (especially hepatitis C) counseling and testing is a core element of Safety Counts. Referrals for viral hepatitis vaccinations are strongly recommended. At each Safety Counts activity, information about the benefits of such services must be made available. If your CBO does not provide HIV and hepatitis C testing or viral hepatitis vaccinations, it must collaborate with agencies that do. Clients' needs for HIV and hepatitis C testing and viral hepatitis vaccinations can be assessed at the program enrollment session, during individual counseling sessions, and during follow-up contacts. Social events provide an excellent time to discuss the importance of HIV and hepatitis C testing and viral hepatitis vaccinations and to even have staff members who conduct such services attend to meet potentially interested clients.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

Safety Counts has the following key characteristics:

- Help the client identify and access sources of social support for accomplishing a personal risk-reduction goal.
- Use different media (e.g., videotapes) for risk-reduction success stories of local drug users who have reduced their risk for HIV and hepatitis.
- Provide ongoing guidance and reinforcement for each client's step-by-step progress in achieving the risk-reduction goal.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and activities.

Procedures for Safety Counts are as follows:

Counseling and Testing

As a result of the activities in Safety Counts, voluntary counseling and testing is offered to clients.

- **If the CBO already offers counseling and testing,** then this intervention fits in well with these services.
- **If the CBO does not offer counseling and testing,** then clients should be referred to organizations or agencies that do.

Although clients are not required to have been tested for HIV before attending the first session, those who have not recently been tested should be encouraged to get tested and learn their HIV status as soon as possible.

Recruiting and Conducting Outreach

In this important component of Safety Counts, clients recruit their peers into the group sessions. A peer who enrolls in the Safety Counts program is encouraged to seek counseling and testing for HIV, hepatitis C, and other infectious diseases as soon as possible, preferably on site. Staff also refer clients to prevention and treatment services; drug treatment services; shelter; and other social, medical, and support services.

Conducting the Intervention (general)

- Provide a meeting space that is comfortable and inviting.
- Plan interventions at the same time and place, which should be convenient and should not conflict with clients' other responsibilities or needs.
- Plan intervention sessions (especially socials) that are lively and developed with plenty of input from clients.
- Create an environment of trust and respect.
- Maintain strict confidentiality.
- Include the capacity to refer clients to other services (domestic abuse agencies, rape counseling, and mental health).

Conducting Sessions (specific)

Group Sessions 1 and 2. The group sessions help clients identify their personal stage of change. These sessions give clients an opportunity to talk with peers and CBO staff about risk behaviors and prevention methods. They also enable clients to view videos about risk reduction. The video provided in the Safety Counts kit is a copy of the video used in the original intervention, showing how local drug users were able to successfully adopt sex- and drug-related risk-reduction strategies. To increase the authenticity of the stories, CBOs are strongly encouraged to make their own videos using persons from their local communities. Alternatively, CBOs may choose to produce audiotapes or written stories or to arrange for live testimonials describing personal risk-reduction successes. Live testimonials, however, are the least desirable mechanism because of their uncontrolled nature. The group sessions help clients understand that personal risk reduction is relevant, needed, and achievable. During the group sessions, clients think about how risk behaviors apply to them, set a personal goal for reducing HIV risk, and decide on a first step toward meeting that goal.

Individual counseling. The individual counseling session, which is conducted after the group sessions, focuses on behavior. It gives clients an opportunity to reflect on their personal risk-reduction goals and barriers to achieving those goals.

- **If the goals were unrealistic or too difficult,** clients work with counselors to revise them and come up with smaller, more achievable steps toward risk reduction.
- **If the goals were easily achievable,** clients and counselors set more challenging goals.

The individual session allows for the intimacy and confidentiality of discussing risk-taking behavior in detail. This session also provides an opportunity to build rapport between the counselor—who acts as a supporter—and the client. Finally, the individual session is an opportunity for assessing a client's needs and referring the client to medical and support services, if needed.

Social events. After participating in the group session, clients attend at least 2 social events. The events must have a planned HIV-related risk-reduction activity such as a game, workshop, or presentation. Typically offered monthly, the social events provide an opportunity to strengthen clients' relationships with the program, CBO staff, and peers. The social events offer a less formal setting, usually with a meal provided, where clients are given support for their progress in achieving personal risk-reduction goals. Clients are encouraged to invite friends and family members. These social events can help motivate clients to complete the full 7-session intervention.

Follow-up contacts. Outreach workers contact their clients at least 2 times after the individual counseling session. These follow-up contacts are structured and planned in advance with input from other CBO staff members who have worked with the client. However, outreach workers are encouraged to attend group sessions and social events so they are well acquainted with clients. Follow-up contacts may be conducted in the CBO, on the street, in the home, or elsewhere in the community. Their purpose is to review clients' progress toward achieving their risk-reduction goals, offer strategies to overcome reported barriers, and offer encouragement to continue toward the goals. Referrals are offered for social, medical, drug treatment, shelter, and other support services, as needed.

RESOURCE REQUIREMENTS

People

At the minimum, Safety Counts requires the following:

- 1 dedicated full-time outreach worker to conduct follow-ups, cofacilitate group sessions 1 and 2, and help with setting up and coordinating the social events
- 1 full-time behavioral counselor (need not be licensed) to conduct individual counseling sessions, facilitate group sessions 1 and 2, and conduct all social events
- 1 part-time (35%) program director to be responsible for overall administration of the intervention, supervise, and help with social events

Ideally, you would want a full-time outreach worker, counselor, group facilitator, and program director. The outreach worker will eventually be so busy conducting follow-ups that he or she might not be available to cofacilitate groups and help with social events.

Team members must be sensitive, skilled, and knowledgeable about the drug-using culture and its various populations. Ideally (for easier management), they should all be from the same agency, but it may be necessary to share human resources with other agencies.

Outreach workers for Safety Counts must be completely familiar with the local drug-using community; it is preferable that they be recovering drug users. CBOs that do not have a lot of experience with outreach to active drug users are encouraged to form a peer advisory panel composed of indigenous current drug users, former drug users, or both. This panel can guide initial recruitment efforts and advise as to what incentives may be most effective.

Space

Safety Counts needs space for group meetings and individual counseling sessions.

Space for group meetings must

- be available when needed
- be large enough for groups (group sessions of 8–10 people, social events of up to 30 people)

- have comfortable seating arrangements for small- and large-group activities

Space for individual counseling sessions should be an office, preferably not a cubicle, where client confidentiality can be maintained. It must have a door for privacy and comfortable seating for counselor and client.

Other

- **Money.** The cost of Safety Counts will vary according to regional and local differences; however, cost can be significantly reduced if supplies, services, and incentives are donated rather than purchased. When implementing Safety Counts, it is best to start with your budget first. Look at the amount of money you have, and then think about how many clients you would like to serve. The Safety Counts program manual suggests 8 to 10 clients per group, which means 8 to 10 per 4-month intervention cycle. Some agencies have implemented Safety Counts using 6 to 8 clients per group. You can consider having ten 4-month Safety Counts interventions a year, recruiting and starting a new 4-month intervention cycle approximately each month, or you can have three 4-month interventions a year. It all depends on your budget. The following example can be used as a general guide. If you have 10 clients per Safety Counts intervention, you need to consider cash or other incentives for all 10 and transportation assistance for all 10, then multiply that by 7 for each intervention activity (core element). That is just transportation assistance and incentives. For refreshments, calculate the cost for food and drink for all 10 at group sessions 1 and 2, and for the social events for the 10 and their guests. Once that is done, take your total (for transportation assistance, incentives, and food) and multiply that by the number of Safety Counts interventions you will conduct a year. That is the total cost to fund just the intervention.
- **Transportation** for clients and outreach workers, depending on where Safety Counts is implemented. In metropolitan areas, subway or bus tokens should be made available to clients, both as an incentive and as insurance that they will attend the intervention activities. In rural areas, consideration should be given to providing funds or vouchers for gasoline. CBOs may also consider asking clients to share rides to Safety Counts events.
- **Supplies** (TV, easels with paper and markers, safer-sex and needle-hygiene kits, photocopier, audiotape recorder/player, VCR, and video camera [optional])
- **Partnerships** with other organizations, if needed
- **Incentives.** Clients should receive an incentive for each and every core element that they successfully complete. Some CBOs will have budgeted for these incentives; some will not have. It is recommended that if cash or cash equivalents (gift coupons to grocery stores or department stores) cannot be distributed, alternatives be found to this type of incentive. It is recommended that members of the target population be asked (either individually or in a focus group) as to what type of incentives they would appreciate for Safety Counts participation. In addition, those CBOs that have no funds for incentives should seek donations from local merchants in order to provide the requested incentives.
- **Referral network** (for needs the CBO cannot meet, especially HIV counseling and testing)

RECRUITMENT

The population recruited for Safety Counts is active drug users. Safety Counts activities are based on the assumption that clients are currently using drugs. Safety Counts is *not* appropriate for, and should not include, persons who are currently enrolled in a formal drug treatment program (including methadone treatment) because it could undermine their treatment plans and the paths they have already chosen. It is appropriate for drug treatment staff to refer persons to the Safety Counts program if they have started using drugs again and do not wish to continue receiving treatment.

In addition, the Safety Counts intervention should *not* be conducted with correctional facility inmates, although information about Safety Counts may be provided at the time they are released. Discharge planners can refer to Safety Counts persons who may have continued or initiated drug use while incarcerated and who indicate a lack of interest in entering an abstinence-based treatment program upon release.

Finally, Safety Counts is *not* appropriate for persons who report alcohol as the only or primary substance they have used in the past 90 days. Although many drug users drink alcohol at the same time that they are using other drugs, those whose substance use is largely limited to alcohol should not be enrolled in this intervention. The Safety Counts program cannot effectively meet the needs of persons whose primary issue is chronic alcohol use or abuse.

Recruitment is an important component of Safety Counts. Safety Counts recruitment and outreach is contingent upon the CBO's ability to work within existing drug-user networks. Recruitment can occur numerous ways: through outreach worker contacts, by enrolling clients accessing the CBO's other services, or by using the drug users' social networks. The social network technique uses current drug-using clients as recruiters. Clients can be given incentives for successfully recruiting new clients eligible for Safety Counts. Many will ask their primary drug-using partner or primary sex partner to enroll in the program. Safety Counts requires that persons who wish to enroll are screened to confirm they are current drug users.

During the recruitment process, outreach workers should not only promote the Safety Counts program, but they should briefly assess potential clients' individual needs for medical and social services (including HIV counseling and testing and drug treatment) and make specific referrals as needed. The needs assessment and referral component of recruitment for Safety Counts is a key benefit of the program. Fold-over handout cards describing services in the local area are highly recommended.

It is also recommended that CBOs prepare business cards, letters, and appointment cards to remind clients of upcoming groups and events. Alternatively, the program can be printed on the back of clients' goal cards. As has been found by CBOs currently implementing Safety Counts, attrition rates can be significant without a system in place to consistently remind clients of Safety Counts events and appointments for individual counseling sessions.

POLICIES AND STANDARDS

Before a CBO attempts to implement Safety Counts, the following policies and standards should be in place to protect clients and the CBO:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client or his or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected, reported, and stored according to CDC requirements.

Linkage of Services

Recruitment and health education and risk reduction must link clients whose HIV status is unknown to counseling, testing, and referral services and persons living with HIV to care and prevention services. CBOs must develop ways to assess whether and how frequently the referrals made by their staff members were completed.

Personnel Policies

CBOs conducting recruitment, outreach, and health education and risk reduction must establish a code of conduct. This code should include, but not be limited to, the following: do not use drugs or alcohol, do use appropriate behavior with clients, and do not loan or borrow money.

Safety

CBO policies must exist for maintaining safety of workers and clients. Plans for dealing with medical or psychological emergencies must be documented.

Selection of Target Populations

CBOs must establish criteria for, and justify the selection of, the target populations. Selection of target populations must be based on epidemiologic data, behavioral and clinical surveillance data, and the state or local HIV prevention plan created with input from state or local community planning groups.

Volunteers

If the CBO uses volunteers to assist with or conduct this intervention, then the CBO should know and disclose how their liability insurance and worker's compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing Safety Counts:

CBOs

Attributes of Team Members

- Familiarity with the process and logistics of drug use
- Familiarity with the drug-using culture and its various populations
- Familiarity with HIV and its prevention
- Good oral communication skills
- Personal characteristics that facilitate communication (e.g., nonjudgmental attitudes; active listening skills; friendly, outgoing, and trustworthy personality)

Implementation Plan

A strong component of quality assurance is preparing a plan to implement Safety Counts. A comprehensive implementation plan will facilitate understanding and buy-in from staff and increase the likelihood that the intervention will run smoothly.

Leadership and Guidance

Someone from the CBO should provide hands-on leadership and guidance for the intervention, from planning through implementation. In addition, a decision maker from the CBO should provide higher level support, including securing resources and advocating for Safety Counts.

Fidelity to Core Elements

It is necessary to determine whether staff members are maintaining fidelity to the 5 core elements.

Clients and Staff

It is necessary to ensure that the intervention is meeting the needs of CBO clients and staff. Staff who are implementing Safety Counts can develop their own quality assurance checklist to help staff identify, discuss, and solve problems.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

Rhodes F, Humfleet GL. Using goal-oriented counseling and peer support to reduce HIV/AIDS risk among drug users not in treatment. Drugs & Society. 1993;(3/4):185–204.

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Rhodes F, Wood MM, Hershberger S. A cognitive-behavioral intervention to reduce HIV risks among active drug users. In: Staying Negative in a Positive World: HIV Prevention Strategies that Work. Sacramento, Calif: California Department of Heath Services, Office of AIDS; 2000:113–124.

Wood, MM, Rhodes F. A cognitive-behavioral intervention to reduce HIV risks among active drug users: implementation issues. Paper presented at: Staying Negative in a Positive World: HIV Prevention Strategies That Work; April 1998; Los Angeles, Calif.

For more information on technical assistance or training for this intervention or to get your name on a list for a future training, please go to www.effectiveinterventions.org.

SISTA

DESCRIPTION

SISTA (Sisters Informing Sisters about Topics on AIDS) is a peer-led, skill-building intervention project to prevent HIV infection in African American women. It is delivered in 5 sessions and includes discussions of self-esteem, relationships, and sexual health.

SISTA has been packaged by CDC's Diffusion of Effective Behavioral Interventions project. Information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

Goal

The goal of SISTA is to reduce sexual risk behavior by heterosexually-active African American women at highest risk for HIV.[1–3]

How It Works

SISTA gives women the social and behavioral skills they need to adopt HIV risk-reduction strategies. It is composed of 5 sessions, 2 hours each, delivered by peer facilitators in a community setting. Each session is gender and culturally relevant and includes behavioral skills practice, group discussions, lectures, role-playing, a prevention video, and take-home exercises.

Theories behind the Intervention

SISTA applies 2 theories: the social cognitive theory and the theory of gender and power.

The social cognitive theory says that people need information, training in social and behavioral skills, and knowledge of norms before they will apply risk-reduction strategies. A change in behavior is dependent upon self-efficacy, self-confidence, and outcome expectations.

The theory of gender and power is a social structural theory that accounts for gender-based power differences in male-female relationships. It examines the division of labor between men and women, the distribution of power and authority within male-female relationships, and gender-based definitions of sexually appropriate conduct. In addition, the theory considers a woman's willingness to adopt and maintain sexual risk-reduction strategies within heterosexual relationships as it pertains to how much power she has, her commitment to the relationship, and her role in the relationship.

Research Findings

The original research was conducted with 128 heterosexually active African American women. Women in the experimental group reported more condom use than did women in the control group,[1] indicating that a social skills training delivered in a community setting can increase condom use.

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based; they are thought to be responsible for the intervention's effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.**

SISTA has the following 7 core elements:

- Conduct small-group sessions to discuss the session objectives, address the challenges and joys of being an African American woman, model skills development, and role-play women's skills acquisition. Discussions, role-playing, lectures, and skills development are included in each of the 5 sessions. SISTA was originally designed for African American women. If the target population changes, the intervention would, in essence, be reinvented. This new intervention would be based upon the theoretical framework of the original SISTA intervention. If the intervention is used with other populations, CBOs should take into account the cultural issues of the new population and keep records of any newly developed materials.
- Use a skilled facilitator to lead the group sessions because the success of SISTA depends on the skill of the facilitator. A skilled facilitator is someone who knows the target population and creates an environment conducive to learning. Specifically, the ambience is one in which clients feel valued and at ease in sharing their thoughts, beliefs, and experiences. In addition, a skilled facilitator is a listener and an observer. She prevents or manages conflict and guides group members in making quality decisions and reaching their session goals. If the CBO has the capacity, 2 cofacilitators are recommended.
- Use culture- and gender-appropriate materials to acknowledge pride and enhance self-worth with regard to being an African American woman (e.g., use poetry, artwork by African American women). The SISTA intervention includes poetry by African American women as well as discussions and role-playing scenarios that are relevant to the African American experience. It is important to use these tools and activities in order to enhance clients' experiences and encourage group discussion. Some clients may want to develop their own poems and role-playing scenarios, which can also enhance their experiences and growth. If a CBO uses SISTA with a population other than African American women, staff members need to identify and pretest culturally appropriate materials.
- Teach women sexual assertion skills so they can show that they care for their partners and negotiate safer behaviors. One session addresses developing safer-sex decision-making skills. Specifically, the session focuses on encouraging women to be assertive in sexual decision making so that if they decide to engage in sexual intercourse, they will protect themselves and their partner (e.g., by using a condom). Clients will also be encouraged to assert abstinence to their partners, particularly if their partner does not want to use condoms. If a CBO uses this intervention with a population other than heterosexually active African American women, its staff members need to understand the cultural and power dynamics of interpersonal relationships between men and women in

their target population because these dynamics may differ across cultures and populations.
- Teach women proper condom-use skills, including positive attitudes and norms toward consistent condom use and knowledge of how to place condoms on a partner.
- Discuss the cultural and gender triggers that may make it challenging to negotiate safer sex. It is important that facilitators understand the cultural and gender nuances of their target population before the first session. This understanding will better equip them to lead discussions on the dynamics of male-female relationships as they relate to one's culture.
- Emphasize the importance of the partner's involvement in safer sex. The homework activities are designed to involve the male partner.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

SISTA has the following key characteristics:

- Adapt the flexible intervention to different populations of African American women (e.g., women in substance abuse treatment facilities, incarcerated women, women residing in shelters, and sex workers).
- Be passionate. Deliver the intervention with conviction and purpose. The facilitator should be able to connect with clients on intellectual and emotional levels. The facilitator should be a peer with whom the clients can identify in terms of gender, race, ethnicity, and age.
- Reflect cultural competency (SISTA was developed by African American women for African American women). The poetry and activities included in the intervention are relevant to African American women and the African American experience. The facilitator should be a peer who is familiar with the lifestyle of the target population. If a CBO is using the intervention with a target population of mixed race and ethnicity, whereby most clients are African American, it is important to use all of the materials within the intervention. If the race and ethnicity of the target population is other than African American, the CBO must adapt the activities included in the intervention. If all of the intervention activities are adapted, this would constitute a culturally appropriate reinvention.
- Discuss many topics in addition to HIV prevention (e.g., relationships, dating, and sexual health). Discussions may also include information on other sexually transmitted diseases.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and characteristics.

The SISTA Project consists of 5 weekly sessions, 2 hours each. Each of the sessions has a specific goal and objectives. It is important to conduct all 5 sessions. Depending upon the clients, the sessions may last 2 hours or longer. At times, the sessions may be shorter. If possible, 1 session should be held per week for 5 weeks. This allows time for clients to discuss homework with their partner or family. However, it is acceptable to conduct more than 1 session per week (e.g., Session 1 on Monday, Session 2 on Wednesday).

Homework should be completed by all clients and their partners because it serves as a mechanism to begin discussions about safer sex. However, if there are challenges in completing the homework, or if the client does not have a partner, the client can talk with a friend, family member, or another client in the class. Clients are not graded on the homework.

Session 1: Ethnic/Gender Pride

Goal: Generate a discussion about being African American and female, having pride in oneself, and valuing oneself.

- Open by handing out and reading a poem. (Poems are included in the intervention kit. However, women may write a poem or bring their favorite poem to read.)
- Introduce
    - the facilitators to the women
    - the intervention to the women
    - the women to each other
- Encourage the women to develop ground rules and expectations.
- Lead a discussion about the positive qualities of African American women and how these qualities can be used as a source of strength and pride and about values, asking the women to prioritize their personal values.
- Encourage the women to complete a simple homework exercise.
- Distribute anonymous evaluation forms to assess session 1.
- Close by handing out and reading a poem and reciting the SISTA motto with the women.

Session 2: HIV/AIDS Education

Goal: Provide factual and statistical information on HIV/AIDS and other sexually transmitted diseases, correct misconceptions about HIV/AIDS, and discuss the importance of protecting oneself.

- Open by handing out and reading a poem.
- Review ground rules and expectations.
- Review the key concepts of session 1 and discuss the homework exercise from session 1.
- Hand out information on HIV/AIDS and initiate discussions about the information.
- Engage the women in a card swap game to demonstrate how people get HIV and spread it to other people.
- Show and discuss a 30-minute video. The SISTA video is called,“It’s Like This” and is used to begin discussions about HIV prevention. CBOs may substitute a different video that also serves as a catalyst to discuss HIV, prevention, transmission, and relationships. The video selected should have actors that reflect the population served. In addition, the video should *not* endorse nonoxynol 9 when discussing condoms. CBOs should inform their project officer of the video they decide to use.
- Distribute homework assignments.
- Distribute anonymous evaluation forms to assess session 2.
- Recite the SISTA motto with the women.

Session 3: Assertiveness Skills Training
Goal: Teach women how to differentiate between assertive, aggressive, and nonassertive behaviors, and teach skills for initiating assertive qualities.

- Open by handing out and reading a poem.
- Review the key concepts of session 2 and discuss the homework exercise from session 2.
- Lead a discussion on the difference between assertion, non-assertion (passivity) and aggression.
- Hand out information about various realistic situations; ask the women to provide examples and consequences of assertive, aggressive, and nonassertive responses to the situations; discuss steps in the decision-making process.
- Distribute homework assignments.
- Distribute anonymous evaluation forms to assess session 3.
- Close by handing out and reading a poem and reciting the SISTA motto with the women.

Session 4: Behavioral Self-Management
Goal: Decrease clients' anxiety about condom use, demonstrate and role-play how to use condoms, and discuss reasons that women do not insist on using condoms.

- Open by handing out and reading a poem.
- Review the key concepts of session 3 and discuss the homework exercise from session 3.
- Lead a discussion about why people do not use condoms, and develop a strategy for overcoming the stated obstacles.
- Distribute condom packets and lubricant.
- Engage the women in a condom-card line-up activity to assess their knowledge of putting a condom on their partner.
- Demonstrate how to put on a condom, using anatomical models.
- Role-play negotiation exercises.
- Distribute homework assignments.
- Distribute anonymous evaluation forms to assess session 4.
- Close by handing out and reading a poem and reciting the SISTA motto with the women.

Session 5: Coping Skills
Goal: Initiate discussion about coping with life experiences, including the link between alcohol and AIDS, coping with alcohol and sex, and coping with negative responses. This session also serves as a review of the previous sessions.

- Open by handing out and reading a poem.
- Review the key concepts of session 4 and discuss the homework exercise from session 4.
- Review the handouts from previous sessions.
- Discuss what coping is and its relationship to alcohol.
- Distribute a handout on coping situations.
- Inform the group of the booster sessions.
- Distribute anonymous evaluation forms to assess session 5.
- Close by handing out and reading a poem and reciting the SISTA motto with the women.

Booster Sessions
The booster (refresher) sessions are offered after the project is completed. Each session lasts 2 hours. These booster sessions provide an opportunity for clients to ask more questions and provide peer support. Although 2 booster sessions are recommended, they are not required.

The first booster session is held 2 months after the last session of the intervention. The women will begin designing their graduation ceremony. The facilitator will lead discussions about

- how the intervention could be strengthened
- whether the clients are using their newly developed skills
- any challenges that the clients have encountered

The second booster session is held 4 months after the intervention. During this session

- additional questions are answered
- the graduation ceremony is held
- certificates of accomplishment are given to each client

It is recommended that the graduation party be held at the close of the second booster session. However, is can be held after Session 5 (Coping).

ADAPTING

SISTA activities were designed specifically for African American women. However, at times, CBOs may find that they will conduct the intervention with groups of clients of mixed race and ethnicity. CBOs that wish to adapt SISTA to populations other than African American women are advised to go back to the original theoretical foundations for SISTA and build an intervention appropriate for the women they serve. They should ask whether the women they will reach live in communities where men are given more power than women regarding condom use during intercourse. If so, then adapting SISTA is appropriate. However, the process of adapting is more than replacing African-inspired poems and proverbs with other race-specific poems and proverbs. It may involve offering new activities and discussions that are not included in SISTA so as to make the intervention culturally relevant to the new population of women. This is called *reinvention* because core elements are added or deleted. Reinvention is not a bad thing if done carefully with the needs of the new target population of women clearly in mind as the adaptation process takes place.

CBOs that reinvent SISTA for their specific target population can rename the program. This intervention would be based upon SISTA.

Before a CBO attempts to adapt SISTA for a population other than African American women, it will need to perform the following activities.

1. Interview key stakeholders.
2. Conduct a focus group with the target population.
3. Design a logic model (to assess risk determinants).

After the training, it will be necessary to pretest intervention materials (with a small target group) and pilot test the intervention (also with a small target group).

RESOURCE REQUIREMENTS

People

In addition to having a project coordinator, it is recommended that 2 persons cofacilitate SISTA. This is because issues among clients may arise within a session, and 1 facilitator may need to remove a client from the class to address the issue while the other facilitator can continue moving the class along. However, CBO capacity to hire 2 facilitators should be taken into consideration; and, if necessary, 1 facilitator can be used. A skilled facilitator is the key to ensuring this intervention is effective.

Facilitators should

- be of the same race and ethnicity as the target population (African American women)
- speak the same language and dialect as the target population
- be able to create a culturally sensitive environment
- be knowledgeable about HIV transmission and prevention
- have a nonjudgmental attitude toward persons living with HIV/AIDS

Space

SISTA needs a place to hold the sessions. It must be

- large enough for 10 to 12 people
- easy to get to using public transportation
- private and secure, so that confidentiality can be maintained
- quiet and without interruptions (such as people entering and exiting the room or outside noise)

Supplies

SISTA needs

- anatomical models (male and female)
- incentives (e.g., transportation tokens, toiletry items, food, money, child care while the woman participates in the sessions, phone cards, gift certificates, and food)
- printer or photocopier
- training materials
- condoms

The SISTA intervention kit provides materials. CBOs will need to copy these materials and purchase incentives. CBOs may need to locate agencies willing to partner.

RECRUITMENT

The population recruited for SISTA is African American women at very high risk for HIV.

To encourage participation, SISTA should be publicized as a program for African American women; a program developed by African American women; and a program that discusses dating, relationships, healthy sex practices, and works at improving women's ability to effectively communicate with sex partners.

Women may be recruited from shelters, juvenile court systems, bars, focus groups, jails and prisons, sexually transmitted disease clinics, or community organizations. Specific cultural needs should be addressed.

If you are not using SISTA with the intended population, the intervention should be publicized as a behavioral change intervention that includes discussions on dating, relationships, and healthy sexual practices and works at improving women's ability to effectively communicate with sex partners.

Review the Recruitment strategy that will work in the setting in which the CBO plans to implement SISTA.

POLICIES AND STANDARDS

Before a CBO attempts to implement SISTA, the following policies and standards should be in place to protect clients, the CBO, and the facilitators:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Informed Consent

CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO’s responsibility and the clients’ rights. Individual state laws apply to consent procedures for minors; but at a minimum, consent should be obtained from each client and, if appropriate, a legal guardian if the client is a minor or unable to give legal consent. Participation must always be voluntary, and documentation of this informed consent must be maintained in the client’s record.

Legal and Ethical Policies

CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners; CBOs are obligated to inform clients of the organization’s responsibilities if a client receives a positive HIV test result and the organization’s potential duty to warn. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Linkage of Services

Recruitment and health education and risk reduction must link clients whose HIV status is unknown to counseling, testing, and referral services and persons living with HIV to care and prevention services. CBOs must develop ways to assess whether and how frequently the referrals made by their staff members were completed.

Personnel Policies

CBOs conducting recruitment, outreach, and health education and risk reduction must establish a code of conduct. This code should include, but not be limited to, the following: do not use drugs or alcohol, do use appropriate behavior with clients, and do not loan or borrow money.

Referrals

CBOs must be prepared to refer clients as needed. For clients who need additional assistance in decreasing risk behavior, providers must know about referral sources for prevention interventions and counseling, such as partner counseling and referral services and other health department and CBO prevention programs.

At times, personal issues among clients may arise whereby they may need immediate referral attention. If there is only 1 facilitator, that facilitator may need to call a “time out” to individually address the client’s issue.

Safety

CBO policies must exist for maintaining the safety of workers and clients. Plans for dealing with medical or psychological emergencies must be documented.

Selection of Target Populations

CBOs must establish criteria for, and justify the selection of, the target populations. Selection of target populations must be based on epidemiologic data, behavioral and clinical surveillance data, and the state or local HIV prevention plan created with input from state or local community planning groups.

Volunteers

If the CBO uses volunteers to assist with or conduct this intervention, then the CBO should know and disclose how their liability insurance and worker's compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing SISTA:

CBOs

- Facilitators should have extensive knowledge of HIV transmission and of local and national HIV/AIDS surveillance data.
- Facilitators must reflect the target population in race and gender and are expected to deliver the information in a non-threatening and culturally relevant manner.
- CBOs should have in place a mechanism to ensure that all sessions and core elements are implemented.
- Quality assurance activities can include direct observation and review of sessions by staff. The review could focus on the quality of the sessions, how well they adhere to content, and the responsiveness and openness of the women to the facilitator.
- Facilitators should collect all evaluation forms after each session and ensure client confidentiality.
- Facilitators should ensure that all clients are actively involved in each of the sessions.
- Facilitators should meet with supervisors twice a month to discuss progress and opportunities for change.

Clients

The clients' satisfaction with the intervention and their comfort should be assessed during each session. CBOs can use the evaluation forms provided in the intervention box or can develop their own.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

Wingood GM, DiClemente R J. The effects of an abusive primary partner on the condom use and sexual negotiation practices of African-American women. American Journal of Public Health. 1997; 87:1016–1018.

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2. Wingood GJ, DiClemente RJ. Partner influences and gender-related factors associated with noncondom use among young adult African American women. American Journal of Community Psychology. 1998;26:29–49.

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STREET SMART

DESCRIPTION

Street Smart is an intensive program to prevent HIV/AIDS and other sexually transmitted diseases among homeless and runaway youth (11–18 years of age) whose behaviors place them at very high risk of becoming infected.[1,2] Street Smart is a multisession, manual-guided, small-group intervention that teaches effective behavior change, problem-solving skills, and strategies to increase safer sexual behaviors. Life circumstances define risk for some youth; being gay, runaway or homeless, or a sex offender increases the potential for risky behavior. Although Street Smart is designed for runaway and homeless youth, it can be easily adapted for youth at very high risk in other settings.

Street Smart has been packaged by CDC's Diffusion of Effective Behavioral Interventions project; information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

Goal

The goal of Street Smart is to reduce unprotected sex, number of sex partners, and substance use among runaway youth.

How It Works

The stabilization and integration of community social services for youth may be the single best predictor of safer sex and drug use behavior. When support from adults is unavailable, youth often rely heavily on peers for information. Therefore, it is essential that HIV/AIDS prevention programs establish strong working links between difference social service agencies at both the leadership and staff levels. Youth need more than just a discussion of where these services can be obtained; they need to be taken so they can personally meet the staff and become familiar with different sites and their services.

Street Smart is held in conjunction with existing services, such as group counseling, that attract youth. The program is held over a 2- to 6-week period. It consists of

- 8 drop-in group sessions (1-1/2 to 2 hours each)
- 1 individual session
- 1 group visit to a community health resource

The sessions aim to improve youths' social skills, assertiveness, and coping through exercises on problem solving, identifying triggers, and reducing harmful behaviors. Although it is preferable that clients attend every session, the program is designed so that each session stands on its own. Ideally, 6 to 10 youth attend the 8 group sessions, which are facilitated by 2 trained counselors. Specifically, CBO staff members provide 2 more opportunities for youth in the form of an individual counseling session and a trip to a relevant community health provider.

The sessions take place in small groups to provide a supportive environment for behavior change. A private session with a counselor enables each client to personally identify risk for HIV transmission and find ways to overcome his or her own barriers to safer sex. Additionally, clients can access medical care, mental health care, and referrals for individual health concerns, if needed.

The Abstinence, Be Faithful, [use] Condoms (ABC) approach can be an important component of HIV prevention for youth. Although abstinence-only interventions have not been proven effective at reducing risk for HIV, integration of the ABC message into evidence-based interventions such as Street Smart may enhance safe-behavior education for youth by offering abstinence from sex or drugs as a part of more comprehensive risk-reduction strategies.

Theory behind the Intervention

Street Smart draws on social learning theory, which describes the relationship between behavior change and a person's beliefs that he or she can change a behavior and that changing that behavior will produce a specific result. It links thoughts, feelings, and attitudes to behavior change. Beliefs about perceptions of self-efficacy and the consequences of behavior are key determinants of effective behavior change.

Research Findings

In research field trials, who completed the Street Smart group sessions reported lower rates of substance use and unprotected sex. Young women reported greater reductions in substance use and unprotected sex than did young men; African American youth reported less substance use than did youth of other ethnic groups.[1,2]

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based; they are thought to be responsible for the intervention's effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.**

Street Smart has the following 6 core elements:

- Increase clients' knowledge about
    - HIV and its transmission
    - Benefits of HIV testing and knowing one's HIV status
    - The role of stigma
    - The changing epidemiology of the epidemic
- Have clients identify peers' and partners' social norms and expectations, to increase self-efficacy.
- Have clients recognize and control feelings and emotional responses.
- Have clients identify their risk, and teach personal use of HIV/AIDS risk hierarchy.
- Use peer support to identify personal triggers to unsafe behavior.

- Build skills in problem solving and assertiveness in social situations to reduce risk for HIV/AIDS.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

Street Smart has the following key characteristics:

- Convene groups of 6 to 10 youth, male and female.
- Deliver 8 sessions (90 to 120 minutes each)
- Hold 1 individual counseling session and 1 trip to a community resource serving at-risk youth.
- Have groups meet 2 to 4 times per week.
- Create a curriculum that is highly structured with built-in flexibility so it can be individualized to particular groups of youth.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and characteristics.

Procedures for the 8 group sessions of Street Smart are as follows:

Getting the Language of HIV and Other Sexually Transmitted Diseases

The main point of this session is to convey that knowing the facts about HIV/AIDS is essential because this knowledge allows people to protect themselves and others. Furthermore, understanding HIV/AIDS allows people to monitor their own effectiveness at implementing HIV prevention strategies. In this session, clients will use an educational game and role-playing to

- become familiar with the key characteristics of the intervention (e.g., use of tokens, “feeling thermometer”)
- learn basic information about HIV and other sexually transmitted diseases and how these diseases are transmitted
- learn their personal risk factors

Assessing Personalized Risk

The main point of this session is to use role-playing and group brainstorming to help clients figure out which of their behaviors put them at risk and which triggers lead to unsafe behaviors. In this session, clients will

- increase familiarity with key characteristics of the intervention
- understand safer sex
- recognize personal risk behaviors
- learn which triggers increase their personal risk
- learn to set personal limits

Learning How to Use Condoms

The main point of this session is for clients to become less anxious and more comfortable talking about and using condoms. Clients will

- increase familiarity with key characteristics of the intervention
- learn and practice the correct use of male and female condoms
- increase their comfort level with condoms

Learning about the Effects of Drugs and Alcohol

The main point of this session is to use role-playing and confronting beliefs so clients can identify how drugs and alcohol affect their thinking and choices. Clients will learn

- how alcohol and drugs affect the ability to practice safer sex
- the pros and cons of substance use
- how drugs and alcohol can affect a person
- about addiction and triggers for substance use
- skills for breaking the cycle of addiction

Recognizing and Coping with Feelings

The main point of this session is to use role-playing and the "feeling thermometer" to help clients identify different coping styles for tough situations and to solve problems. Clients will

- learn skills for coping with stressful feelings
- become familiar with the SMART method for coping and problem-solving. SMART stands for
    - State the problem
    - Make a goal
    - Actions you can take
    - Reach a decision
    - Try and review it
- learn relaxation techniques

Negotiating Effectively

In this session, clients will

- review key characteristics of the intervention
- learn how to stand up for their personal values
- use interpersonal problem-solving and role-playing to
    - explore personal sexual values
    - learn to deal with peer pressure
    - develop problem-solving skills
    - learn to communicate effectively using "I" statements

Doing Self-Talk

In this session, clients engage in educational games and exercises to learn how to use their thoughts and self-talk to help them make safer decisions. Clients will

- review key characteristics of the intervention
- learn how to think through positive and negative events to facilitate protective actions
- learn to break the cycle of negative thoughts
- practice thinking positive thoughts about themselves
- learn helpful self-talk to keep themselves safe

Practicing Safer Sex
In this session, clients engage in a small-group discussion and create a media message (music video, soap opera, commercial) to figure out why they engage in risky behaviors and to learn how to argue against their rationalizations. Clients will

- review key characteristics of the intervention
- figure out personal risk in unclear sexual situations
- learn to combat rationalizations
- strategize how to deal with slip-ups
- apply what they have learned to the media message they create

ADAPTING

Street Smart was field tested among homeless and runaway youth in homeless shelters the Los Angeles, California area. Most of the clients were black and Latino youth. Street Smart could be adapted for use in other venues and among other race or ethnicity groups.

Street Smart could be translated into Spanish, and some of the language could be paraphrased for clients who have literacy challenges.

RESOURCE REQUIREMENTS

People

To effectively implement Street Smart, CBOs should have a project coordinator, 2 trained adult facilitators with the required skills and experience, and 1 staff person with skills to conduct the evaluation of the intervention.

Street Smart facilitators should have extensive experience working with youth, especially at-risk youth. Facilitators should be aware that some participating youth may already have been adversely affected by the HIV/AIDS epidemic and should be trained with regard to counseling about HIV/AIDS. The Street Smart implementation manual has guidance on things facilitators need to know and tips for successful implementation of the intervention.

Facilitators

- should include at least 1 with experience in youth group facilitation
- must both complete Street Smart training conducted by a qualified capacity building assistance provider
- should include at least 1 with a degree in counseling or 1 of the behavioral sciences (e.g., psychology, sociology, anthropology)

Facilitators should understand

- the underlying principles of the program
- the theories behind the intervention

- how youth operate (e.g., that few youth know how to apply safer-sex practices, that adolescence is a time of experimentation, and that having been sexually abused increases the risk that youth will practice unsafe sex)

Facilitators need to be skilled in

- reinforcing positive behaviors
- labeling feelings
- encouraging active participation
- learning effective coping strategies
- creating concern over unsafe behaviors
- encouraging group cohesion of appropriate norms for behavior
- using role-playing activities
- understanding group dynamics
- relating the intervention content to the lives of the youth
- rewarding positive behavior
- being supportive and nonjudgmental
- giving praise
- building on strengths

Space

Street Smart needs a private room that is inviting, comfortable, safe, and large enough for the groups.

Supplies

Street Smart needs a VCR, TV, video camera, and people to operate the equipment.

Other

Youth participating in Street Smart also need

- community resources to support the desired behavior (safer sex)
- access to HIV counseling, testing, and referral; health care; alcohol and drug treatment; legal aid; advice on how to take the general equivalency diploma (GED) examination; help in enrolling in athletic programs; and housing
- transportation to community agencies and centers where they can personally meet the staff and learn about what they offer
- enough notice to be able to change their schedules to fit the program
- a telephone number they can call with questions about the program
- snacks

The CBO should also have

- attractive and easily understood promotional materials
- enough supplies (e.g., nametags, tissues, paper, pens and pencils, handouts) for all clients
- clear, correct, and understandable visual aids
- a suggestion box
- strong relationships with different social service agencies at both the leadership and staff levels

- access to at-risk youth (CBOs implementing Street Smart must serve at-risk youth or have established relationships with organizations serving at-risk youth [e.g., juvenile detention centers, homeless shelters, drop-in youth centers, youth outreach centers]). CDC does not endorse Street Smart for in-school programs.
- access to community resources for youth
- CBO commitment to
    - have adult facilitators complete Street Smart intervention training (3 full days)
    - implement the entire program
    - adapt program with fidelity to core elements
- adequate funds or creative community resources to provide incentives for clients (e.g., food or small prizes for the activities and games)
- system to refer clients to additional services (e.g., counseling) if required

RECRUITMENT

The population recruited for Street Smart is youth at very high risk. The intervention can be presented to runaway and homeless shelters as part of their best practices that benefit clients. Incentives, when possible, can play a role in recruitment. General recruitment into the 8 Street Smart sessions can include word of mouth, peer-to-peer recruitment, and other marketing strategies, including flyers, newsletters, and special events.

Street Smart was designed for and tested among a very specialized group of homeless and runaway teens: those who are the most marginalized and desperate and those living on the streets for some length of time. Therefore, Street Smart may not be appropriate for all homeless and runaway teens. For example, very young children (aged 10–12) who have been homeless or who have run away from home fewer than 6 months may not be ideal populations for this intervention. Young persons, new to the streets, may not have adopted many of the risk behaviors considered in the intervention. Before implementing Street Smart, CBOs should consider screening youth to ascertain extent of risk behaviors and dividing younger children and those who are not sexually active into groups with similar backgrounds and experiences.

Review Recruitment in this document to choose a recruitment strategy that will work in the setting in which the CBO plans to implement Street Smart.

POLICIES AND STANDARDS

Before a CBO attempts to implement Street Smart, the following policies and standards should be in place to protect clients and the CBO:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client or his or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Informed Consent

CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO’s responsibility and the clients’ rights. Individual state laws apply to consent procedures for minors; but at a minimum, consent should be obtained from each client and, if appropriate, a legal guardian if the client is a minor or unable to give legal consent. Participation must always be voluntary, and documentation of this informed consent must be maintained in the client’s record.

Legal and Ethical Policies

CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners; CBOs are obligated to inform clients of the organization’s responsibilities if a client receives a positive HIV test result and the organization’s potential duty to warn. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Referrals

CBOs must be prepared to refer clients as needed. For clients who need additional assistance in decreasing risk behavior, providers must know about referral sources for prevention interventions and counseling, such as partner counseling and referral services and other health department and CBO prevention programs.

Volunteers

If the CBO uses volunteers to assist with or conduct this intervention, then the CBO should know and disclose how their liability insurance and worker’s compensation applies to volunteers.

CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing Street Smart:

CBOs

Implementation Plan

Developing a comprehensive implementation plan will facilitate understanding and buy-in from key stakeholders and will increase the likelihood that the intervention runs smoothly.

Leadership and Guidance

Quality assurance also requires that someone at the CBO provides hands-on leadership and guidance for the intervention, from preparation through institutionalization. Also needed is a decision maker at the CBO who will provide higher level support, including securing resources and advocating for Street Smart, from preparation to institutionalization.

Fidelity to Core Elements

Throughout implementation, it is necessary to determine whether staff members are delivering Street Smart with fidelity to the 4 core elements. A fidelity checklist is available in the intervention kit and can be used as a quality assurance tool. It is also necessary to identify and address any issues to ensure that the intervention is meeting the needs of CBO clients and staff.

Clients

Quality assurance is also present in the protocol used when linking youth and escorting youth to community resources. Community resource staff can be paired with youth when touring the resource and its services. CBOs should ensure that these community resource staff members follow up and invite youth back and provide feedback to the CBO with regard to the visits.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

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Rotheram-Borus MJ, Noelle L. Training facilitators to deliver HIV manual-based interventions to families. In: Pequegnat W, Szapocznik J. (eds.) Working with Families in the Era of HIV/AIDS. New York: Sage; 2000.

Rotheram-Borus MJ, Song J, Gwadz M, Lee M, Van Rossem R, Koopman C. Reductions in HIV risk among runaway youth. Prevention Science. 2003;4(3):173–187.

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1. Rotheram-Borus MJ, Van Rossem R, Gwadz M, Koopman C, Lee M. Reductions in HIV Risk Among Runaway Youths. Los Angeles, Calif: University of California, Department of Psychiatry, Division of Social and Community Psychiatry; 1997.

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TOGETHER LEARNING CHOICES

DESCRIPTION

Together Learning Choices (TLC), formerly Teens Linked to Care,[1–4] is an evidence-based HIV prevention intervention and health promotion intervention for young people (13–29 years of age) living with HIV. Teens may be recruited or referred from HIV treatment programs. TLC was originally called Teens linked to Care because it was designed to target teens and youth (ages 13–24) enrolled in HIV treatment programs. However, the intervention was renamed Together Learning Choices because HIV-infected young people could be linked to a broader range of care that includes emotional and social health as well as medical treatment. The age range was extended because the intervention addresses challenges faced not just by teens but also by young adults who are living with HIV.

NOTE: TLC is still being developed under the Replicating Effective Programs process and will transition into the Diffusion of Effective Behavioral Interventions project in 2006.

Goal

TLC aims to help young people identify ways to increase use of health care, decrease risky sexual behavior and drug and alcohol use, and improve quality of life.

How It Works

TLC is delivered in small groups and uses cognitive-behavioral strategies to change behavior. It provides young people with the tools and skills necessary to live the best life and to be able to make healthy choices. TLC consists of 3 sequential modules, each containing 8 sessions.

- *Staying Healthy* encourages healthy living by focusing on health maintenance and forging effective partnerships with health care providers.

- *Acting Safe* is dedicated to primary and secondary HIV prevention by addressing sex- and substance use-related risk behaviors and reducing new infections and re-infections.

- *Being Together* emphasizes emotional well-being and improving quality of life. This module is optional.

Delivery and scheduling of the sessions are flexible. Clients can enter whenever they wish and are not required to attend every session. Each module is focused on a different behavioral outcome: staying healthy, acting safe, and being together. TLC should be implemented in the order in which it was developed: the Staying Healthy module first, followed by the Acting Safe module. The third module, Being Together, which is optional, can be implemented last.

Theory behind the Intervention

TLC is based on social action theory,[5] which emphasizes how contextual factors influence a person's ability to respond effectively to stressful situations, solve problems, and act effectively to reach goals. This theory was chosen on the basis of results from qualitative studies and other intervention research with disenfranchised young people, mostly people of color.[6–9]

Research Findings

Module 1

Staying Healthy. This module has been shown to increase the number of positive lifestyle behaviors and use of positive action coping styles by young women and use of the social support coping style by young people of both sexes.

Module 2

Acting Safe. Research indicates that young people who attended the intervention reported fewer partners; fewer HIV-negative partners; fewer unprotected sex acts; and significant reductions in a weighted substance use index, use of alcohol or marijuana, and use of illicit drugs.

Module 3

Being Together. Members of a research group reported decreases in feelings of distress, physical symptoms of distress, generalized anxiety, and fear-based anxiety.

A number of important modifications have been made to TLC on the basis of results of packaging and field testing.

First, the number of sessions delivered in Modules 1 and 2 has been reduced to 8 sessions each (from the original 12 and 11, respectively). Implementation of the original version of TLC with HIV-infected youth was challenging in settings other than clinical care. Retention of youth over the required 2–3 months and 12 sessions per module for the complete delivery of the original intervention was determined to be unfeasible for some CBOs and public health programs.

For more than 1 year, CDC's Replicating Effective Programs team collaborated with the original researchers and a Community Advisory Board (CAB) to reduce the number of sessions for Modules 1 and 2 without compromising the integrity of TLC's effective behavior modification model.

This decision to reduce the number of sessions to 8 per module is consistent with the results of the original research on TLC, in which the mean number of sessions participants attended was 7.7 for Staying Healthy and 7.6 for Acting Safe. For Staying Healthy, 70% of participants attended at least 6 sessions, and 73% attended at least 5 sessions of Acting Safe.

The decrease in number of sessions did not result in reduction or change to the content of the intervention. Significant portions of the information have been updated to reflect new developments in the medical management of HIV and a new realization that HIV is a chronic disease. Changes that were made to the original protocol are

- elimination of redundant concepts and activities
- addition of updated information on prevention technology, medical management of HIV, and "club drugs"

- integration of a perspective that treats HIV as a chronic disease, greater emphasis on nonscripted role plays.

Second, TLC now focuses on HIV-infected adolescents and young adults13–29 years old who are receiving HIV-related services in medical clinics or social service agencies. It can be easily be adapted for other settings such as mental health centers.

Third, the behavior modification paradigm was made more accessible and user friendly by incorporating a more explicit and easier to remember "Feel-Think-Do" framework. The Feel-Think-Do framework is a rewording of problem-solving processes intrinsic in social cognitive theories and used in TLC activities.

Fourth, Module 3, Being Together is now optional. The prevention outcomes of Staying Healthy and Acting Safe were most rigorously evaluated and showed significant effect. The Being Together module, however, was less rigorously evaluated due to limited follow-up data; and the outcomes, although significant, were not linked to HIV risk reduction. In addition, the techniques used in the module may require extended training. Being Together can be accessed at http://ucla.chipts.edu. Technical assistance can be obtained from the UCLA Center for Community Health.

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based; they are thought to be responsible for the intervention's effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.**

TLC has the following 5 core elements:

- Help clients develop awareness and identify feelings, thoughts and actions.
- Teach, model, and practice 4 core skills.
    - Emotional regulation using the Feel/Think/Do framework
    - SMART problem solving (Specific, Measureable, Achievable, Realistic, Time-phased)
    - Goal setting
    - Assertiveness
- Consistently show appreciation and reinforce positive client behavior through the use of thanks tokens.
- Help clients identify their ideal self to help motivate and personalize behavior change.
- Deliver sessions in highly participatory, interactive small groups.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

TLC has the following key characteristics:

- Encourage clients to attend all sessions of the intervention, but give them flexibility to drop in for particular sessions on their own schedule.
- Consider use of incentives. Although we recommend using incentives to encourage participants to return to sessions, whether or not to use incentives at all and, if so, what kinds and of what estimated value are up to your agency.
- Modify time intervals. Modify the intervals between sessions to fit the needs and capacity of your agency and population.
- Limit session times. With practice, all sessions can be finished in the time indicated in the Implementation Manual. Agencies may wish to extend the length of their sessions as a result of discussions running longer. It is recommended that the sessions be kept to two hours as much as possible.
- Conduct sessions about once a week. The frequency of the sessions depends on the availability of the facilitators and clients. A rule of thumb is to conduct sessions once a week.
- Let group needs determine facilitators. Although having 2 facilitators of opposite sex may be recommended for purposes of modeling and providing a sex-specific point of view, agency and client circumstances may dictate use of same-sex facilitators or even just 1 facilitator.
- Be flexible about group composition. CBOs may modify TLC with respect to the age, gender, and sexual orientation of clients. For example, if your potential participant population is sufficiently large, you may consider holding separate groups for younger (e.g., under 18) and older clients.
- Start with small groups. We recommend that TLC groups contain from 4 to 8 clients, although slightly larger groups (up to 12) may be workable once your facilitators have sufficient experience to be comfortable with a group of that size.
- Build group cohesion. Clients may disclose personal experiences during TLC sessions, and they need to feel safe and supported as they do so. Building cohesion lays the foundation for building trust, and trust creates the safe and supportive environment necessary for TLC. However, agencies may use different cohesion-building activities.
- Provide food/snacks. CBOs are encouraged to provide refreshments for their participants. This is not a core element but strongly recommended.
- Use visual aids. Visual aids, like the wall charts supplied in the TLC intervention package, can help clients comprehend and retain concepts.
- Consider your location. TLC can be held anywhere there is a private room with enough space to accommodate clients, the role-playing activities, and a refreshment table. The space should be handicapped accessible. For some communities, locations that advertise services for people living with HIV/AIDS are not good places to hold TLC sessions.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and characteristics.

Procedures for TLC are as follows:

Delivering Specific Content

Although the process of change is the same in each session, the content differs between sessions and is based on findings from qualitative research into what young people living with HIV think is important.

Determining Session Format

HIV-infected young people meet regularly in small groups to provide social support, learn and practice new skills, and socialize. Every session in each of the 3 TLC modules establishes a routine to help clients confront a specific attitude or belief, address thoughts and feelings, and change a specific behavior. CBOs that implement TLC must include the following core components in each session:

- Clients review previous goal.
- Facilitator provides engaging activities focused on skill development, problem-solving, attitude formulation, and knowledge acquisition.
- Facilitators help clients reframe negative behavior patterns. A series of fun activities is used. Clients may videotape themselves meeting a new friend, disclosing their HIV status, or brainstorming on how to get angry with a doctor without then receiving poor medical care.
- Facilitators reinforce desired behavior through use of incentives.
- Clients set a new goal.
- Clients are complimented and compliment each other for trying to change their lives.

Identifying Mechanisms of Behavior Change

HIV-infected young people identify ways to improve their quality of life within specific areas by setting new habits and daily social routines. Young people set goals around their health, their sexual relationships, drug use, and daily peace. Once goals are set, the group helps each person set realistic ways to meet these goals and helps to solve problems related to reaching the goals.

The steps of problem solving are as follows:

1. Determine what you want.
2. Identify ways to get what you want.
3. Evaluate the best way to get what you want.
4. Practice how to get what you want.
5. Try to get what you want.
6. Review how successful you were in reaching your goal.

Clients not only work on their own goals, but they role-play helping other young people reach their goals (e.g., a change in job, living arrangements, education, or social relationships). At the end of every session, clients agree on the next week’s plans to improve their lives. Improving the quality of life, meditation, and focused attention skills are part of TLC.

ADAPTING

TLC was field tested in 9 clinical care sites in 4 AIDS epicenters (Los Angeles, New York, San Francisco and Miami). Most participants were black and Latino youth. TLC could be adapted for use in other venues and among other racial or ethnic groups.

RESOURCE REQUIREMENTS

Resource needs depend on the number of people living with HIV who are served by the CBO.

People

Program supervisor (at least 1)

- Program supervisors spend 50% of time training, supervising, and coordinating implementation during the first year.
- Program supervisors will need experience in behavioral theories of change and in conducting interventions with persons in small groups.
- Program supervisors need to spend 8 days in training (2 training courses, 4 days each, 1–2 months apart). This training can be spread out over 4 to 8 months. Trained program supervisors may be asked to train all CBO staff.

2 trained facilitators
1 program assistant

Space

TLC can be done anywhere that confidentiality of clients can be assured (for example, a private room) and where a group of young people living with HIV can meet.

Supplies

TLC uses

- special intervention tokens
- a “feeling thermometer”
- condoms
- models for practicing condom use
- standardized program workbooks

RECRUITMENT

The population recruited for TLC is young people living with HIV. They may be recruited from a variety of sites (community venues, AIDS service organizations, medical clinics) using a variety of techniques (word of mouth, print advertisements, flyers).

The Acting Safe module of TLC was designed to reduce sexual risk and substance use behaviors that contribute to increased risk for transmitting HIV. Perinatally infected youth who are not sexually active may not be ideal targets for this component of the intervention. Before implementing TLC organizations should consider screening youth to ascertain extent of risk behaviors and should assign those who are not sexually active into groups with similar ages, backgrounds, and experiences.

Review Recruitment in this document to choose a recruitment strategy that will work in the setting in which the CBO plans to implement TLC.

POLICIES AND STANDARDS

Before a CBO attempts to implement TLC, the following policies and standards should be in place to protect clients, the CBO, and the TLC intervention team:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client or his or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Informed Consent

CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO's responsibility and the clients' rights. Individual state laws apply to consent procedures for minors; but at a minimum, consent should be obtained from each client and, if appropriate, a legal guardian if the client is a minor or unable to give legal consent. Participation must always be voluntary, and documentation of this informed consent must be maintained in the client's record.

Legal and Ethical Policies

By virtue of participation in TLC, clients will be disclosing their HIV status. CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners; CBOs are obligated to inform clients of the organization's responsibilities and the organization's potential duty to warn. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Referrals

CBOs must be prepared to refer clients as needed. For clients who need additional assistance in decreasing risk behavior, providers must know about referral sources for prevention interventions and counseling, such as comprehensive risk counseling and services, partner counseling and referral services, and other health department and CBO prevention programs for persons living with HIV.

Volunteers

If the CBO uses volunteers to assist with or conduct this intervention, then the CBO should know and disclose how their liability insurance and worker's compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing TLC:

Facilitators

Training for facilitators should address the following 3 areas:

- Completion of a training workshop, including review of the intervention theory and materials
- Participation in practice sessions
- Observed cofacilitation of groups, including practice of mock intervention sessions

A review mechanism should be in place to assure that all session protocols are followed as written. For quality assurance, key staff and supervisors can review the sessions. They should look for

- adherence to session content

- use of key cognitive behavioral skills techniques
- accessibility and responsiveness to expressed client needs
- important process elements (e.g., time allocation, clarity, use of social rewards)

Selected intervention record reviews should focus on ensuring that consent forms (signed either by the participant, if older than 18 or emancipated, or by a legal guardian) are included for all participants and that session notes are of sufficient detail to ensure that clients are participating actively.

Clients

Clients' satisfaction with the intervention and their comfort should be assessed at the final session of each module. Process monitoring systems should also track the number of sessions each client attends, as well as reasons for not attending.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

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A complete copy of the TLC intervention is available at: http://chipts.ucla.edu/interventions/manuals/.

CDC would like to acknowledge and thank the faculty and staff of the Center for HIV Identification, Prevention, and Treatment Services (CHIPTS) in the UCLA Center for Community Health for their assistance in compiling this Procedural Guidance for Implementation of TLC.

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VOICES/VOCES

DESCRIPTION

VOICES/VOCES (Video Opportunities for Innovative Condom Education and Safer Sex) is a single-session, video-based program for the prevention of HIV and other sexually transmitted diseases. VOICES/VOCES was designed to encourage condom use and improve condom negotiation skills among heterosexual African American and Latino men and women, aged 18 years and older, who are at very high risk for HIV and other sexually transmitted diseases.

The original research was conducted in sexually transmitted disease clinics; however, many clients who are at very high risk for getting or transmitting HIV and other sexually transmitted diseases but are not being treated in sexually transmitted disease clinics might benefit greatly from VOICES/VOCES. The intervention has also been conducted in family planning centers, community health centers, drug rehabilitation clinics, correctional facilities, and other settings.

VOICES/VOCES has been packaged by CDC's Diffusion of Effective Behavioral Interventions project; information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

Goals

VOICES/VOCES is designed to encourage condom use and improve condom negotiation skills by African American and Latino men and women.[1]

How It Works

This brief intervention, in English and Spanish, is a workshop that can be easily integrated into the flow of services provided by busy CBOs. It fits effective prevention education into the time frame of a clinic visit or other brief opportunity to reach clients during a "teachable moment." For example, having to visit a sexually transmitted disease clinic may motivate a person to change behavior.

To implement VOICES/VOCES, health educators convene groups of 4 to 8 clients for a single, 45-minute session. Whenever possible, groups are gender- and ethnic-specific so that clients can develop prevention strategies appropriate for their culture. Information on HIV risk behaviors and condom use is delivered using videos, facilitated group discussion, and a poster board showing features of various condom brands in English and Spanish. Two culturally specific videos are used: 1 for African American clients and 1 (bilingual) for Latino clients. Skills in condom use and negotiation are modeled in the videos, then role-played, practiced, and discussed. At the end of the session, clients are given samples of the types of condoms they have identified as best meeting their needs.

Theory behind the Intervention

VOICES/VOCES is based on the theory of reasoned action, which explains how people's behaviors are guided by their attitudes, beliefs, and experiences as well as by how they believe others think they should act in a given circumstance (i.e., the social and cultural norms of their community).

Research Findings

VOICES/VOCES is also based on extensive research exploring cultural and gender-based reasons why people engage in unsafe sex practices and how they can be encouraged to change their behavior. VOICES/VOCES produced significant results in field trials, demonstrating both biological markers and self-reported behavior change. Participants in VOICES/VOCES had a significantly lower rate of infection with new sexually transmitted diseases than did control participants. In addition, participants had increased knowledge about the transmission of HIV and other sexually transmitted diseases as well as increased intentions to use condoms regularly. They were also more likely to go get more condoms at a neighborhood store in the weeks after their clinic visit.[1]

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based; they are thought to be responsible for the intervention's effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.**

VOICES/VOCES has the following 4 core elements:

- Show culturally specific videos portraying condom negotiation.
- Convene small-group skill-building sessions to work on overcoming barriers to condom use.
- Educate clients about different types of condoms and their features.
- Distribute samples of condoms identified by clients as best meeting their needs.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

VOCES/VOCES has the following key characteristics:

- Introduce VOICES/VOCES as a routine part of clinic or CBO services.
- Convene groups of 4 to 8 persons of the same gender and race and ethnicity, to allow for open discussion of sensitive issues among persons holding similar cultural values.
- Conduct the intervention session in a private space.
- Deliver the intervention in a single session (40–60 minutes).
- Begin the session by showing a culturally specific video (15–20 minutes).
- Show a video that

  - reflects up-to-date information about HIV and other sexually transmitted diseases
  - uses male and female actors whose race and ethnicity is similar to that of the clients
  - depicts real-life situations involving characters like the clients themselves
  - shows condom negotiation as a shared responsibility between sex partners
  - models communication skills and prevention attitudes and behaviors with regard to HIV and other sexually transmitted diseases
  - includes subject matter that is explicit but appropriate for viewing at the site
- Use the characters and situations depicted in the video to launch group discussions.
- Address barriers to condom use and safer sex by
  - increasing awareness of personal risk for infection with HIV and other sexually transmitted diseases
  - providing information on safer sex to prevent infection
  - correcting misinformation about condom use
  - presenting the features of different types of condoms
- Give clients a minimum of 3 condoms each of the type they identified as best meeting their needs.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and characteristics.

Procedures for VOICES/VOCES are as follows:

Showing Culturally Specific Videos

Videos quickly transmit information and model attitudes and behaviors regarding safer sex appropriate for members of particular cultures. In VOICES/VOCES, videos provide a nonthreatening starting point for groups of strangers, brought together for 1 brief session, to discuss intimate topics and behaviors. Videos also provide a safe context for discussing culturally sensitive issues. This context is especially important when group facilitators differ from clients in race and ethnicity or other characteristics, as is often the case with community health agencies providing services to diverse client populations.

Two videos have been developed for the VOICES/VOCES intervention: *Porque Sí,* in Spanish and English, for Latino men and women, and *Love Exchange,* for African Americans. The VOICES/VOCES videos were specifically designed for heterosexual African American and Latino adult men and women and may not be appropriate for all target populations. Other videos may be substituted or added, as long as they meet the criteria outlined in the VOICES/VOCES intervention package (see “Selecting Videos to Use in Delivering VOICES/VOCES,” VOICES/VOCES implementation manual, page 17). If an alternative video is selected, it should be screened for appropriateness by CBO staff as well as consumers and community members (e.g., community advisory board, consumer focus groups, materials review panels). When an alternative video is used for VOICES/VOCES, staff facilitators should update the video activity sheets (see VOICES/VOCES implementation manual, pages 37–39) to identify specific “trigger points” that will be used during the small-group sessions.

Conducting Small-Group Skill-Building Sessions

The interactive sessions are held after clients watch the video; the sessions are the heart of the VOICES/VOCES intervention. They help clients develop and practice the skills they need to negotiate condom use. They also provide an opportunity for clients to discuss problems that they have encountered in trying to adopt safer-sex behaviors and, with peers, develop and practice strategies for overcoming these problems.

Facilitators lead groups of 4 to 8 clients, using a standardized protocol. Facilitators begin by asking specific questions about the characters and events depicted in the video, then encourage clients to relate these situations to their own lives. Sessions address barriers to condom use and safer sex by providing information, correcting misinformation, discussing condom options, and having clients practice condom-negotiation techniques. Sessions follow a consistent format, but the content is adapted to address the concerns and experiences of each group. If possible, groups should comprise members of the same gender; that is, they should be men only or women only, to allow open discussion of sensitive issues surrounding sexual behaviors and attitudes.

Educating Clients about Condoms

The condom education component of the intervention supplements the skill-building session by providing clients with detailed information about condoms and how to choose a condom that they and their partner will feel most comfortable using. This component offers aids to familiarize clients with condoms and their features, making it easier for them to obtain and correctly use condoms. The Condom Features poster board, in English and Spanish, available in the VOICES/VOCES intervention kit, is used for this activity. In accordance with CDC's Statement on Nonoxynol-9 Spermicide (May 10, 2002, which is available at www.cdc.gov/mmwr/preview/mmwrhtml/mm5118a1.htm), condoms lubricated with nonoxynol-9 have been removed from the Condom Features poster board, and use of nonoxynol-9 spermicide is not encouraged in the VOICES/VOCES intervention.

Distributing Condom Samples

At the end of the VOICES/VOCES session, clients are given samples of the types of condoms they have identified as best meeting their needs.

ADAPTING

VOICES/VOCES was specifically designed for heterosexual African American and Latino adult men and women who are at very high risk for acquiring HIV. CBOs may adapt VOICES/VOCES for other populations who are at very high risk. However, before doing so, CBOs should conduct formative research to assess whether VOICES/VOCES, its theory of behavior change, and intervention activities are appropriate for the influencing factors, HIV risk behaviors, and cultural norms of the target population. For example, if discussion or use of condoms is largely prohibited in a particular cultural group, VOICES/VOCES may not be a good fit for that cultural group.

When using VOICES/VOCES for other populations at very high risk for acquiring HIV, CBOs should use an appropriate culturally specific video that represents members of the target population and their primary language.

CBOs may adapt VOICES/VOCES for settings other than sexually transmitted disease clinics. VOICES/VOCES has been implemented successfully in settings such as a neighborhood health center, prison, CBO, and school-based clinic. CBOs implementing VOICES/VOCES in settings other than clinics are encouraged to develop recruitment and other processes that accommodate the flow of client services at a particular agency. Although the core elements of VOICES/VOCES may not be altered or omitted, CBOs may modify the key characteristics of the intervention to better meet the needs of the target population.

RESOURCE REQUIREMENTS

People

VOICES/VOCES needs 1 to 2 facilitators and a program coordinator/manager.

Facilitators

- recruit clients
- show the video
- run the small-group skill-building sessions

Existing CBO staff members make good facilitators as long as they know how to do the above. Having more than 1 facilitator helps ensure continuity and consistency of the program in instances of absences or turnover. Facilitators also can support one another and help troubleshoot any issues that arise. Staff facilitators should possess some group facilitation skills or attend group facilitation training to develop those skills. Staff facilitators are strongly encouraged to attend a VOICES/VOCES training of facilitators to learn how to plan and implement the intervention. Staff facilitators, who will facilitate the VOICES/VOCES sessions, are strongly encouraged to attend the 2-day VOICES/VOCES training of facilitators.

Regarding materials costs, CBOs should budget for the distribution of a minimum of 3 condoms per person in the intervention. Because clients select which types of condoms best meet their needs, CBOs should budget for a diverse supply of condoms.

Program Coordinators/Managers

- oversee the intervention and supervise the staff facilitators
- should attend the VOICES/VOCES training of facilitators
- oversee maintenance, quality control, and documentation
- introduce the intervention and support it through implementation
- ensure that the intervention becomes a regular part of services
- help secure resources
- work in partnership with local and state public health agencies
- identify and address potential problems and answer questions

- serve as advocates for improved prevention services

Program Coordinators/Managers and those interested in learning more about the intervention are encouraged to read the VOICES/VOCES preview/administrator's guide, which can be found at www.effectiveinterventions.org as well as in the VOICES/VOCES intervention package. Half-day orientation trainings are not being offered.

Space

VOICES/VOCES can use existing clinic and CBO space. New users should examine their own clinic and CBO settings and develop strategies for delivering the intervention so the greatest number of clients will benefit. The main requirement is a private, quiet room for having confidential discussions and watching videos. Recommended sites include

- sexually transmitted disease clinics
- family planning clinics
- community health centers
- CBOs
- drug treatment centers
- prisons and jails

Supplies

VOICES/VOCES needs

- a TV and VCR
- money for
    - personnel costs
    - rented space, if needed
    - video equipment
    - staff training
    - materials such as condoms (CBOs should budget for the distribution of at least 3 condoms per person in the intervention. Because clients select which types of condoms best meet their needs, CBOs should budget for a diverse supply of condoms, including the types shown on the Condom Features poster board.)
    - ongoing technical assistance

Because VOICES/VOCES is primarily intended to fit into the opportunity provided by a client's routine visit to a sexually transmitted disease clinic or similar health service or community agency, additional costs incurred by clients are often negligible, since little additional travel or time investment is required.[2]

RECRUITMENT

The population recruited for VOICES/VOCES is persons who are at very high risk for HIV and other sexually transmitted diseases. VOICES/VOCES should be a part of routine services and offered on a regular basis to as many clients as possible every week. Successful recruitment involves determining where VOICES/VOCES fits into the flow of CBO services. CBO staff can recruit and enroll clients by presenting the intervention as part of the client's regular clinic visit.

General recruitment into the VOICES/VOCES sessions can include word of mouth, peer-to-peer recruitment strategies, and other marketing strategies (e.g., flyers, newsletters, and special events).

POLICIES AND STANDARDS

Before a CBO attempts to implement VOICES/VOCES, the following policies and standards should be in place to protect clients and the CBO:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client or his or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Informed Consent

CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO's responsibility and the clients' rights. Individual state laws apply to consent procedures for minors; but at a minimum, consent should be obtained from each client and, if appropriate, a legal guardian if the client is a minor or unable to give legal consent. Participation must always be voluntary, and documentation of this informed consent must be maintained in the client's record.

Legal and Ethical Policies

CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners; CBOs are obligated to inform clients of the organization's responsibilities if a client receives a positive HIV test result and the organization's potential duty to warn. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Referrals

CBOs must be prepared to refer clients as needed. For clients who need additional assistance in decreasing risk behavior, providers must know about referral sources for prevention interventions and counseling, such as partner counseling and referral services and other health department and CBO prevention programs.

Volunteers

If the CBO uses volunteers to assist with or conduct this intervention, then the CBO should know and disclose how their liability insurance and worker's compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing VOICES/VOCES:

CBOs

Leadership and Guidance

The CBO manager must provide hands-on leadership and guidance for the intervention—from preparation through institutionalization. The orientation session enables the CBO manager (and facilitators) to provide this guidance.

Implementation Manual

The VOICES/VOCES implementation manual provides procedures for quality assurance, process monitoring, and process evaluation and describes the experiences of others who have used the intervention. The manual also guides staff on how to incorporate feedback and findings from quality assurance and process evaluations into VOICES/VOCES programming.

Fidelity to Core Elements

Throughout implementation of VOICES/VOCES, it is necessary to determine whether staff members are delivering the intervention with fidelity to the 4 core elements. It is also necessary to ensure that the intervention is meeting the needs of CBO clients and staff. Staff will use the quality assurance checklist contained in the implementation manual to identify, discuss, and solve problems in successfully implementing the intervention.

Clients

Clients' satisfaction with the services and their comfort should be assessed periodically. Staff will use the client satisfaction survey contained in the implementation manual or their own satisfaction survey to collect feedback from clients. The results of the survey will be used to strengthen the intervention.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

O’Donnell L, San Doval A, Duran R, O’Donnell CR. Predictors of condom acquisition after an STD clinic visit. Family Planning Perspectives. 1995;27:27–29.

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RESPECT

DESCRIPTION

RESPECT is a 2-session, individual-level intervention for HIV-negative women and men. This client-focused counseling model was designed to assess clients' risk for HIV, enhance clients' perception of personal risk and work with clients to develop a risk reduction plan. The researchers also believe that the RESPECT model can be effective for persons living with HIV to assist in reducing transmission to others. RESPECT can be used as a stand-alone intervention or integrated into other HIV prevention interventions such as HIV Counseling, Testing, and Referral (CTR) or Comprehensive Risk Counseling and Services (CRCS).

RESPECT has been packaged by CDC's Diffusion of Effective Behavioral Interventions (DEBI) project. Information on training and related materials on the intervention is available at www.effectiveinterventions.org.

Goals

RESPECT aims to reduce clients' high-risk behaviors and prevent HIV (and STD) acquisition and transmission.

How It Works

RESPECT is intended to 1) heighten clients' awareness of their personal risk for HIV through the use of "teachable moments," and 2) support clients in developing a realistic and achievable plan to reduce their risk behaviors. Teachable moments are situations or circumstances that can create an opportunity for behavior change. During the sessions, counselors may discover that there is inconsistency between a client's beliefs and behaviors. When pointed out, this inconsistency may result in an internal conflict (i.e., emotional discomfort), which is also called cognitive dissonance. The RESPECT model relies heavily on these concepts.

Using a structured protocol, the counselor engages in an interactive, one-on-one conversation with the client. In the first session, the counselor conducts a risk assessment, asks questions to better understand the context of the client's high-risk behaviors, addresses contradictions between the client's beliefs and behaviors, guides the client in developing a risk-reduction strategy, and offers referrals for services to support the client in attaining his/her risk-reduction goal. In the second session, the counselor delivers the HIV test result (if a test was given, such as in a CTR setting), follows up with the client to gauge progress toward meeting their risk-reduction objective, works with the client on developing a long-term risk-reduction plan, and provides additional referrals (as needed). Although the original RESPECT model was used with standard HIV-testing, RESPECT can also be used with rapid testing.

Theory behind the Intervention

Two theories undergird RESPECT—the Health Belief Model and Social Cognitive Theory. However, the Theory of Reasoned Action and the Transtheoretical Model also play important roles in this intervention.

The ***Health Belief Model*** is a framework that explains and predicts health behaviors by focusing on the extent to which individuals perceive themselves to be at risk for a particular condition or disease. According to this model, behavior is guided by individuals' perceived susceptibility of acquiring a health condition, perceived severity of the health condition, perceived benefits of engaging in risk-reduction activities, and perceived barriers to engaging in risk-reduction activities. Individuals will be motivated to change their behaviors if they believe that the benefits of doing so outweigh the consequences of not changing their behavior. The Health Belief Model is used in RESPECT to increase a client's perception of his/her personal risk for HIV and encourage risk-reduction behaviors through the development of a realistic risk-reduction plan, followed by incremental steps to achieve it.

Social Cognitive Theory posits that behavior is acquired and maintained through a reciprocal relationship between personal factors (e.g., cognitions and emotions), the environment, and aspects of the behavior itself. Key tenets of this theory are 1) that individuals will be more likely to change their behavior if they foresee positive outcomes resulting from the change, 2) that behavior change can occur via vicarious learning (i.e., observing the behavior of others), and 3) that in order to change behavior, individuals need to believe in their ability to do so (i.e., self-efficacy). Drawing on Social Cognitive Theory, RESPECT counselors help clients build the skills and self-confidence to implement a risk-reduction strategy. In addition, this theory can be used to help the client explore friends' and family members' beliefs and determine who in their life would be supportive of their plan.

According to the ***Theory of Reasoned Action***, behavior change is influenced by one's individual beliefs, attitudes, and intentions to engage in a behavior. During the two RESPECT sessions, the counselor explores with clients how their decisions to engage in risk behaviors are influenced by their attitudes and beliefs. Because a person's intention to engage in a behavior is believed to be a key determinant in whether the person will ultimately change the behavior, the RESPECT counselor gets a commitment from the client to take the first step toward a larger risk-reduction plan in the first session. The plan is written on an appointment card so that the client has a written reminder of a return appointment as well as the plan he or she has developed and agreed to attempt. This theory also addresses the influence of one's peers on an individual's behavior, so RESPECT counselors gauge the client's perceptions of what his/her peers believe and do.

The ***Transtheoretical Model*** (also known as Stages of Change) presents five stages of behavior change: precontemplation, contemplation, preparation, action, maintenance. Although some individuals go through the five stages in a linear fashion, it is expected that some individuals will relapse before being able to maintain their new behavior successfully. The Transtheoretical Model plays a smaller, but important, role in RESPECT, and it is used to assess the readiness of a client to commit to risk-reduction behaviors. Since not all clients are ready or willing to develop a risk-reduction plan, counselors should ensure that they assess where their clients are on the continuum before proceeding with the development of a plan.

Research Findings

The efficacy of RESPECT was assessed in a multicenter randomized controlled trial with 5,758 HIV-negative heterosexual persons aged 14 and older who visited an STD clinic.[1] Three interventions were compared in the Project RESPECT study:

1. Brief RESPECT counseling consisting of 2 sessions that totaled 40 minutes;
2. Enhanced RESPECT counseling consisting of 4 sessions that totaled 200 minutes; and
3. Brief educational messages consisting of 2 sessions that totaled 10 minutes, which was the standard practice at the time.

Compared with participants in the educational messages intervention, participants in the 2- and 4-session RESPECT interventions had lower STD incidences and higher self-reported 100% condom use up to 12 months after participating in the interventions. Because research demonstrated that participants in the 2-session RESPECT counseling model achieved similar results as those in the 4-session model, CDC has packaged the 2-session model as a DEBI to make it more feasible for agencies to implement this intervention.

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are critical components of an intervention's conceptualization and design that are believed to be responsible for the intervention's effectiveness. These core elements are derived from the behavioral theories upon which the intervention is based. **Core elements are essential and cannot be ignored, added to, or changed, in order to maintain intervention fidelity and intent.**

RESPECT has the following 5 core elements:

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

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

RESPECT has the following key characteristics:

- Conduct sessions using open-ended questions, prompting the client to engage actively in the discussion.
- Allow the *client* to identify an achievable risk-reduction step.
- Engage in role-plays with the client to increase the client's self-efficacy to engage in risk-reduction behaviors.
- Provide referrals based on the client's self-identified needs.

- Modify the time needed to complete all of the protocol components, taking cues from client needs and agency requirements.
- Provide on-site conventional HIV testing, which will allow the client to attempt to implement the risk-reduction step between sessions. When implemented in non-HIV testing settings, it is recommended that a second session be scheduled for purposes of following up on the attempt to implement a plan.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and characteristics. Procedures for RESPECT are as follows:

Engaging in client-focused counseling

Many clients are knowledgeable about the ways in which HIV can be transmitted, but they do not perceive their own behaviors as risky. Therefore, during client-focused counseling, it is important to focus specifically on what places the client at risk, rather than provide general HIV education. Using the protocol guides or counselor cards, the counselor should engage in an interactive conversation with the client to 1) determine what behaviors place the client at risk for HIV (or STDs), 2) use a “teachable moment” to increase the client’s concern about his/her personal HIV risk, and 3) develop a strategy to reduce identified risks.

Note: *Client-focused HIV prevention counseling should not be confused with Carl Rogers’ client-centered approach to counseling, which allows the client to guide the direction of the counseling session. In RESPECT, the counselor guides the flow of the session using a structured protocol with open-ended questions and other counseling techniques to ensure active engagement of the client.*

The following components should be addressed in each of the RESPECT sessions:

Session 1 Stages

Stage 1: Introduce and orient the client to the session.
Stage 2: Enhance the client’s sense of self-risk.
Stage 3: Explore the specifics of the most recent risk incidence.
Stage 4: Review previous risk-reduction experiences.
Stage 5: Summarize the risk incident and risk patterns.
Stage 6: Negotiate a risk-reduction step.
Stage 7: Identify sources of support and provide referrals.
Stage 8: Close the session.

Session 2 Stages

Stage 1: Frame the session and orient client.
Stage 2: (Give result)
Stage 3: Review the risk-reduction step.
Stage 4: Revise the risk-reduction step.
Stage 5: Identify sources of support.
Stage 6: Provide referral.
Stage 7: Close the session.

The main elements of Session 2 will be the same regardless of setting. The primary difference in a test setting will be providing the result at the beginning of the session.

Developing a risk-reduction plan

One of the main objectives of the first session is to enhance the client’s perception of his/her risk. Once the client views himself/herself at risk, the counselor works with the client to develop a risk-reduction step that the client can attempt before the next session. Ultimately, this step will lead to a larger behavioral goal. It is important that the counselor allow the client to identify the behavior to change rather than choosing the behavior for the client. This will allow the client to have ownership over the risk-reduction plan and will increase the likelihood that the new behavior will be adopted.

Some clients may choose an unrealistic goal that may be beyond their reach. The counselor should break the long-term goal into smaller steps and work with the client to select one of the incremental steps. Together, the client and counselor should anticipate and problem-solve any potential barriers that may arise so that the client can readily overcome these obstacles. In addition, skills and strengths identified from previous risk-reduction attempts are acknowledged and built upon to facilitate future attempts. The counselor should make sure that the client is committed to trying the step and feels confident in his/her ability to implement the step before leaving the session. Finally, the counselor should write the step down on paper for the client to refer to after the session. In subsequent sessions, the client builds on his/her initial risk-reduction step to develop a long-term plan of behavior change.

Making referrals. During the RESPECT sessions, counselors may discover that clients need additional support in initiating and maintaining their behavior change. Counselors may recognize areas of concern to which the client is not attuned. The counselor should make sure that the client is amenable to the referrals, prioritizing them according to the needs most expressed by the client. In addition, the counselor should be cognizant of not overwhelming the client with too many referrals. Examples of appropriate referrals include the following:

- Alcohol and drug treatment programs
- Crisis intervention hotlines
- Emergency food sources
- Family planning clinics
- Financial assistance sources
- Free health care clinics (for persons without insurance)
- HIV treatment specialists
- Housing programs
- Legal aid sources
- Mental health professionals
- Services for sexually or physically abused persons
- Support groups and intensive HIV prevention intervention organizations
- Transportation programs

Counselors should not assume that clients will be able to access these services on their own. Therefore, they should provide as much information and assistance as possible to ensure that clients will follow-through on the referral (often called an *active* referral). It may be helpful for the counselor to phone the service provider for the client. If possible, the counselor should provide the following information about the referral agency:

- Name of the provider or agency
- Range of services provided
- Target population(s)
- Service area(s)
- Contact name, telephone and fax numbers, street address, e-mail address, and web site
- Directions, transportation information, and accessibility to public transportation
- Hours of operation
- Cost for services
- Eligibility criteria
- Application materials
- Admission policies and procedures
- Competence in providing services appropriate to the client’s culture, language, gender, sexual orientation, age, and developmental level
- Previous clients’ satisfaction with services

Delivering the HIV test result (if applicable)

Before the session, the counselor should confirm that the HIV test result belongs to the client. In addition, the counselor should be emotionally prepared to handle the potential emotions or reactions that could arise during the session, especially if the result is positive. After welcoming the client back, the counselor should state the result in a clear and simple manner. It is important to provide the result at the beginning of the session so as not to prolong any anxiety that the client may be experiencing.

If the result is negative, the counselor should explain that the result means that the client was not infected as of 3 months ago, but that the test would not cover all recent risk exposures. It may identify some but not all new infections. The counselor should work with the client on developing a long-term risk-reduction plan that builds on the risk-reduction step selected in the first session. The counselor should also explore the client’s reaction to the result, determine whether the client needs to be retested based on recent risk behavior, and provide any necessary referrals.

If the result is positive, the counselor should allow the client time to process the meaning of the result. In a supportive manner, the counselor should note how the client is coping with the news and address any questions the client may have. It is important that the counselor assess the client’s wellness strategy (for both emotional and physical health) and access to health care. If the client is emotionally ready to explore risk-reduction issues, the counselor should help the client to devise a plan to reduce the risk of transmission to current and future partners. Regardless, it is important for the counselor to validate the client’s feelings and make sure that the client is ready to end the session. The counselor should ask the client what his/her next steps are, while at the same time not pressuring the client to make any major decisions that are not urgent. It may be helpful to the client to discuss who he/she will be seeing in the near future and how he/she will handle the situation. Finally, the counselor should summarize the key issues that were discussed in the session and encourage the client to call if he/she has any questions or concerns. The counselor might ask the client for contact information so that he/she can follow up in the next few days. The counselor should end the session by exploring what services the client might need and providing the appropriate referrals.

Note: *The above process will be different when using RESPECT in conjunction with rapid testing because Sessions 1 and 2 will be conducted on the same day. Therefore, the client will likely not be able to practice the risk-reduction step that was agreed upon in Session 1.*

ADAPTING

RESPECT can be used in various settings where individuals are at high behavioral risk for HIV. In the original study, RESPECT was found to be effective with HIV-negative heterosexual women and men whose main risk for HIV was through sexual transmission. However, the intervention can be used with populations who have other risk factors such as injection drug use. RESPECT can also be used with HIV-positive persons to prevent transmission of HIV or acquisition of an STD. In addition, RESPECT was found to be highly effective with younger persons, so an agency might adapt RESPECT for use with adolescents. Finally, although the original RESPECT model was used with standard HIV-testing, RESPECT can also be used with rapid testing, although researchers found that the latter might be slightly less effective with men.[2]

RESOURCE REQUIREMENTS

People

RESPECT requires paid or volunteer staff members or experienced mental health professionals who are trained in the RESPECT counseling model, general counseling principles, fundamentals of HIV prevention counseling, and their local organizational requirements for HIV CTR and related interventions. The number of RESPECT counselors depends on the demand for counseling and testing in the agency. However, because RESPECT is an individual-level intervention, only one counselor is needed per session. In addition, at least one supervisor who is trained and skilled in the RESPECT counseling model and is able to provide ongoing support, guidance and quality assurance is required.

Space

RESPECT needs space that is private and secure so that confidentiality can be assured.

Supplies

The RESPECT package includes the implementation manual, counselor cards, protocol script cards, risk-reduction step forms, a training video, and quality assurance recommendations and forms. In addition to these materials, RESPECT also requires a referral resource guide that should be compiled by the agency implementing RESPECT.

RECRUITMENT

RESPECT originally targeted persons who visited a public STD clinic. Often individuals self-refer for counseling and testing because they are concerned about their risk for HIV (or STDs). The following are additional recruitment strategies that can be used to reach clients for RESPECT:

- Recruit HIV-positive and high-risk HIV-negative persons to encourage people in their social networks to participate in RESPECT.
- Recruit from other agencies that serve high-risk populations, such as substance abuse treatment facilities or homeless shelters.
- Recruit from, or integrate into, other HIV prevention services such as CRCS.
- Recruit high-risk adolescents who are receiving services through other agencies.

Review the Recruitment section of the Procedural Guidance document to choose a recruitment strategy that will work in the setting in which the CBO plans to implement RESPECT.

POLICIES AND STANDARDS

Before a CBO attempts to implement RESPECT, the following policies and standards should be in place to protect clients, the CBO, and the RESPECT intervention team:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client or his or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of these guidelines for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Informed Consent
CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO's responsibility and the client's rights. Individual state laws apply to consent procedures for minors; but at a minimum, consent should be obtained from each client and, if appropriate, a legal guardian if the client is a minor or unable to give legal consent. Participation must always be voluntary, and documentation of this informed consent must be maintained in the client's record.

Legal and Ethical Policies
If agencies offer HIV testing with RESPECT, clients will learn their HIV status when they return for their test results. CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners. CBOs are obligated to inform clients of the organization's responsibilities if a client receives a positive HIV test result and the organization's potential duty to warn. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Referrals
CBOs must be prepared to refer clients as needed. For clients who need additional assistance in decreasing risk behavior, providers must know about referral sources for prevention interventions and counseling, such as comprehensive risk counseling and services, partner counseling and referral services, and other health department and CBO prevention programs.

Volunteers
If the CBO uses volunteers to assist with or conduct this intervention, the CBO should know and disclose how their liability insurance and workers' compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

Quality assurance is an ongoing process that ensures that counselors maintain fidelity to the core elements of the intervention.[3] The following quality assurance activities should be in place when implementing RESPECT:

Counselors and Supervisors
Training
Both counselors and supervisors should participate in training and continuing education to ensure that they have the requisite skills to implement RESPECT successfully. In addition to training on RESPECT, training on the following topics is recommended:

- Assuring Quality Assurance of HIV Prevention Counseling
- Counseling, Testing, and Referral
- Fundamentals of HIV Prevention Counseling
- HIV 101

Information about RESPECT training can be found at www.effectiveinterventions.org. Information on other training offered by CDC and our partners can be found on the Training Events Calendar at www.cdc.gov/hiv/topics/cba/index.htm.

Session Observation

The supervisor should observe the counseling sessions to ensure that counselors are consistently adhering to the RESPECT protocol and are providing high-quality counseling. These observations may be done in person, or the counselor might video- or audiotape the session for later review by the supervisor or peer-review groups. Before observing the session, the counselor must obtain the consent of the client.

It is recommended that a new counselor be observed by a supervisor once a week. As counselors become more experienced in using RESPECT, the frequency of observations can decrease. A counselor with 6–12 months' experience might be observed once a month, whereas a counselor with 1 year of experience might be observed once every 6 months. The counselor and supervisor should debrief after each observation.

Record Review

Records should be reviewed regularly to ensure that counseling sessions are documented consistently and correctly. The following information might be documented:

- Process and outcome data requirements
- Main risks and circumstances related to client's most recent risk incident
- Date of most recent risk incident
- Risk-reduction step
- Referrals and rationale for the referrals

Case Conferences

Case conferences are an ideal opportunity for counselors and supervisors to obtain support from and provide constructive feedback to other staff in the agency. During case conferences, the counselors and supervisors can present challenging sessions, practice using the RESPECT materials, and discuss strategies for better serving their clients. Peer role-playing can be a useful strategy during these meetings.

Clients

RESPECT staff should administer client satisfaction surveys to clients at each session. These anonymous surveys can be used to assess clients' satisfaction with the overall counseling experience, session components (e.g., negotiating a risk-reduction step), and counselor characteristics (e.g., display of empathy). Clients should also be given the opportunity to offer suggestions on how to improve the sessions.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

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2. Metcalf CA, Douglas JM, Malotte CK, Cross H, Dillon BA, Paul SM, Padilla SM, Brookes LC, Lindsey CA, Byers RH, Peterman TA, for the RESPECT-2 Study Group. Relative efficacy

of prevention counseling with rapid and standard HIV testing: A randomized, controlled trial (RESPECT-2). Sexually Transmitted Diseases. 2005;32:130–138.

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MODELO DE INTERVENCIÓN PSYCOMÉDICA (MIP)

DESCRIPTION

The Modelo de Intervención Psychomédica (MIP) (Psycho-Medical Intervention Model [PIM]) is a holistic behavioral intervention for reducing high-risk behaviors for infection and transmission of HIV among intravenous drug users (IDUs). The intervention is theory-driven and intensive, combining individualized counseling and comprehensive case management over a 3–6-month period. The strategies of motivational counseling (Miller and Rollnick, 1991), self-efficacy (Bandura, 1997; Beck, Wright, Newman, and Liese, 1993), and role induction (Stark and Kane, 1985) are used.

This innovative approach focuses on the continuous interaction between the participant and the members of the MIP team—supervisor, counselor, and case manager. Together, they assess the participant’s risk behaviors, and his or her integration into healthcare services, drug abuse treatment, family support system, and the recovery community.

The MIP approach consists of 6 individualized and structured counseling sessions with specific activities, each with a comprehensive case management component, and 1 booster that reviews and reinforces achievements and challenges throughout the intervention. The development of these activities is guided by the fundamental principles of motivational counseling. These principles are 1) expressing empathy, 2) developing discrepancy, 3) avoiding argumentation, 4) not confronting resistance openly (roll with resistance), and 5) supporting self-efficacy. The ultimate objective of motivational counseling is to help the participant explore and resolve the ambivalence related with behavior change. This assumes an increase of the participant’s self-efficacy regarding the behaviors that are the focus of the intervention.

Several interrelated approaches that characterize this intervention are 1) treating the participant with respect and dignity, 2) fostering autonomy and self-efficacy; 2) helping the participant envision a more satisfactory life, 3) creating a plan for behavior change that includes the actions necessary to achieve the participant’s goal, and 4) helping him or her obtain the primary health care, drug treatment, and other human services necessary to meet basic needs. In addition, the intervention team helps participants to identify and build skills and take the steps required to reduce their drug- and sex-related risk behaviors. These behaviors may result (or may already have resulted) in the participant’s contracting and/or transmitting HIV and viral hepatitis.

MIP has been packaged by CDC’s Diffusion of Effective Behavioral Interventions Team. Project. Information is available at www.effectiveinterventions.org.

Goals

The goals of MIP are to 1) reduce risk behaviors for infection and transmission of HIV among injection-drug users, 2) engage participants in drug treatment and healthcare services, and 3) enhance participants' self-efficacy for maintaining behavior change and preventing relapse.

Target Audience

The primary target population is injection-drug users who are 18 years of age and older recruited from the community; however the program can be adapted for other drug users, including IDUs in methadone treatment for the past year. If agencies would like to work with poly-drug users who are currently not injection-drug users, CDC will provide technical assistance for adaptation.

How it Works

The MIP team consists of a case manager, counselor, and supervisor**.** The case manager identifies and recruits the participant in the community, initiates the induction process and serves as an advocate, helping the participant work with all the systems—e.g., health care, drug treatment, legal, and human services—necessary to achieve his or her risk-reduction goals. The case manager remains active with the participant and provides support throughout the intervention, for example, by coordinating appointments and transportation, accompanying the participant, and making other appropriate referrals as necessary.

The counselor meets with the participant and begins conducting formal structured sessions to help the participant achieve the behavior and attitude changes necessary for preventing HIV, reducing injection-drug use, and developing self-efficacy. During one-on-one counseling sessions, the counselor and the participant focus on the participant's motivation to change behavior. They develop a work plan based on what the participant wants to facilitate and maintain behavior change and to prevent relapse. They also focus on strategies participants can use to explain their risk-reduction goals to their peers. These strategies promote the use of clean needles and consistent and correct male and female condom use. HIV and hepatitis C counseling and testing are encouraged and offered throughout the intervention.

The supervisor is constantly involved in the implementation of the services, quality control, and providing feedback and support to other team members. The supervisor is also responsible for identifying resources and creating a guide that will be used by the team and by the participants.

Theories Behind the Intervention

The Transtheoretical Model of Change helps the MIP team understand the participant's level of readiness and commitment to behavior change. This model emphasizes that the stages of change are dynamic, that change happens over time, and that it occurs in stages.

The Motivational Counseling Model uses a direct client-centered style of counseling. It is a tool that the MIP team uses for the participant to explore and resolve ambivalence about behavior change. It clearly establishes a directive style aimed at helping the MIP team establish collaboration with the client in clarifying and resolving ambivalence. It is considered a client-centered style because the ultimate responsibility to change falls on the participant.

The Social Learning Theory holds that behavior change will occur when the participant learns, via modeling and practice, different information-processing strategies and behavioral responses to high-risk situations. Role Induction Theory helps the participant understand his or her commitment and expectations within the program. Role induction strategies can increase the participant’s perception of the MIP team's credibility, expertise, and empathy.

Role induction is a strategy used throughout the intervention. Role induction, as conceptualized in MIP, entails the evaluation and clarification of the participant’s expectations and preconceptions regarding the project and each proposed activity in MIP (Diaz and Perez, 2000).

Research Findings

The MIP intervention study showed that among drug injectors not in treatment, the 6 sessions and 1 booster counseling intervention, using motivational interviewing strategies in conjunction with case management techniques, were effective in helping participants to enter drug treatment, discontinue drug injection, and reduce needle sharing. The intervention was directly associated with discontinuing drug injection. Overall, participants who received the MIP intervention were nearly 2 times more likely to enter drug treatment and half as likely to continue drug injection. For subjects who continued injecting drugs, the MIP intervention enhanced self-efficacy for discontinuing the practices of needle sharing, pooling money to buy drugs, and sharing cotton. The research team stressed that the importance of this study was the success of the two-pronged intervention—the combination of counseling and case management.

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that are thought to be responsible for the intervention’s effectiveness. They come from the models and behavioral theories upon which the intervention or strategy is based. **Core elements are essential to the intervention; they cannot be ignored, added to, or changed.**

MIP has the following 7 core elements:

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

7. Conduct a booster session that reviews the participant's achievements, needs, strengths, and outstanding issues and includes an exit plan with specific strategies to maintain healthy behaviors and enhance self-efficacy.

Key Characteristics

Key characteristics are the activities and delivery methods that are critical for conducting an intervention. To meet the needs of the target population and ensure the strategy is culturally appropriate, key characteristics may be adapted for different venues and various at risk-populations.

The MIP intervention has the following key characteristics.

1. **Cultural Competence and Sensitivity.** Conduct whole-staff training to ensure understanding of the culture(s) of the target population(s) and the culture of drug use.
2. **Team Structure and Training**
   -Form an MIP team consisting of a case manager, a counselor, and a supervisor.
   -Ensure that the team is committed to participating in a uniform orientation about the intervention process.
   -Ensure that the team members demonstrate competence in Motivational Interviewing, the Transtheoretical Model of Change, the Social Learning Theory, Role Induction Theory, the bonding process, and developing strategies to ensure participants' access to critical medical and drug treatment resources
   -Ensure that the MIP team has completed a basic HIV/AIDS course and secured HIV counseling and testing certification.

3. Offer counseling and testing and or effective referrals for HIV and viral hepatitis at each contact.

4. **Counseling Team Interaction and the Bonding Process:** Promote close working relationships among members of the MIP team in order to establish a unified approach to the participant's accomplishing his/her goals and ensure the success of MIP.

Procedures

Procedures are detailed descriptions of the above-listed elements and activities. The procedures for MIP are as follows:

Recruiting and Conducting Outreach

Recruitment for MIP is conducted through traditional community outreach, referrals, and social networking. Team members receive training in the techniques of community mapping and in safety procedures. The team maps the community for potential recruitment and intervention sites, e.g., where participants live, congregate, or sell/take drugs. They attempt to establish a positive presence in the community and enlist the support of proven community resources, such as primary health care services, drug treatment programs, HIV testing, detoxification programs, and housing. Community assessment will help the program in developing relationships and memoranda of agreement with these health and social service agencies.

Counseling and Testing

As part of the MIP activities, voluntary HIV and hepatitis C counseling and testing are offered to participants.

- **If the CBO already offers counseling and testing,** this intervention fits in well with those services.
- **If the CBO does not offer counseling and testing,** participants should be referred to organizations or agencies that do. This activity must be documented through a memorandum of agreement.

Although participants do not have to be tested for HIV before attending the first session, those who have not recently been tested should be encouraged to get tested and learn their HIV status as soon as possible.

Conducting the MIP Intervention (general)

- Provide a meeting space that is comfortable and inviting.
- Plan interventions at the same time and place, which should be convenient and should not conflict with participants' other responsibilities or needs.
- Plan intervention sessions according to participants' time and availability.
- Create an environment of trust, respect, and positive reinforcement (to facilitate the bonding process).
- Maintain strict confidentiality.
- Include the capacity to refer participants to other services (e.g., domestic abuse, rape counseling, mental health services).

Conducting the MIP Sessions (specific)

The MIP intervention consists of 6 sessions and 1 booster session. Each session has the same structured format, although content and implementation may not be linear. This will depend on the needs and readiness of the participant. At the beginning of every session the participant, together with the counselor, assesses the progress he or she has made toward the goals established during the previous session. The participant may also indicate his or her readiness to tackle another topic. If the participant feels he or she has made enough progress in a specific area he or she may skip to another topic. The session topics are as follows:

1. Induction
2. Taking care of your health
3. Readiness for entering drug treatment
4. Relapse prevention
5. Reducing drug-related HIV risk
6. Reducing sex-related HIV risk
7. Booster

Format of Sessions

Each session is approximately 45 minutes to 1 hour long. Case management should be offered and provided after each session. The sessions are designed for individuals and not for groups. In each session, the participant identifies, with the counselor's help, changes he or she wishes to make based on his or her self-assessment during the previous session and what has happened in the interim (e.g., securing health insurance such Medicaid or other indigent care services, the decision or actual visit to a physician, using condoms, not sharing needles, entering a drug treatment program). The sequence of the sessions is based on the participant's readiness to change.

The location of the sessions is flexible. However, the space used for the sessions must guarantee the safety, privacy, and confidentiality for both the participant and counselor.

It is highly likely that the induction session (first session) may take place in the community, at the location where the participant is first identified by the case manager or another MIP team member. Generally, after the induction session, the following sessions take place at the team's community office, and the counselor or supervisor conducts the sessions. If necessary, the case manager or other team member escorts the participant to and from the session. This time is very valuable because the case manager or other team member can use it to explain MIP, gather information about the participant's progress and challenges, and explore and promote relationships with family and significant others, which the case manager will communicate to the counselor.

Session 1: Induction

The objective of this session is for the participant to accept and continue participating in the intervention, health care, and utilization of services. During a structured session, the case manager and/or counselor explains what MIP is, gives specific information about the intervention, and explains the sessions and the benefits the participant can obtain the case manager and/or counselor clearly states the roles and responsibilities of the MIP team and the participant. This session can be conducted in any community venue—the project site, a treatment program, or any other place in which the environment is favorable.

Once the participant agrees to take part in the intervention, the counselor inquires about critical problems the participant faces and reasons for considering entering into a process to change the behaviors that affect these critical problem areas. Together, the counselor and participant list the problems they will address and create an action plan. The plan details the steps the participant agrees to take to change, those behaviors he or she has identified as being most critical and for which the participant is likely to have the support of significant others within their social network for addressing any obstacles to making the changes. The counselor records action plans targeting the specific behavior addressed in each session.

This session also begins to address the participant's health or human services needs, as identified in the action plan. At this stage, the counselor refers the client to the case manager for assistance in securing health care or other human services. The case manager will make appointments on behalf of the participant and provide escort and transportation services if necessary.

At the end of the session the participant fills out a self-evaluation, and the counselor provides feedback about the participant's readiness to progress to the next stage of change. The counselor and the participant summarize the issues they discussed, and agree on a plan to address them. They make the next counseling appointment.

Session 2: Taking Care of Your Health

The objective of this session is to get the participant to make an appointment with a physician to take care of his/her health. The participant receives educational information about what constitutes a health examination, and explores the participant's experience with the healthcare system, if any. If the participant is not receiving appropriate health care, the counselor would strongly encourage the participant to explore his or her health care needs and seek appropriate services from a physician, infectious disease clinic, or community-based organization that offers medical care.

The MIP team will follow up on the participant's plan for seeking health care. The counselor meets with the participant to ensure adherence to medical recommendations, including laboratory tests, prescriptions, or referrals to other medical specialist. The counselor uses encouragement and reviews prior action plan agreements from the induction session. The case manager will make appointments on behalf of the participant and provide escort and transportation services if necessary.

At the end of the session the participant fills out a self-evaluation, and the counselor provides feedback about the participant's readiness to progress to the next stage of change. The counselor and the participant summarize the issues they discussed, and agree on a plan to address them. They make the next counseling appointment.

Session 3: Readiness for Entering Drug Treatment

The objective of this session is for the participant to accept a referral to a drug treatment program (detoxification, inpatient and/or outpatient drug treatment including methadone). Then, the counselor and participant develop a history of the participant's drug use and treatment and, using decisional balance strategies (listing the pros and cons), discuss the positive and negative aspects of continuing present patterns of drug use and of entering a detoxification and/or treatment program. By means of role induction, the counselor explains how the intervention can help start the admission process into a drug treatment program. The counselor clarifies the role of MIP in this process, as well as the participant's expectations about what will happen during the visit and/or admission.

The counselor and the participant set goals and develop a plan for this aspect of the intervention. If the participant agrees to enter treatment, the MIP team will ensure that the process of admission is started immediately.

At the end of the session the participant fills out a self-evaluation, and the counselor provides feedback about the participant's readiness to progress to the next stage of change. The counselor and the participant summarize the issues they discussed, and agree on a plan to address them. They make the next counseling appointment.

Note: Session #3 may require multiple contacts for completion of session goals.

Session 4: Relapse Prevention

The objective of this session is to maintain the participant in action stage in relation to the positive changes in risk-reduction behaviors around drug use and to help develop skills to prevent drug use relapse. The session includes examples of situations that precipitate relapse. Counselor and participant develop an individualized profile of high-risk situations for relapse by exploring the participant's last relapse event. It is recommended that they explore three dimensions in the analysis of relapse: feelings, thoughts, and behavior (cognitive behavioral approach). The counselor uses decisional balance (pros and cons) strategies to discuss the positive and negative aspects of preventing relapse.

After the session, the case manager and participant discuss ways in which the case manager could be available to provide support when needed. For example, if the participant needs help to prevent relapse, he or she could contact the case manager, who would help the participant deal with the thoughts or feelings that are placing the participant at risk for relapse.

At the end of the session the participant fills out a self-evaluation, and the counselor provides feedback about the participant's readiness to progress to the next stage of change. The counselor and the participant summarize the issues they discussed, and agree on a plan to address them. They make the next counseling appointment.

Session 5: Reducing Drug-Related HIV Risk

The objective of this session is to start making changes and develop skills for the reduction of high-risk injection behaviors for HIV infection. The counselor reviews with the participant the action plan discussed in the prior sessions and develops a history of the participant's behaviors that place him or her at high-risk for HIV infection. This session involves building the participant's skills for practicing safer injection, including cleansing and sharing of works and paraphernalia and learning about drug-related risks for acquiring or transmitting HIV and hepatitis C. The MIP team provides the participant with safety kits (bleach, cookers, cotton, condoms, lubrication, alcohol pads, water, over-the-counter antibiotic ointment).

Note: Needles may not be distributed at any time using federal funds. Funding for MIP may not be used to support needle exchange services.

The counselor provides a summary and feedback about the issues discussed regarding the participant's risk behaviors. Using decisional balance strategies, the counselor and participant discuss the positive and negative aspects of continuing with present drug injection practices, as well as the pros and cons of making changes in these areas. If necessary, the MIP team transports the participant to other services (e.g., drug treatment program).

At the end of the session the participant fills out a self-evaluation, and the counselor provides feedback about the participant's readiness to progress to the next stage of change. The counselor and the participant summarize the issues they discussed, and agree on a plan to address them. They make the next counseling appointment.

Note: It is recommended that this session is delivered to participants seeking drug treatment prior to admission.

Session 6: Reducing Sex-Related HIV Risk
The objective of this session is to get the participant to start making changes and develop skills to reduce sexual practices that place the participant at high risk for HIV, hepatitis C, and STDs. The counselor reviews with the participant the action plan discussed in the prior session and develop a profile of sex behaviors that place the participant at high risk for HIV infection. The MIP team provides the participant with safety kits (bleach, cookers, cotton, condoms, lubrication, alcohol pads, water, over-the-counter antibiotic ointment).

The counselor provides feedback about the issues discussed in relation to the participant's risk behaviors. Using decisional balance strategies, they examine the positive and negative aspects of continuing with present sex behaviors and the pros and cons of changing these behaviors.

At the end of the session the participant fills out a self-evaluation, and the counselor provides feedback about the participant's readiness to progress to the next stage of change. The counselor and the participant summarize the issues they discussed, and agree on a plan to address them. They make the next counseling appointment.

Session 7: Booster
The objective of this session is to maintain the participant in action in relation to the changes obtained during the participation in the intervention. This session reviews achievements and reinforces self-efficacy in relation to the positive changes the participants made in risk-reduction behaviors during the MIP intervention, identifies barriers, and propose possible solutions. This is the closing session. The counselor and the participant summarize the issues discussed by topic, and the counselor uses affirmations to support the participant's success in completing the established plan for each stage. The counselor highlights the achievements and benefits of the intervention and encourages the participant to continue with changes. The counselor and case manager commend the participant for each of the safer behaviors he or she has adopted and other accomplishments achieved.

At the conclusion of this session, the counselor and participant develop an after-care plan that will support the participants' protective behaviors (use of health services, use of drug treatment services, safer sex practices, and safer injection practices).

RESOURCE REQUIREMENTS

People
At a minimum, the MIP intervention requires the following:

- 2 full-time case managers to conduct resource mapping, outreach, and recruitment; collect information on the target population and on follow-up. Case managers must have comprehensive case management skills and knowledge of motivational interviewing, the principal counseling technique used by the MIP to help each participant move through the stages of change. Case managers escort and or arrange transportation to support the participant, advocate for participants and their participant/families, review the previous

session with the participant at each contact, and participate (along with counselor) in the staging of the participant and distribution of safety kits.
- 1 full-time counselor (need not be licensed according to state procedures) to conduct psychoeducational sessions (individual work). Counselors conduct resource mapping, provide and interpret self-evaluation scales, and provide information at each session. They must be trained in and have an excellent grasp of motivational interviewing techniques and stages of change theory; experience working with substance users; Spanish/English addiction counseling competence (according to SAMHSA guidelines); cultural sensitivity regarding diverse populations; and risk reduction experience.
- 1 full-time program supervisor to be responsible for overall administration of the intervention. The supervisor coordinates activities and plans on-going, in-house training and quality assurance. The person functions as counselor or case manager in their absence; develops service mapping, resource inventory, and memoranda of agreement with other service providers and local police; and has experience with motivational interviewing techniques.

Team members must be sensitive, skilled, and knowledgeable about the drug-using culture and its various populations. Case managers for MIP must be completely familiar with the local drug-using community. Community based organizations that do not have much experience with recruitment of active drug users are encouraged to form a peer advisory panel composed of indigenous current drug users, former drug users, or both. This panel can guide initial recruitment efforts and advise on what incentives may be most effective.

Space for Individual Counseling Sessions

Counseling sessions should be held in an office where participant confidentiality can be maintained, preferably not a cubicle. The office must have a door for privacy and comfortable seating for counselor and participant.

Other

- **Funding.** The cost of MIP will vary according to regional and local differences. When implementing MIP, agencies should first consider their own budget and available funds and determine how many participants the agency would like to serve. The original research implemented MIP with about 12 participants per month (144 participants per year) for a 4- year period. A reasonable estimate is to start with 20 participants per cycle every 2 months (approximately 120 participants per year).

  The following example can be used as a general guide: Each participant has a minimum of 7 contacts with your agency (e.g., 120 participants x 7 minimum sessions = 840 contacts). If you have 20 participants per MIP intervention or cycle, you need to consider incentives (usually non-monetary), transportation assistance, and refreshments for all 20, and multiply that amount by 7 (for the 7 sessions). This is the total for one cycle. To obtain a yearly estimate, take that amount and multiply by the number of MIP interventions or cycles you will conduct a year (for example, 6 cycles per year). That is the total cost to fund the intervention alone, not including staffing and overhead.
- **Transportation** for participants and case managers, depending on where MIP sessions and or referral service will be implemented. In metropolitan areas, subway or bus

tokens should be made available to participants, both as an incentive and as insurance that they will attend the activities. In rural areas, consideration should be given to providing funds or vouchers for gasoline. Organizations may also provide transportation services to participants if needed.

- **Supplies.** For example, TV, easels with paper and markers, safer-sex and needle-hygiene kits, photocopier, VCR, and video camera [optional].
- **Partnerships** with other organizations, if needed.
- **Memoranda of Agreement** with other service providers.
- **Incentives.** Participants should receive non-monetary incentives for each session they successfully complete. CBOs must budget for incentives if appropriate. It is recommended that cash equivalents (gift coupons to grocery stores or department stores) be alternatives to cash incentives as appropriate by funding guidelines. It is recommended that participants of the target population be asked what type of incentives they would like.
- **Referral Networks.** If the CBO cannot provide a service, especially HIV and hepatitis C counseling and testing, these services should be secured through a Memorandum of Agreement with a local provider.

RECRUITMENT

The population recruited for MIP is active IDUs who are not in a formal or informal drug treatment program. MIP may be appropriate for current injectors who, in addition to injecting, use other drugs (poly-drug users) and are currently in methadone treatment programs.

Since the etiology of alcohol use and abuse may be different from that of drug use, this intervention may not effectively meet the needs of persons whose primary problem is chronic alcohol use.

MIP recruitment and outreach is contingent upon the CBO’s ability to work within existing drug-user networks. Recruitment can occur numerous ways: through targeted recruitment contacts, by enrolling participants who access the CBO’s other services, or by using the drug users’ social networks (peer-driven recruitment). The social network technique uses current drug-using participants as recruiters. Participants can be given incentives for successfully recruiting new participants eligible for MIP and for successfully helping retain peers in the program. Many will ask their primary drug-using partner or primary sex partner to enroll in the program. MIP requires that persons who wish to enroll through social network techniques be screened to confirm they are current drug users. Social network recruiters should be trained in recruitment methodology and the importance of confidentiality.

During the recruitment process, case managers/community educators should not only promote the MIP program, but they should also briefly assess potential participants’ individual needs for medical and social services (including HIV counseling and testing and drug treatment). They should effectively communicate to potential participants the advantages of getting into this program to work on meeting those needs. The needs assessment and outreach presence of MIP in the community are key benefits of the program. Fold-over handout cards describing the MIP program and services in the local area are highly recommended.

It is also recommended that CBOs prepare business cards, letterhead, and appointment cards to remind participants of upcoming sessions.

POLICIES AND STANDARDS

Before a CBO attempts to implement MIP, the following policies and standards should be in place to protect participants and the CBO:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a participant is referred, signed informed consent from the participant or his or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profiles of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of participants, if possible, or make translation services available, if appropriate. CBOs should facilitate community and participant involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, which should be used as a guide for ensuring cultural competence in programs and services. (Please see “Ensuring Cultural Competence” in the Introduction of this document for standards for developing culturally and linguistically competent programs and services).

Data Security

To ensure data security and participant confidentiality, data must be collected, reported, and stored according to CDC requirements.

Linkage of Services

As part of recruitment, health education, and risk-reduction, MIP staff must link participants whose HIV status is unknown to counseling, testing, and treatment services; and persons living with HIV to care and prevention services. CBOs must develop ways to assess whether and how frequently the referrals made by their staff members are completed.

Personnel Policies

CBOs conducting recruitment outreach, and health education and risk reduction must establish a code of conduct for employees. This code should include, but not be limited to, the following: do not use drugs or alcohol, do use appropriate behavior with program participants, and do not loan money to program participants or borrow money from program participants.

Safety

CBO policies must exist for maintaining the safety of workers and participants. Plans for dealing with medical or psychological emergencies must be documented.

Selection of Target Populations

CBOs must establish criteria for, and justify the selection of, the target populations. Selection of target populations must be based on epidemiologic data, behavioral and clinical surveillance data, and the state or local HIV prevention plan created with input from state or local community planning groups.

Volunteers

If the CBO uses volunteers to assist with or conduct this intervention, the CBO should know and disclose how their liability and workers' compensation insurance applies to volunteers. CBOs must ensure that volunteers receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

CBOs should adhere to the following quality assurance standards when implementing MIP:

Attributes of Team Members

- Familiarity with the process and logistics of drug use
- Familiarity with the drug-using culture and its diverse populations
- Familiarity with HIV and its prevention
- Good oral communication skills
- Personal characteristics that facilitate communication (e.g., nonjudgmental attitude, active listening skills, friendly, outgoing, and trustworthy)

Implementation Plan

A strong component of quality assurance is preparing a plan to implement MIP. A comprehensive implementation plan will facilitate understanding and “buy-in” from staff and increase the likelihood that the intervention will run smoothly.

Leadership and Guidance

Someone from the CBO should provide hands-on leadership and guidance for the intervention, from planning through implementation. In addition, a decision maker from the CBO should provide higher level support, including securing resources and advocating for MIP.

Fidelity to Core Elements

CBOs must ensure that staff members are maintaining fidelity to all core elements.

Participants and Staff

It is necessary to ensure that the intervention is meeting the needs of CBO participants and staff. Staff who are implementing MIP can develop their own quality assurance checklist to help them identify, discuss, and solve problems.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, participant-level data, and program performance indicators are under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection, evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be asked to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

Robles R, Reyes J, Colon H, Sahai H, Marrero A, Matos T, Calderon J, Shepard E. Effects of combined counseling and case management to reduce HIV risk behaviors among Hispanic drug injectors in Puerto Rico: A randomized controlled study. Journal of Substance Abuse Treatment. 2004;27:145–152.

Marrero, CA, Robles RR, Colon HM, Reyes JC, Matos TM, Sahai H., et al. Factors associated with drug treatment dropout among injection drug users in Puerto Rico. Addictive Behaviors. 2005; 30:397-402.

For more information on technical assistance or training for this intervention, please go to www.effectiveinterventions.org.

Focus on Youth with Informed Parents and Children Together (ImPACT): An HIV Prevention Intervention for African American Youth

DESCRIPTION

Focus on Youth with Informed Parent and Children Together (ImPACT) is a community-based eight-session group HIV/STD prevention program with an additional parent component. It is targeted to high-risk urban African American youth. The original study and intervention program, known as Focus on Kids, has shown this intervention to be effective with low-income urban African American youth in providing them with the knowledge and skills they need to protect themselves from HIV and other sexually transmitted diseases. The program has been adapted and renamed Focus on Youth as part of the Diffusion of Effective Behavioral Interventions project to reduce the risk of HIV among high-risk youth. It was designed for youth ages 9 to 15; however, it has been used with youth as old as 20 in communities where the average age at which youth initiate sex is older. Because it is important to reach youth before they are sexually active, communities should individually determine the appropriate age group for the program by looking at local or statewide data on average age of sexual initiation, teen pregnancy, or STD rates.

Goals

Focus on Youth is intended to increase knowledge about HIV/AIDS and improve communication, decision making, and condom use among youth. Abstinence and avoidance of substance use and drug trafficking are also emphasized.

Theories Behind the Intervention

The theoretical framework on which Focus on Youth is based is the Protection Motivation Theory (Rogers, 1983), a social cognitive theory that:

- Emphasizes the balance between pressures to engage in risk behaviors, risks involved and considerations of the alternatives;
- Emphasizes that attitudes or behavior change occurs when protection motivation is aroused, and not when a person is simply fearful;
- Posits that two pathways, a coping appraisal and a threat appraisal, combine to result in motivation to protect oneself. This protection motivation, in turn, leads to either reduction or cessation of a harmful behavior or instigation of a healthful behavior.

How it Works

The group-level intervention consists of fun, interactive activities such as games, role-plays, group discussions and community projects to convey HIV prevention knowledge and risk reduction skills. Focus on Youth specifically enhances the following skills: 1) decision making regarding risk and protective behaviors, 2) refusal and negotiation skills, 3) correct condom use, and 4) communication.

ImPACT, the parental component of the program, is a 60-minute parental monitoring intervention targeting parents and guardians of high-risk urban youth and their adolescent children. The intervention is delivered by a health educator to the parent and child in their home or convenient community location. ImPACT consists of an approximately 25-minute culturally appropriate video documentary, a discussion with a health educator, two guided role plays, a workbook, and a condom demonstration. The documentary video, viewed by the health educator, parent, and child together, features scenes of real parents and youth talking and professionals working with parents and youth, and stresses the importance of parents talking to their children openly and clearly about their values and expectations as they relate to sexual practices. It is followed by a health educator–led discussion focused on reinforcing messages from the documentary on monitoring, communication, and HIV prevention. The health educator leads two supervised, guided role-plays in which parent(s) and youth participate in a mock communication about monitoring, communication, abstinence, sex, condoms, STDs, and HIV. A condom demonstration during which both the parent and child practice correct condom use is the final component of the intervention.

Research Findings

In the original study of the Focus on Youth intervention in Baltimore, Maryland, participants were more likely than controls to use condoms if they were sexually active (85% vs. 61%). The intention to use condoms was higher than at baseline, and the program also appeared to lower truancy, drug dealing, and fighting.

In a study in which participants were randomized to groups receiving Focus on Youth alone, or ImPACT, which included a parental monitoring intervention, youth in the parental monitoring group reported significantly lower rates of sex, sex without a condom, alcohol use and cigarette use. At the 24-month follow-up, they had lower rates of school suspension, weapon carrying, use of tobacco, use of marijuana and other illicit drugs, and were likely to know if a sex partner had used a condom.

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based; they are thought to be responsible for the intervention’s effectiveness. **Core elements are essential and cannot be ignored, deleted, or changed.**

Implementation core elements are the essential characteristics of a program that relate to some of the logistics that set up a conducive learning environment, such as program setting, facilitator–youth ratio, dosage and sequence of sessions.

Content core elements are the essential characteristics of a program that relate to WHAT is being taught by the program, that is, the knowledge, attitudes and skills that are addressed in the program's learning activities and are believed to change sexual risk behaviors. The knowledge, attitudes and skills addressed in a program generally map with the determinants or risk and protective factors addressed by a program.

Pedagogical core elements are the essential characteristics of a program that relate to HOW its content is taught. The core components in this category identify the teaching methods, strategies and student interactions that contribute to the program's effectiveness.

Focus on Youth has the following 8 core elements:

Implementation Core Elements

- Deliver intervention to youth in community‐based settings.
- Use two skilled facilitators to model communication, negotiation and refusal skills for the youth.
- Use "friendship" or venue‐based groups (i.e., a basketball team, a scout troop, church group, an existing youth group) to strengthen peer support.

Content Core Elements

- Use culturally appropriate interactive activities proven as effective learning strategies to help youth capture the important constructs in the theory.
- Include a "family tree" to contextualize and personalize abstract concepts, such as decision-making and risk assessment.
  -In this activity, youth are given a skeleton of a family tree and asked to create the circumstances of and the relationships between the family members. The characters in the family are used throughout the curriculum to put decision-making into a personal context for the youth.
- Enable participants to learn and practice a decision‐making model such as Stop, Options, Decide and Act (SODA).
- Train participants in assertive communication and refusal skills specifically related to negotiation of abstinence or safer sex behaviors.
- Teach youth proper condom use skills.

The parent component, **ImPACT**, has the following 7 core elements:

Implementation Core Elements

- Deliver intervention *one‐on‐one* to parents and youth in the home or a community‐based setting with privacy at a time and place that is convenient for the parent/guardian.

- Use a facilitator whom the parents find credible. The facilitator should be skilled at building rapport with parent and youth at the beginning of the session.

Pedagogical Core Elements

- Show and discuss the Focus on Youth parent documentary that depicts the challenges and importance of parents monitoring and talking to their children aged 12−15 years about sex, abstinence, STDs, HIV, and condoms. Facilitator must sit down and watch the video with parent and youth. Youth and parent must watch the video together.
- Relay important information through an entertaining format such as role-playing activities.

Content Core Elements

- Enable youth−parent to learn and practice communication skills.
- Teach parent and youth proper condom use skills.
- Distribute and guide parent and youth through an educational workbook that includes the following topics:
  1. Basic components of good communication and how to talk to your kids
  2. Importance of parental monitoring
  3. Condom use steps
  4. Facts about STDs and HIV, including prevalence data among young African – Americans

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

Focus on Youth has the following key characteristics:

- Include between 6 and 10 youth in the program.
- New members should not join once the series of sessions has begun. If youth join after first session, a make-up session should be offered.
- Each session should last approximately 90-120 minutes
- Use skilled facilitators who are the same gender as the youth target population.
- Have at least one facilitator who is of the same race and ethnicity as the majority of the participants.
- Embed culturally and linguistically based activities for the target population.
- Form groups that contain members of the same gender and age group. Youth groups should have no more than a 3-year age difference between members in a group.
- Inform parents about the program and its goals and activities, and tell them that they should sign a parental permission form.

Any modification of Core Elements and Key Characteristics should be done with great care and should not compete with or contradict the intent, theory, and internal logic of the intervention.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and activities.

Procedures for Focus on Youth are as follows:

Needs Assessment

Before implementing the Focus on Youth intervention, agencies should conduct a needs assessment to determine the risk behaviors of the youth being targeted for the program, obtain support from parents and community leaders, and ensure that the program is appropriate for the targeted youth. A formal strategy for conducting a needs assessment involves the development of an advisory board consisting of community members, leaders, and youth. Another strategy is to conduct a few focus group meetings with groups of 8 to 10 parents and youth to ask what they believe youth need to learn to protect themselves from HIV. A final strategy is to get survey information, if available, to determine risk behaviors most common among youth in your targeted community. The needs assessment should include conducting focus groups and interviews with youth and community leaders.

Findings from the needs assessment should be used to determine whether any adaptations are needed for the intervention. Culturally and linguistically appropriate changes to the intervention can help ensure that the program best meets the needs of the targeted youth.

Conducting Focus on Youth Sessions

The Focus on Youth sessions should occur on a weekly basis. Each of the sessions has a specific goal, key message and objectives. The goals and key messages of each of the sessions are as follows:

Session 1: We're All in This Together

Purpose: To establish a cohesive group, set ground rules and allow youth to begin learning skills for decision making.

Key Message: The decisions you make as an adolescent affect you when you become an adult.

Session 2: Risks and Values

Purpose: Youth will examine risk behaviors and look at why they might feel invincible or invulnerable in order to understand how this can place them at risk for HIV/STD or unplanned pregnancy. In addition, youth will identify their values through discussion, ranking and voting activities.

Key Messages:

- Certain situations can make individuals feel invulnerable and invincible. This can cause them to make decisions that could lead to unwanted pregnancy or contracting HIV.
- Everyone has different values and it is okay to listen to different points of view.
- Identifying and ranking personal values, as well as developing an understanding of those with differing values, helps with decision making.
- Knowing your values can help you make decisions to prevent HIV and other STDs.

Session 3: Educate Yourself: Obtaining Information

Purpose: Youth will learn ways to obtain information in order to make good decisions by applying the decision-making model and researching answers to questions.

Key Messages:

- Being informed about local resources and HIV and STD prevention can aid in the decision - making process.
- Discussing HIV and other STD prevention with parents or guardians promotes healthy choices.

Session 4: Educate Yourself: Examining Consequences

Purpose: Youth will learn how to weigh the positive and negative consequences of options as they make decisions. Session provides skills-building through condom demonstration.

Key Messages:

- Understanding proper steps for condom use and being comfortable with saying you want to use condoms increases the chances of actually using them.
- Understanding the good consequences (pros) and bad consequences (cons) of various options can help you make better decisions.

Session 5: Build Skills: Communication

Purpose: Youth will learn communication and negotiation skills to assist in carrying out responsible decisions. Participants practice aggressive, assertive and non-assertive communication styles.

Key messages:

- Understanding that certain styles of communication can help your point of view be better understood by others.
- Using body language to enhance communication with others.
- Understanding the importance of being aware of the nonverbal messages others are communicating.
- Understanding the consequences of miscommunication and ways to avoid it

Session 6: Sexual Health and Showing You Care Without Having Sex

Purpose: Youth will engage in role-play to explore various ways to show they care without having sex and will learn information about sexual health.

*Key Messages***:**

- Understanding that sex is a normal, healthy part of life, but it is important to wait to have sex in a way that is safe, healthy and in line with one's values.
- Learning that there are many ways to show one cares without having sexual intercourse.
- Understanding the advantages, disadvantages and effectiveness of each method of contraception.

(See Optional All-Day Retreat, below)

Session 7: Attitudes and Skills for Sexual Health

Purpose: Youth will learn attitudes and skills that support sexual health through listening to a speaker, completing a goal-setting activity and role-playing refusal and negotiation skills.
Key Messages:

- Understanding that there is value in setting both long – term and short – term goals and tracking your progress toward reaching those goals.
- Understanding the process and consequences of decision making and self-awareness of values and goals to avoid or prevent obstacles.
- Recognizing that while some obstacles to goals cannot be prevented, having solutions for each obstacle including the presence of supportive people are keys to reaching goals.

Session 8: Review and Community Project
Purpose: Youth will build self-efficacy about HIV/STD prevention through analyzing their concerns and how they can take responsibility; testing their HIV knowledge, affirming each other and planning community projects.
Key Messages:

- Reviewing the components of safer-decision making about sex and other important decisions, taking responsibility for one's actions and effective communication.
- Recognizing the potential for being a positive force in the community.

Optional All-Day Retreat for Session 6
Purpose: The retreat offers an opportunity for boys' and girls' groups to work together as well be inspired by an outside speaker.

Sample Agenda:

- Introduction Game and Opening Ritual
- Review of Session 5
- Ways to Show You Care
- HIV Transmission Game
- Recreational Activities
- Lunch
- Outside Speaker
- Contraception Lesson
- Recreational Activities
- Wrap-Up and Closing Ritual

Location: A park or camp site
Transportation: Agencies should provide or reimburse youth for transportation to the park.
Lunch: Agency should provide lunch for youth at the park.
Recreational Activities: Agencies should allow the youth to decide on appropriate recreational activities such as relays, tug-of-war, hikes, scavenger hunts.
Guest Speaker: The invited speaker should be a respected member within the community. It is important for agencies to know in advance what the guest speaker will say to ensure it will be an appropriate message for the youth. Recommended topics for the speaker to address include the importance of having an HIV test and knowing your partner's status; discussing sex with parents

and other trusted adults; choosing abstinence or condom use; and the consequences of unprotected sex.

For the all-day retreat, there should be parent chaperons. A good ratio is 1 adult for every 4 youth. In addition, agencies should have emergency contact and medical information on record for all participants.

ImPACT Parent Intervention

Purpose: To build increased monitoring and communication skills for parents, and enhance parent-child relationships.

<u>Format</u>: Parent's home, preferably; however, a private space at the agency can also be considered.
<u>Timing</u>: Preferably before the first session or by the third session in order to set the stage for youth and their parents to discuss and learn what the program is about.
<u>Who Should Attend:</u> one or both parents can participate with their child.
<u>Childcare:</u> Agencies should make provision for childcare if the intervention cannot be delivered at the parent's home.
<u>Vignette activities:</u> The facilitator may make changes to the names or locations in the vignettes to make them more relevant to their group.
<u>Refreshments:</u> Agencies should provide light refreshments.

During this session, the facilitator will

- Explain the purpose of the session.
- Review the purpose of the Focus on Youth intervention.
- Conduct an icebreaker activity.
- Provide HIV 101 information.
- Show and discuss parent documentary.
- Demonstrate the steps for proper condom use.
- Conduct the condom demonstration game or condom use card activity.
- Engage parents and their child in role-playing of various vignettes.
- Ask parents and youth for questions related to any of the activities or the intervention.
- Review with parents some basic tips about communicating with their youth about abstinence, sex, HIV, and condoms.

The Focus on Youth parent documentary is short film documentary designed to teach parents effective ways to talk to their teenaged children about sex and HIV/AIDS. The video stresses the importance of open communication between parents and teens. This video tackles these issues head-on in an effort to increase open and honest communications with the teenage children *before* they start having sex. The film allows teens, their parents and experts to talk openly about their feelings about sex and HIV/AIDS. The film shows these topics through various points of view, including teens, parents and educators.

The key messages for the parent documentary are listed below:

1. It is important to talk to your child about sex.
2. It is important to know who your child is with, what they are doing and where they are.
3. Talking with your child is difficult but it gets easier after time.
4. If you feel you cannot talk to your children about sex, it is important that you find someone else who shares your values to talk to them.
5. It is important for youth to know how they would respond if they are in a situation in which they might be pressured into having sex (the pressure could be a positive—boyfriend discussion of how much he loves you).
6. Parents should talk to their children about proper condom use.
7. Communication goes both ways.
8. There are serious consequences to risky sexual behavior.
9. Allow youth to grow towards independence, but set guidelines.

RESOURCE REQUIREMENTS

Facilitators

The Focus on Youth intervention should be facilitated by two health educators (at least one full-time employee). The facilitators should be of the same race/ethnicity and gender as the target population. The staff should be well-versed on HIV transmission and methods for preventing HIV transmission and should have a nonjudgmental attitude toward youth who engage in risky sexual behaviors. Partnering agencies, if any, should be identified as well as a location to conduct a group session with 6–10 youth.

Facilitators should possess the following qualifications:

- Ability to reach young people
- Ability to keep the group fun and interactive
- Experience in managing youth groups
- Comfort in addressing issues of sexuality and sexual health
- Ability to work collaboratively with other leaders in the community, such as teachers, clergy, and local service providers
- Ability to present information in a nonjudgmental manner
- Mastery of HIV and STD prevention concepts
- Commitment to the purpose of the program
- Previous experience in facilitating youth groups

Before implementing the intervention, facilitators should thoroughly review all program materials, plans, and logistics. Specific materials and instructions are provided in the intervention kit. In addition, the staff should copy materials and purchase incentives and other materials necessary to implement the intervention. Facilitators should create a culturally sensitive environment and should understand the participants' cultural heritage and peer norms. Facilitator–participant language and dialect matches should also be considered. This will enable the facilitators to understand how their youth relate to their peers, parents and community.

Materials

The Focus on Youth intervention package is available through the ETR Associates. The intervention package includes

- Facilitator Curriculum
- Youth Workbook
- Facilitator Parent Session Guide
- Parent Session Workbook
- Parent Video (DVD)
- Evaluation Manual and Monitoring Forms
- Technical Assistance Guide

For more information on receiving training or technical assistance on this intervention, please visit www.etr.org or www.effectiveinterventions.org.

RECRUITMENT

Youth Participants

To encourage participation, Focus on Youth should be publicized as a program for at-risk youth who are in the appropriate age group as determined by the needs assessment. Focus on Youth is a behavioral change intervention targeting youth at high risk for infection with HIV. In the original study, Focus on Kids used "natural friendship groups," or youth who already spend time together. Agencies are expected to recruit members from after-school extracurricular or tutorial programs, recreation clubs, dance groups, sport teams, group homes for youth, or other relevant groups. Youth can also be recruited through street outreach efforts using flyers or brochures. Specific cultural needs and social barriers should be addressed when recruiting youth.

Incentives can be used to enhance retention in the Focus on Youth program. For example, agencies may use bus tokens to provide youth with transportation to and from the sessions, or provide snacks, food, gift certificates or small gifts. In addition, childcare may be provided during the sessions. School credit and small stipends are all used as positive reinforcements.

Parents or Caregivers

Ensuring that parents or caregivers are brought into the program is important. Prior to the delivery of the program, agencies should offer a pre-session orientation that explains what the program is about and allows parents or caregivers to sample some of the activities used in the curriculum. During the orientation, parents are expected to sign a consent form for their child to participate in the program. In certain circumstances, such as with runaway or homeless youth, permission slips are not needed. In this pre-orientation, facilitators should also speak to parents about participating in ImPACT and start signing parents up for dates and times, with a process for reminder correspondence. This orientation should be later followed by the ImPACT parent session to help youth and their parents or caregivers improve their communication skills and strengthen the impact of the program. The session should occur before the third youth session.

Local Community Businesses

Obtaining support from community organizations and businesses is an important function of the Focus on Youth intervention. Local businesses can support the program in various ways. These include providing snacks, gift certificates, movie tickets, or other incentives. Businesses can be recruited for support via donation letters and face-to-face visits. Solicitation of help should be sought from businesses at the beginning of the program since certain businesses donations have to be approved in advance and go through a chain of command.

NECESSARY POLICIES AND STANDARDS

Before an agency attempts to implement Focus on Youth, the following policies and procedures should be in place to protect youth, the agency, and the facilitators:

Targeting of Services

Agencies must establish criteria for, and justify the selection of, the youth target populations. Selection of appropriate youth populations must be based on epidemiologic data, behavioral and clinical surveillance, and the state or local HIV prevention plan created with input from the state or local community planning group(s).

Parental Informed Consent

Agencies must have a parental consent form, which carefully and clearly explains in accessible language the agency's responsibility and the participants' and parents rights. Individual state laws may vary regarding consent procedures for minors, but at a minimum consent should be obtained from each parent or a legal guardian if the participant is a minor or unable to give legal consent. Youth participation must always be voluntary, and documentation of this parental consent must be maintained by the agency.

Safety

Agency policies must exist for maintaining safety of facilitators and youth. Plans for dealing with medical or psychological emergencies must be documented.

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all youth in the program. Before sharing any information with another agency to which a youth is referred, signed parental informed consent from a parent or legal guardian must be obtained.

Legal/Ethical Policies

Agencies must know their state laws regarding disclosure of HIV status to sex and/or needle-sharing partners, and agencies are obligated to inform parents of the agency's responsibilities if a youth tests positive for HIV and/or if the youth self-discloses an intention to hurt him/her self or others.. Agencies also must inform parents or legal guardians about state laws regarding the reporting of domestic violence, child abuse, and sexual abuse of minors.

Linkage of Services

Recruitment and health education and risk reduction must be linked to counseling, testing, and referral services for youth of unknown status, and to care and prevention services for people living with HIV. Agencies must develop ways to assess whether and how frequently the referrals made by staff were completed.

Referrals

Agencies must be prepared to supply appropriate referrals to session participants as necessary. Providers must know about referral sources for prevention interventions/counseling if youth need additional assistance in decreasing risk behavior.

Data Security

Data must be collected and reported in accordance with CDC requirements to ensure data security and client confidentiality. The data should be kept in a secure, locked place that is accessible only to appropriate staff at their work place.

Cultural Competence

Agencies must strive to offer culturally competent service by being aware of the demographic, cultural, and epidemiologic profile of their communities. Agencies should hire, promote, and train staff across all disciplines to be representative of and sensitive to these cultures. In addition, materials and services must be offered in the preferred language of youth where possible, or make translation available, if appropriate. Youth and parent involvement in designing and implementing prevention services is encouraged to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, which should be used as a guide for ensuring cultural competency in programs and services.

Personnel Policies

Agencies conducting recruitment, outreach, and health education and risk reduction must establish a code of conduct for personnel. This code should include, but not be limited to, no drug or alcohol use, appropriate professional behavior with youth and their parents, and no loaning or borrowing of money.

Volunteers

If an agency is using volunteers to assist in or conduct this intervention, the agency should know and disclose how their liability insurance and workers' compensation applies to volunteers. Agencies must ensure that volunteers receive the same training and are held to the same performance standards as employees. Agencies must also ensure that volunteers sign and adhere to a confidentiality statement. All training should be documented.

QUALITY ASSURANCE

Quality assurance (QA) activities for both providers and participants should be in place when implementing the Focus on Youth intervention.

Facilitator

Facilitators of the Focus on Youth program should have knowledge of HIV risk and transmission and statistics in their local jurisdictions as well as national statistics. Training for facilitators should address the following three areas: 1) completion of a training course, including review of the intervention and evaluation materials; 2) participation in practice sessions; and 3) observed co-facilitation of groups, including practicing mock intervention sessions.

Facilitators should reflect the target population in race and gender and will be expected to deliver the information in a non-threatening and culturally relevant manner. Agencies should have in place a mechanism to ensure all sessions and core elements are implemented with fidelity. QA activities can include direct observation and review of sessions by staff involved in the intervention. Facilitator observation forms are provided with the intervention package. The form focuses on the quality (or adherence to the fidelity) of the sessions delivered and the responsiveness and openness of the youth to the facilitators. Facilitators should collect all evaluation forms following each session and ensure participant confidentiality. In addition, facilitators should ensure that all youth are actively participating in each of the sessions. Bimonthly meetings with supervisors to discuss progress and/or opportunities for change are encouraged.

Participants

The participants' satisfaction with the intervention and their comfort should be assessed during each session. Evaluation forms are provided in the intervention package and should be disseminated during each session. In addition, agencies can develop their own forms to assess participant satisfaction.

MONITORING AND EVALUATION

Program evaluation is an essential activity for any public health program. The Focus on Youth intervention contains an evaluation manual and monitoring forms to assist agencies in their evaluation of the program. The manual provides sample tools and information to help agencies determine the impact of their program delivery and what changes may improve the impact. The resulting data can be used to improve program delivery, write agency reports, determine additional program or service needs, or conduct a formal evaluation of their Focus on Youth program.

Evaluations are typically designed to answer a series of outcome and process questions. These questions, as they pertain to Focus on Youth, are described below:

Process Questions

The answers to process evaluation questions help program implementers determine why the outcome results may have occurred, and what changes may need to be made to the program to improve outcome performance. These questions focus on the program activities, materials and resources; they determine whether the program actually being evaluated reflects the program that was intended, what factors had an impact on delivery, and whether participants would recommend participation in the program to others.

Examples of process questions addressed in the Focus on Youth program:

- Did facilitators deliver the program as intended? Did they use the materials correctly? Did they skip any key concepts? What changes did they make? What difficulties did they encounter?
- What percentage of youth who were recruited for the program attended Session 1? What percentage of youth who participated in the program attended all 8 sessions?
- What percentage of youth participants' parents participated in the ImPACT intervention?
- Were youth engaged in the sessions? Did youth enjoy the program and program facilitators?
- Were parents engaged in the ImPACT session? Did they enjoy this component and the program facilitators?

Outcome Questions

It is important for agencies to determine whether the intended outcomes of their Focus on Youth program have been achieved. Outcomes may be immediate or long-term. Short-term outcome questions reflect changes in knowledge, skill and attitudes. Long-term outcomes reflect intended behavior change. Depending on the length of follow-up with youth, intensity of the intervention, and unique participant characteristics, it may be unrealistic to expect immediate change in youth behavior after participation in the Focus on Youth program. However, if evaluation expertise and resources are available, agencies are encouraged to follow up with their youth participants 3 and 6 months after their participation in Focus on Youth to examine changes in HIV risk behaviors.

Outcome evaluation questions are answered by comparing performance of program participants to that of groups of similar individuals who did not participate in the program. The best evaluation studies randomly assign potential participants to either receive the program or to receive another program or no program. However, this typically is costly and difficult logistically. An alternative is to find groups of youth who are very similar to program youth and also have them respond to the evaluation instruments. This would allow agencies to determine whether or not their Focus on Youth program is making a significant impact in decreasing youth HIV risk behaviors. If this is not possible, often the best that can be done is outcome monitoring that evaluates youth performance on outcomes prior to participating in the program and then again after program completion.

Sample outcome questions addressed in the Focus on Youth program:

Overall evaluation question: Did the youth participating in the program attain the desired program outcomes?

Immediate outcomes: At the conclusion of Focus of Youth, can participating youth

- State correct information about HIV and other STDs, including modes of transmission and prevention? (knowledge change)
- State their own personal values and understand how these relate to pressures to engage in sexual risk behaviors? (knowledge and attitudinal changes)
- Demonstrate skill in decision-making, communicating and negotiating with other youth regarding sexual and drug topics? (skill/behavior changes)
- Demonstrate how to use a condom correctly? (skill/behavior change)
- Indicate intention to discuss sex with their parent or guardian? (intention change)

- Indicate intention to use a condom or abstain from sex? (intention change)

Long-term outcomes:

- Do Focus on Youth participants now report more condom usage, more HIV/STD testing, and higher rates of abstinence compared with their behaviors prior to participating in the program? (outcome monitoring)
- Do Focus on Youth participants report more condom usage, more HIV/STD testing and higher rates of abstinence than youth who did not participate in the program or who participated in another program? (outcome evaluation–optional)

Suggested evaluation and monitoring intervention activities include the following:

- Collect and report process and outcome monitoring data in accordance with CDC requirements;
- Enter and transmit data for CDC-funded services on PEMS (Program Evaluation Monitoring System), a CDC-provided browser-based system, or describe plans to make a local system compatible with CDC's requirements;
- Collect and report data consistent with CDC requirements to ensure data quality, security and client confidentiality.

KEY ARTICLES AND RESOURCES

Technical Assistance

Agencies directly funded by CDC, can request Capacity Building Assistance (CBA) services through the CBA Request Information System (CRIS) at www.cdc.gov/hiv/cba. Once a request has been processed, it will be forwarded to both the project officer and the appropriate CBA provider for that particular focus area.

Theory

Rogers RW. Cognitive and physiological processes in fear appeals and attitude change: a revised theory of protection motivation. In: Cacioppo J, Petty R, eds. Social Psychophysiology. New York: Guilford Press; 1983.

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Stanton B, Li X, Ricardo I, Galbraith J, Feigelman S, Kaljee L. A randomized controlled effectiveness trial of an AIDS prevention program for low-income African-American youth. Archives of Pediatrics and Adolescent Medicine 1996; 150:363–372.

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Implementation

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Romer D, Hornik R, Stanton B, Black M, Li X, Ricardo I, Feigelman, S. "Talking" Computers: An efficient and private method to conduct interviews on sensitive health topics. Journal of Sex Research 1997;34:3–9.

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Stanton B, Li X, Galbraith S, Cornick G, Feigelman S, Kaljee L, Zhou Y. Parental underestimates of adolescent risk behavior: A randomized controlled trial evaluating an intervention designed to increase monitoring in a low income urban setting. Journal of Adolescent Health 2000;26:18–26.

Stanton B**,** Li X, Galbraith J, Feigelman S, Kaljee L. STDs, HIV and pregnancy prevention: Combined contraceptive practices among urban African-American early adolescents. Archives of Pediatrics and Adolescent Medicine 1996;150:17–24.

Stanton B, Li X, Pack R, Cottrell L, Harris C, Burns J. Longitudinal influences of perception of peer and parental factors on African-American adolescent risk involvement. Journal of Urban Health 2002; 79:536–548.

PARTNERSHIP FOR HEALTH

DESCRIPTION

The Partnership *for* Health intervention offers an evidence-based approach to integrating a healthcare provider–delivered behavioral intervention to HIV-positive patients each time they attend the medical clinic. The intervention is short, usually taking only 4 minutes of time, and uses a technique called 'loss-framed' or 'consequence-framed' messages delivered to the HIV-positive patient by the healthcare provider.

How it Works

The Partnership *for* Health intervention uses the outpatient clinic and healthcare providers to provide brief behavioral prevention messages with each clinic visit. Partnership *for* Health uses message framing, repetition of the message, and reinforcement during patient visits to increase HIV-positive patients' knowledge, skills, and motivations to practice safer sex. The program is designed to improve patient–provider communication about safer sex, disclosure of HIV serostatus, and HIV prevention.

Research Findings

The Partnership *for* Health intervention was tested in a quasi-experimental design in which clinics were randomized according to the manner in which the prevention message was framed: 2 clinics used the 'gain-frame message,' 2 clinics used the 'loss-frame message' (also called the consequence-framed message), and 2 clinics used standard patient education. Patients in the clinics offering the 'loss-frame message' demonstrated significantly fewer HIV risk behaviors than did patients in the clinics that used the 'gain frame messages' or standard patient education. Further analysis at the individual patient level indicated that patients who had 2 or more sex partners or at least one casual partner and who received consequences-framed messages were significantly less likely to engage in unprotected anal or vaginal sex.[1]

CORE ELEMENTS AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory upon which the intervention or strategy is based; they are thought to be responsible for the intervention's effectiveness. Core elements are essential and cannot be ignored, added to, or changed.

Partnership *for* Health has the following 9 core elements:

- Have providers deliver the intervention to HIV-positive patients in HIV outpatient clinics.
- Have the clinic adopt prevention as an essential component of patient care.
- Train all clinic staff to facilitate integration of the prevention counseling intervention into standard practice.
- Use waiting room posters and brochures to reinforce prevention messages delivered by the provider.
- Build on the ongoing supportive relationship between the patient and the provider.
- During routine visits, have the provider initiate at least a 3- to 5-minute discussion with the patient or client about safer sex that focuses on self-protection, partner protection, and disclosure.
- Have the provider incorporate good communication techniques and use of consequences-framed messages for patients or clients engaged in high-risk sexual behavior.
- Provide referrals for needs that require more extensive counseling and services.
- Integrate the prevention message into clinic visits so that every patient is counseled at every visit.

Procedures

Procedures are detailed descriptions of some of the above-listed elements. Procedures for Partnership *for* Health are as follows:

Preparation

Implementation of Partnership *for* Health includes development of clinic and staff "buy-in" and training. Incorporating prevention into a busy clinic can be difficult but can be facilitated with some modification of the clinic structure and flow. Any clinic that wishes to adopt Partnership *for* Health must engage in a 4-hour training on the intervention for all clinic staff who will help deliver the intervention. This 4-hour training can be delivered in the clinic setting.

Creating an atmosphere that endorses an integrated approach shows that HIV prevention is important to the medical care provider and staff. Posting prevention messages in the waiting and examination rooms and giving every patient printed material related to HIV prevention reminds the medical care provider and prepares the patient to discuss HIV prevention.

Providing Prevention Messages

The provider conducts a brief screening for risky behavior, and if the patient reports engaging in risky behaviors (unsafe sex or injection practices), the medical care provider should provide an appropriate brief prevention message. This message may include

- a general prevention message
- a tailored message that addresses behaviors or concerns specific for this patient
- correction of misconceptions about risk
- reinforcement of steps the patient has already taken to decrease risk for HIV transmission

Prevention messages should stress that the only ways to ensure that HIV is not transmitted are abstinence or sex with a partner of concordant HIV serostatus. However, patients should also know that sex with partners of concordant HIV serostatus does not protect against other sexually transmitted diseases or reinfection with HIV. For sexually active patients, condom use is the safest way to prevent transmission or acquisition of HIV and other sexually transmitted diseases. Patients should also be made aware of the importance of disclosing their HIV serostatus to potential sex partners.

Following Up

Finally, medical care providers should recognize that risk is not static. Patients' lives and circumstances change, and their risk of transmitting HIV may change from one medical encounter to another. Screening and providing risk-reduction messages should occur at every medical visit unless the client has other medical needs that take precedence.

The Partnership *for* Health model is diagrammed below.

Patient is given a brochure or flyer (in patient's preferred language) by front desk staff and asked to read it before seeing the medical care provider. Patient reads it while waiting and also sees the prevention posters in the waiting room.

Patient goes into examination room and sees a small poster on the wall that reinforces the same messages in the brochure.

Medical care provider examines the patient.

After the examination, the medical care provider conducts a brief (3–5 minute) intervention. Medical care provider conducts a brief risk screening and gives a brief prevention message that fits the needs of the patient.

Medical care provider uses the brochure, poster, or other prevention materials to help with counseling. Medical care provider or patient places a check mark next to behaviors noted in the brochure and sets goals for behavior change. Medical care provider documents in the patient's chart that counseling was done.

If needed, the medical care provider refers the patient to other services. Medical care provider tells patient that he or she will be interested in hearing how the patient is doing at the next appointment.

Patient leaves feeling cared about, knowing more about safer sex and disclosure of HIV serostatus, and ready to practice safer behaviors.

At follow-up visits, medical care provider asks about progress on goals and referrals, if given at last visit. Medical care provider offers reinforcement for healthy behavior and helps patient find ways to

overcome obstacles. Medical care provider and patient set goals for next time.

RESOURCE REQUIREMENTS

People

Partnership *for* Health uses existing providers and clinic staff, so no new staffing is required. Providers are asked to spend 3 to 5 minutes during each patient visit to discuss safer sexual behavior and disclosure of HIV serostatus. Providers and clinic staff will need to attend an orientation to the intervention, a half-day training, and another 2-hour booster training.

Each clinic should appoint a nurse or physician assistant to work half-time on this project as prevention coordinator. This person will

- set up training
- make sure that materials are on hand
- make sure that the intervention is being carried out

Clinics should have support and a commitment from all their staff to the following:

- training
- talking with patients about sex and drug use
- understanding prevention interventions and factors related to risk behavior

Space

Partnership *for* Health is done at HIV outpatient healthcare clinics. Clinics should have private examination rooms where medical care providers and patients can talk privately about the patient's sexual behaviors.

Supplies

Materials

The following materials are helpful for introducing the concept of integrated prevention and care services:

- **Posters,** in languages appropriate to the populations served, displaying the general prevention messages, to hang in clinic waiting areas and hallways
- **Brochures,** in languages appropriate to the populations served, given to patients when they register at the front desk. The brochures should emphasize the following:
    - the role of sexually transmitted diseases in HIV transmission and the need to be tested and treated at the first sign or suspicion of symptoms of sexually transmitted diseases
    - the potential role of drug use in increasing risky behaviors
    - the risks of unsafe sex or injection practices for patients and their partners, even in the presence of a low or undetectable viral load
    - the importance of disclosing HIV serostatus
- **Posters to hang in examination rooms,** in languages appropriate to the populations served, that contain the same messages as the brochure

- **Documentation of patient counseling,** which may be done with a chart sticker, a stamp, or a check box in the printed or electronic medical record. The purpose is to remind the provider to do the counseling regularly.
- **Additional supportive materials,** given out as supplements to the brochure at subsequent visits. Materials can address additional prevention topics of interest and may include helpful information and testimonials related to changing behavior.

Along with staff time for training, these supplies are the major expenses for Partnership *for* Health.

RECRUITMENT

Agencies that choose to follow the recommendations will offer prevention services as the standard of care in their clinics; therefore, no specific recruitment strategy is endorsed for Partnership *for* Health. All clinic patients will receive the intervention with appropriate messages at each appointment. However, all patients should be informed that the clinic has adopted a model of integrated service so that they may make an informed choice regarding their attendance at the clinic.

POLICIES AND STANDARDS

Before a clinic attempts to implement Partnership *for* Health, the following policies and procedures should be in place to protect clients and the clinic:

Clinic Support

Clinic management must demonstrate support for Partnership *for* Health by

- encouraging staff to attend 1 training related to providing prevention services (i.e., providing paid time off to attend)
- obtaining, distributing, and maintaining prevention materials
- committing to having primary care providers deliver patient counseling, and allowing providers the time to deliver prevention messages at every visit

Confidentiality

A system must be in place to ensure that the confidentiality is maintained for all clinic patients.

Cultural Competence

The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Informed Consent

All clinic patients should be informed that addressing issues of sexuality and HIV prevention is part of the standard of care at the clinic that incorporates HIV prevention into medical care. As with any patient care issues, they have the right to refuse treatment.

Legal and Ethical Policies

By virtue of participation in this intervention, clients will be disclosing their HIV serostatus. Clinics must know their state laws regarding disclosure of HIV serostatus to sex partners and needle-sharing partners; clinics are obligated to inform clients of the organization's responsibilities and the organization's potential duty to warn. Clinic also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Referrals

For clients who need additional assistance in decreasing risk behavior, providers must know about referral sources for prevention interventions and counseling, such as prevention case management, partner counseling and referral services, and health department and CBO prevention programs for persons living with HIV.

QUALITY ASSURANCE

The following quality assurance activities should be in place for Partnership *for* Health.

Auditing

Charts should be audited to ensure that providers are delivering and noting the delivery of prevention messages.

Assessment of providers

The following attributes of providers should be assessed:

- skill in eliciting behavioral information and providing prevention messages
- attitudes and beliefs about their role in delivering prevention messages
- frequency of message delivery
- satisfaction with the intervention

Intervention process and materials

The clinic coordinator should ensure that materials are maintained in the waiting and examination rooms and ensure that patient brochures and informational flyers are handed out to all patients.

Patients

Patients' satisfaction with the services and their comfort should be assessed periodically.

MONITORING AND EVALUATION

Monitoring and evaluation of Partnership *for* Health include the following:

- Collecting and reporting standardized process and outcome monitoring data consistent with CDC requirements
- Entering and transmitting data for CDC-funded services on the Program Evaluation Monitoring System, a CDC-provided browser-based system, or describing plans to make a local system compatible with CDC's requirements
- Collecting and reporting data according to CDC requirements to ensure data quality and security, and client confidentiality
- Collaborating with CDC in assessing the effects of HIV prevention activities by participating in special projects, upon request

KEY ARTICLES AND RESOURCES

Academy for Educational Development. Diffusion of Effective Behavioral Interventions Website, Partnership *for* Health. Available at http://www.effectiveinterventions.org/go/interventions/partnership-for-health

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Other Activities, Services, and Strategies

COMPREHENSIVE RISK COUNSELING AND SERVICES FOR PERSONS LIVING WITH HIV

DESCRIPTION

Comprehensive Risk Counseling and Services (CRCS), formerly Prevention Case Management (PCM), is a client-centered HIV prevention activity. Originally, CRCS was conceived as a combination of HIV risk-reduction counseling and conventional case management for persons at high risk of transmitting or acquiring HIV. As such, CRCS typically provided intensive, ongoing, individualized prevention counseling, support, and service brokerage. However, information from CRCS demonstration projects indicates that a more successful model for CRCS for HIV-infected persons clearly defines the prevention case manager's primary role as a prevention counselor, working closely with existing case management systems to provide other services to clients. Where such case management systems are not available, the prevention case manager is still encouraged to support the client by providing traditional case management services such as linkage to needed services.

Priority for CRCS services should be given to HIV-infected persons who are having, or are likely to have, difficulty initiating or sustaining practices that reduce or prevent HIV transmission and reinfection.

Goal

The goal of CRCS is to promote the adoption and maintenance of HIV risk-reduction behaviors by clients who have multiple, complex problems and risk-reduction needs.[1,2]

How It Works

CRCS provides multiple sessions of client-centered HIV risk-reduction counseling. It helps clients initiate and maintain behavior change to prevent the transmission of HIV; it also addresses competing needs that may make HIV prevention a lower priority. CRCS addresses the relationship between HIV risk and other issues such as substance abuse, mental health, social and cultural factors, and physical health.

CRCS involves the coordination of intensive prevention activities and often involves close collaboration with Ryan White Comprehensive AIDS Resource Emergency Act (RWCA) case management providers. CRCS prevention activities might include conventional risk-reduction objectives such as

- decreasing the number of sex partners and needle-sharing partners
- increasing use of condoms
- adhering to medication
- taking an active role in medical care
- abstinence

- referral to needed psychological, social, and medical services affecting risk behavior (e.g., treatment for mental health and substance abuse, diagnosis and treatment of sexually transmitted diseases)

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. **Core elements are essential and cannot be ignored, added to, or changed.**

CRCS for Persons Living with HIV has the following 6 core elements:

- Provide CRCS as intensive, client-centered HIV risk-reduction counseling, and include conventional case management services only when the client does not have access to those services.
- Base CRCS services on the premise that some people may not be able to prioritize HIV prevention when they face problems perceived to be more important and immediate.
- Focus on persons living with HIV who have multiple, complex problems and risk-reduction needs who are having, or are likely to have, difficulty initiating or sustaining practices that reduce or prevent HIV transmission.
- Recruit persons who expressed some degree of commitment to ongoing risk-reduction counseling.
- Hire case managers with the appropriate training and skills to complete the CRCS activities within their job description.
- Develop clear procedure and protocol manuals for the CRCS program to ensure effective delivery of CRCS services and minimum standards of care.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

CRCS for Persons Living with HIV has the following key characteristics:

- Develop a client recruitment and engagement strategy.
- Screen and assess clients to identify those who are at highest risk and appropriate for CRCS.
- Develop a written, client-centered prevention plan.
- Provide multiple HIV risk-reduction counseling sessions.
- Actively coordinate services with follow-up. To avoid duplication of services, prevention case managers should not provide case management services to the extent that they are already provided by existing case management systems.
- Monitor and reassess clients’ needs, risks, and progress.
- Discharge clients from CRCS once they attain and maintain their risk-reduction goals. Agencies should establish protocols to classify clients as “active,” “inactive,” or “discharged,” and outline the minimum active effort required to retain clients.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and characteristics.

Procedures for CRCS for Persons Living with HIV are as follows:

Recruitment and Engagement

Providers should ensure that clients understand the reason for a referral to CRCS, the role of the CRCS program, and the role of the CRCS provider. The CRCS counselor or other designated recruitment specialist should work with the client to obtain written, informed consent describing all relevant policies and procedures (including the confidential and voluntary nature of the service) and indicating their commitment to participate in ongoing risk-reduction counseling. Clients should be given a copy of this consent form, and the original should be maintained in the client's record. Each client should have an individual confidential record, and all records should be kept in a locked file cabinet; access should be limited to the prevention case manager and his or her immediate supervisor.

From the beginning, CRCS providers should develop a personal and working relationship with clients. This process, also known as engagement, may help clients feel comfortable discussing their behaviors. However, given the psychosocial challenges in the lives of CRCS clients, many potential clients tend to stay on the fringes of the program for some time before being ready to become fully engaged in CRCS. Agencies that provide CRCS should prepare for this by developing other engagement strategies, such as referring these clients to client support groups. In such groups, clients often develop more interest in discussing risk issues over time and, thus, their willingness to commit to CRCS increases.

Eligibility Screening and Initial Assessment

All clients must be screened for eligibility for services. Appropriate screening procedures should be developed to identify persons at highest risk for transmitting or acquiring HIV. The initial assessment should address transmission risks for HIV and other sexually transmitted diseases; substance use or abuse; and medical, psychological, and social needs. The client contacts should be conducted in a culturally appropriate manner.

Developing a Prevention Plan

After completing the initial assessment, the CRCS provider and the client should begin to develop a prevention plan and sign it. The prevention plan is a work in progress, probably will not initially define all of a client's prevention needs, and is subject to modification throughout the client's enrollment in CRCS. In fact, CRCS is most successful when the client focuses on a small number of goals at 1 time. CRCS providers should coordinate with the RWCA, Medicaid, or other case managers, whenever possible, to provide the best possible constellation of services. The initial plan should

- outline and define 1 or 2 risk-reduction behavioral goals and strategies for behavior change, including appropriate and SMART objectives. SMART stands for
    - Specific
    - Measureable
    - Achievable

    - Realistic
    - Time-phased
- include referral to medical care, if needed
- address adherence to retroviral medication, if appropriate
- include referral for evaluation and treatment of sexually transmitted diseases, tuberculosis, hepatitis, and other related health concerns
- address referral for substance abuse treatment or mental health services, if needed
- address partner counseling and referral services
- outline plans for referral follow-up

Delivering Counseling Sessions

Although some risk-reduction discussions can begin as soon as the CRCS counselor contacts a client, the CRCS counselor will intensify CRCS session when risk behaviors have been identified and appropriate risk-reduction strategies have been outlined. Counseling sessions are aimed at meeting the identified behavioral objectives. These sessions may include education, skill development, role-playing, and support. Case notes should be filed after each session with a client, indicating, at a minimum, the following:

- The goal and objective(s) addressed during the session, with specific steps agreed upon to accomplish each objective. Remember that small steps are often more realistic and, once accomplished, can lead to larger steps.
- Progress toward the goal. Remember to reward even small accomplishments.
- Barriers to behavior change and the way these are being or will be addressed
- Review of risk-reduction objectives and any needed modifications
- Referrals made and plans for follow-up
- A plan for the next session

Coordinating Services

To avoid duplication of services, CRCS providers should ensure active coordination of services with follow-up. Prevention case managers should not provide case management services to the extent that they are already provided by existing case management systems. If referrals are a part of the prevention plan, the CBO should have a standardized written referral process; a system should be in place to ensure availability and access to these referral services and to track their completion. This system might include agreements, such as memoranda of agreement with relevant service providers. Before communication between agencies begins, written informed consent for sharing client information should be obtained from the client. Medical and psychological services should be available in case of emergencies, and referral agreements for these services should be in place before initiating CRCS. Current referral and access information for all community providers should be maintained.

Following Up

Ongoing needs assessment is essential for monitoring progress toward CRCS goals and monitoring changing needs of the client. Prevention plans must be updated to reflect any change. After the client is able to maintain risk-reduction behaviors, the client and the CRCS provider should determine whether the client is ready for discharge from CRCS. Agencies implementing

CRCS must have discharge protocols in place to ensure that discharged clients are connected to needed services and resources and that they are able to return to CRCS, if needed.

RESOURCE REQUIREMENTS

People

CRCS needs staff members who are familiar and comfortable with the client base. Prevention counselors have commented that prior work experience in HIV services helped them with the delivery of CRCS. In addition to training on CRCS (e.g., training in helping clients set goals and objectives and particularly on risk-reduction counseling), CRCS staff members should have worked with or at least know how to recognize people with mental health issues (e.g., licensed counselors or other mental health providers) because CRCS clients often need mental health services. In addition, the number of staff members for CRCS depends on the number of clients that a CBO expects to serve, the needs of those clients, and what other services are offered in the area. A typical caseload will include no more than 20 clients for each full-time (or equivalent) CRCS provider.

In areas with limited referral services, CRCS providers will need to meet a wide range of client needs themselves; thus, they may need to reduce the number of clients that they can see. In areas with ample referral services, CRCS providers will be able to refer more clients and carry a higher caseload, with which they can concentrate on their clients' risk-reduction needs.

Space

CRCS needs a location that is

- easy to get to using public transportation
- private and secure, so that confidentiality can be maintained
- quiet and without interruptions (such as people entering and exiting the room or outside noise)
- close to other services that CRCS clients are accessing

Providers may need to meet clients outside of an office setting. When they do, efforts should be made to secure a location that will assure the confidentiality and safety of the client and CRCS counselor and minimize distractions and interruptions. Regardless of where actual CRCS sessions occur, the CBO implementing the intervention must ensure that all records are maintained securely in accordance with the agency's policy for protecting client confidentiality. In addition, agencies need to develop protocols to assure safety of clients and staff at all times.

RECRUITMENT

CRCS programs rely on referrals and recruitment to establish a client base. To recruit clients for CRCS, programs are often more successful at recruiting clients when they are located in an agency or community setting that offers other services (e.g., outreach, counseling and testing services, Ryan White case management, medical care, assessment and treatment of sexually transmitted diseases, substance abuse treatment, and mental health services) for the target population. In this way, clients can be referred to CRCS from existing services. If these services are not offered on site, referral agreements from agencies providing these services should be established. Incentives (for example, bus tokens, hygiene kits, t-shirts) can be used to increase participation.

POLICIES AND STANDARDS

Before a CBO attempts to implement CRCS, the following policies and standards should be in place to protect clients, the CBO, and the prevention case manager:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, informed consent signed by the client or his or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Informed Consent

CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO’s responsibility and the clients’ rights. Individual state laws apply to consent procedures for minors; but at a minimum, consent should be obtained from each client and, if appropriate, a legal guardian if the client is a minor or unable to give legal consent. Participation must always be voluntary, and documentation of this informed consent must be maintained in the client’s record.

Legal and Ethical Policies

CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners; CBOs are obligated to inform clients of the organization’s responsibilities around HIV-infected clients and the organization's potential duty to warn. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Referrals

CBOs must be prepared to refer clients as needed. For clients who need additional assistance with decreasing risk behavior, providers must know about referral sources for prevention interventions and counseling, such as partner counseling and referral services and health department and CBO prevention programs for persons living with HIV. All persons screened for CRCS, regardless of eligibility, should be referred to services relevant to their needs.

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If the CBO uses volunteers to assist with or conduct this intervention, then the CBO should know and disclose how their liability insurance and worker's compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing CRCS:

Providers

Experience and Supervision

Providers of CRCS services might find it helpful to have experience working in the fields such as mental health or substance abuse services (e.g., licensed counselors or mental health providers) and HIV prevention, although experience working with the target population is also helpful. CRCS providers should meet at least monthly with either a direct supervisor or with a peer supervisor. Supervisors, other management personnel, and those providing CRCS services directly to clients are strongly encouraged to participate in appropriate training that covers the foundations of CRCS as well as the specific CRCS approach used by the agency in which they work. Training resources can be accessed by contacting your CDC Project Officer or state health department.

Session Review

CBOs should have in place a mechanism to ensure that all sessions address the prevention plan, either by focusing on risk reduction specifically or on contextual issues that are related to risk behavior. Quality assurance activities can include observation and review of sessions by key staff and supervisors involved with the activity.

Record Review

Selected intervention record reviews should focus on assuring that consent forms (signed either by the client, if older than 18 or emancipated, or by a legal guardian) are included for all participants and that session notes are of sufficient detail to assure that clients are participating actively.

Clients

Clients' satisfaction with the services and their comfort should be assessed periodically. Process monitoring systems should also track the number of sessions each client attends, as well as reasons for not attending.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

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COMPREHENSIVE RISK COUNSELING AND SERVICES FOR UNINFECTED PERSONS AT VERY HIGH RISK FOR HIV

DESCRIPTION

Comprehensive Risk Counseling and Services (CRCS), formerly Prevention Case Management (PCM), is a client-centered HIV prevention activity that provides intensive, ongoing, individualized prevention counseling, support, and service brokerage. Priority for CRCS services should be given to persons at very high risk for HIV. Originally, CRCS was conceived as a combination of HIV risk-reduction counseling and conventional case management for persons at high risk of transmitting or acquiring HIV. However, information from CRCS demonstration projects indicates that a more successful model for CRCS clearly defines the prevention case manager's primary role as a prevention counselor, working closely with other referral providers to assist clients whose psychosocial needs are a barrier to their risk reduction goals. Often case management services and benefits are not available, especially for persons who are HIV negative or who do not know their status. Therefore, the prevention case manager is encouraged to provide traditional case management service such as linkage to services that may be available (for example, mental health or substance abuse services).

Goal

The fundamental goal of CRCS is promoting the adoption and maintenance of HIV risk-reduction behaviors by clients who have multiple, complex problems and risk-reduction needs.[1,2]

How It Works

CRCS provides several sessions of client-centered HIV risk-reduction counseling. It helps clients initiate and maintain behavior change toward HIV prevention while addressing competing needs that may make HIV prevention a lower priority. CRCS addresses the relationship between HIV risk and other issues such as substance abuse, mental health, social and cultural factors, and physical health.

CRCS prevention activities might include conventional risk-reduction objectives such as

- decreasing the number of sex partners and needle-sharing partners
- increasing condom use
- abstinence
- referral to needed psychological, social, and medical services affecting risk behavior (e.g., treatment for mental health and substance abuse, diagnosis and treatment of sexually transmitted diseases)

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. **Core elements are essential and cannot be ignored, added to, or changed.**

CRCS for Uninfected Persons at Very High Risk for HIV has the following 6 core elements:

- Provide CRCS as a combination of intensive, client-centered HIV risk-reduction counseling and linkage to other services that may be needed by clients in order to support or even make risk reduction possible.
- Base CRCS services on the premise that some people may not be able to prioritize HIV prevention when they perceive other problems to be more important and immediate.
- Consider persons whose HIV status is negative or unknown to be eligible if they have a recent history (past 6 months) of 1 or more of the following:
  - unprotected sex with a person who is living with HIV
  - unprotected sex in exchange for money or sex
  - multiple (e.g., more than 5) or anonymous sex partners
  - multiple or anonymous needle-sharing partners
  - a diagnosis of a sexually transmitted disease
- Recruit persons who expressed some degree of commitment to participating in ongoing risk-reduction counseling.
- Hire case managers with the appropriate training and skills to complete the CRCS activities within their job description.
- Develop clear procedures and protocol manuals for the CRCS program to ensure effective delivery of CRCS services and minimum standards of care.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

CRCS for Uninfected Persons at Very High Risk for HIV has the following key characteristics:

- Develop a client recruitment and engagement strategy.
- Identify clients who are at highest risk and appropriate for CRCS (screening and assessment).
- Develop a written, client-centered prevention plan.
- Provide multiple HIV risk-reduction counseling sessions.
- Actively coordinate services with follow-up.
- Monitor and reassess clients' needs, risks, and progress and revise prevention plans accordingly.
- Discharge clients from CRCS once they attain and maintain their risk-reduction goals. Agencies should establish protocols to classify clients as "active," "inactive," or "discharged," and outline the minimum active effort required to retain clients.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and characteristics and what makes them work.

Procedures for CRCS for Uninfected Persons at Very High Risk for HIV are as follows:

Recruitment and Engagement

Providers should ensure that clients understand the reason for a referral to CRCS, the role of the CRCS program, and the role of the CRCS provider. The CRCS counselor or other designated recruitment specialist should work with the client to obtain written, informed consent describing all relevant policies and procedures (including the confidential and voluntary nature of the service) and indicating their commitment to participate in ongoing risk-reduction counseling. Clients should be given a copy of this consent form, and the original should be maintained in the client's record. Each client should have an individual confidential record, and all records should be kept in a locked file cabinet; access should be limited to the prevention case manager and his or her immediate supervisor.

From the beginning, CRCS providers should develop a personal and working relationship with clients. This process, also known as engagement, may help clients feel comfortable discussing their behaviors. However, given the psychosocial challenges in the lives of CRCS clients, many potential clients tend to stay on the fringes of the program for some time before being ready to become fully engaged in CRCS. CBOs that provide CRCS should prepare for this by developing other engagement strategies, such as referring these clients to client support groups. In such groups, clients often develop more interest in discussing risk issues over time and, thus, their willingness to commit to CRCS increases.

Eligibility Screening and Initial Assessment

All clients must be screened for eligibility for services. Appropriate screening procedures should be developed to identify persons at highest risk for transmitting or acquiring HIV. The initial assessment should address transmission risks for HIV and other sexually transmitted diseases; substance use or abuse; and medical, psychological, and social needs. The client contacts should be conducted in a culturally appropriate manner.

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- outline and define 1 or 2 risk-reduction behavioral goals and strategies for behavior change, including appropriate and SMART objectives. SMART stands for
    - Specific
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- include referral to appropriate medical care, if needed, and referral for evaluation and treatment of sexually transmitted diseases, tuberculosis, hepatitis, and other related health concerns
- address referral for substance abuse treatment or mental health services, if needed
- include objectives related to counseling and testing, as needed, for clients whose HIV status is negative or unknown
- outline plans for referral follow-up

Delivering Counseling Sessions

Although some risk-reduction discussions can begin as soon as the CRCS counselor contacts a client, the CRCS counselor will intensify CRCS session when risk behaviors have been identified and appropriate risk-reduction strategies have been outlined. Counseling sessions are aimed at meeting the identified behavioral objectives. These sessions may include education, skill development, role-playing, support, or other techniques. Case notes should be filed after each session with a client indicating, at a minimum, the following:

- The goal and objective(s) addressed during the session, with specific steps agreed upon to accomplish each objective. Remember that small steps are often more realistic and, once accomplished, can lead to larger steps.
- Progress toward the goal. Remember to reward even small accomplishments.
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- A plan for the next session

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CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

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HIV COUNSELING, TESTING, AND REFERRAL

DESCRIPTION

Background

CDC estimates that approximately 1 million persons in the United States are living with HIV; of these, an estimated 25% are unaware of their infection. Evidence suggests that more than half of the estimated 40,000 new HIV infections each year occur through transmission from persons who are unaware of their HIV status.

CDC is revising its HIV counseling and testing guidelines. Separate guidelines are being developed for HIV testing in health care settings and HIV counseling, testing, and referral in non-healthcare settings. The guidance provided in this document may change, depending on the results of the guideline revision process; however, until that time, the recommendations in this document should be adhered to.

Specifically, Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings will be published later in 2006. They will replace CDC's 1993 Recommendations for HIV Testing Services for Inpatients and Outpatients in Acute-Care Hospital Settings; and they will update aspects of CDC's 2001 Revised Guidelines for HIV Counseling, Testing, and Referral that apply to health care settings and the 2001 Revised Recommendations for HIV Screening of Pregnant Women. In addition, the process for updating recommendations for HIV testing in non-healthcare settings is under way, with publication expected in 2007.

Goals

HIV counseling, testing, and referral (CTR) [1,2] is a collection of activities designed to increase clients' knowledge of their HIV status; encourage and support risk reduction; and secure needed referrals for appropriate services (medical, social, prevention, and partner counseling and referral services).

How It Works

Clients can receive CTR at clinics, dedicated sites, and through outreach or other services. CTR can be delivered anonymously or confidentially, but it should be undertaken voluntarily and only with informed consent. Several HIV test technologies have been approved by the Food and Drug Administration; they vary by fluid tested (whole blood, serum, plasma, oral fluids, and urine) and time required to run the test (conventional vs rapid tests). Testing options facilitate access to testing and increase acceptability of testing.

HIV CTR may be anonymous or confidential.

- **Anonymous** means the client's name is neither known nor solicited and is not recorded.

- **Confidential** means the client provides his or her name and may or may not provide additional contact information.

HIV CTR may be provided by self-referral or by referrals from other related services.

- **Self-referral** means the client initiated the services.
- **Referrals from other related services** come from medical or mental health care providers, substance abuse treatment facilities, homeless shelters, and partner counseling and referral services.

HIV CTR uses rapid or conventional HIV testing. (Please see Rapid HIV Testing in Nonclinical Settings in this document for more information about the rapid HIV test.)

CTR can use a variety of methods, but all CTR providers must do the following:

- Inform clients about HIV transmission routes and prevention methods, the HIV antibody testing process, how and when to get test results, and the meaning of a positive or a negative test result.
- Provide client-centered counseling about recognizing one's risk for HIV infection, the need for testing, and develop a risk-reduction plan.
- If the client consents, test using the best available method.
- When using the rapid HIV test, follow all standards and procedures related to the use of the rapid test, including guidelines for providing preliminary positive results and obtaining specimens for confirmatory testing.
- Address needs for additional services and provide appropriate referrals to meet those needs.

Research Findings

Research demonstrates that after receiving a positive HIV test result, persons generally decrease their risk behavior.[3]

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. **Core elements are essential and cannot be ignored, added to, or changed.**

CTR has the following 8 core elements:

- Obtain informed consent before delivering HIV CTR, which is a voluntary service.
- Provide information and education about
    - the HIV test and its benefits and consequences
    - risk for HIV transmission and how HIV can be prevented
    - the type of HIV antibody test used
    - the meaning of the test result, including the window period for HIV seroconversion (the time after infection, before antibodies are produced by the

    body, during which an antibody test might be negative despite the presence of HIV)
  - the importance of obtaining test results and explicit procedures for doing so
  - where to obtain more information, counseling, or other services (medical, mental health, or substance abuse care)
- Provide client-centered HIV prevention counseling to address the client's
  - readiness for testing
  - personal risk assessment
  - steps taken to reduce risk
  - goals for reducing risk
  - realistic plans for achieving those goals
  - support systems
  - referral needs
  - plans for obtaining results, if necessary (if testing is done and the CBO is not using rapid testing)
- With the health departments (state, local, or both) and community mental health providers, establish clear and easy guidelines and sobriety standards to help counselors determine when clients are not competent to provide consent.
- Use an HIV testing technology approved by the Food and Drug Administration.
- Deliver test results in a manner that is supportive and understandable to the client.
- Assess referral needs for risk reduction or medical care, provide appropriate referrals, and help link clients with referral services. A system must be in place for emergency medical or mental health referral, if needed.
- Track referrals made and completed.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

CTR has the following key characteristics:

- Provide information and education about testing in 1 of 3 ways.
  - Individual face-to-face sessions
  - Small or large group sessions
  - Brochures, handouts, videos, or audiotape
- Deliver client-centered counseling and test results in an individual, face-to-face session. Although some providers have given negative test results over the telephone when a face-to-face session was not feasible, it is recommended that positive results be given in person to ensure that the client has the necessary support and completes referrals for care and prevention services.
- Use a variety of specimens and test types for HIV antibody testing, depending on the setting in which testing is conducted and the needs of the organization and the client.
- Match service referrals to client's self-identified priority needs (increases likelihood that referral will be completed), if possible.
- For clients whose test results are positive, place priority on referrals for medical care, partner counseling and referral services, and prevention and support services.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and characteristics.

Although HIV CTR may be conducted in a clinic or dedicated setting or in less conventional places as a part of outreach or other services (Comprehensive Risk Counseling and Services or other prevention interventions), each instance of CTR must follow a similar set of procedures, as follows.

Giving information. The client is first given information about HIV and the HIV antibody test. This information must include

- a discussion of the risk factors for HIV and how HIV can be prevented
- the type of test to be used and the manner in which the specimen will be collected
- the difference between anonymous and confidential testing
- the timeframe for testing, including when the results will be available and the importance of obtaining the results
- the meaning of positive and of negative test results
- the window period for HIV seroconversion (so that the client can determine whether testing at a later time might provide more information)
- the need for partner counseling and referral services if the test result is positive
- the jurisdiction's requirements for reporting positive test results to the health department

Client-centered counseling. Client-centered counseling techniques should be used to help clients determine their readiness for testing and to provide support systems to access while waiting for and after receiving the test results. Client-centered counseling also assesses the client's ability to cope with a positive test result.

An individualized risk assessment should be conducted to determine the client's risk behaviors. This information should be used to help the client better understand his or her risk and to enable the client and the counselor to identify, acknowledge, and understand the details and context of the client's risk. Keeping the focus of the assessment personal helps the client identify concrete, acceptable protective measures to reduce personal risk for HIV. Factors associated with continued risk behavior that might be important to explore include

- using drugs or alcohol before sexual activity
- underestimating personal risk
- perceiving that taking precautions to reduce risk (e.g., using condoms) are not an accepted peer norm
- perceiving limited ability to change behavior
- perceiving reinforcement for frequent unsafe practices (e.g., receiving a negative HIV test result despite risk behaviors)
- perceiving that vulnerability is associated with luck or fate

The counselor should first acknowledge and provide support for positive steps that the client has already made toward risk reduction. At this point, the counselor should focus more on reducing the client's current risk and less on general education about HIV transmission modes and the meaning of HIV test results.

Next, the counselor should negotiate a concrete and achievable behavior-change step to further reduce HIV risk. Although the ultimate goal is to eliminate HIV risk behaviors, small behavior changes can reduce the probability of acquiring or transmitting HIV. Behavioral risk-reduction steps should be

- acceptable to the client and appropriate for the client's situation
- relevant to reducing the client's own HIV risk
- focused on reducing the most critical risk the client is willing to commit to changing (for the client with several high-risk behaviors)
- focused on a small, explicit, and achievable goal, not a global goal

Identifying (using interactive discussion, role-playing, recognizing social support, or other methods) the barriers and supports to achieving a step will increase the likelihood of success. In addition, the counselor should help the client build skills for achieving the goal, such as having the client demonstrate proper condom use or cleaning of drug paraphernalia (with feedback) or role-playing negotiation of abstinence or safer sex.

Clients with ongoing risk behaviors should be referred to additional prevention and related support services. A structured protocol outlining session goals can help keep the counselor focused on risk reduction and can ensure consistent counseling delivery for all clients. An example of client-centered counseling can be found at www.cdc.gov/hiv/projects/respect/default.htm.

After all aspects of the HIV antibody test have been disclosed, the client can make an informed decision about whether to be tested. The client should then provide consent (oral or written, as required by state and local policy), indicating his or her willingness to be tested for the presence of HIV antibodies. If testing is anonymous, the client should be informed that providing a sample for testing implies consent.

Testing

After counseling, referrals are provided, if needed, and a specimen is obtained or the rapid HIV antibody test is conducted according to the procedures outlined by the test's manufacturer. A follow-up appointment is scheduled, if necessary or desirable. The counselor should schedule the appointment at the time and place that is most likely to result in the client returning for results.
If conventional HIV antibody testing is used, results are given at a second appointment.
If rapid HIV antibody testing is used, a follow-up appointment may not be needed to deliver test results but may be desirable for additional prevention counseling.

Results should be provided at the beginning of the results-giving session, using explicit language. Counselors should never ask the client to guess the test results. Counselors should, however, clarify test results. (For an explanation of test results, please refer to the Revised Guidelines for HIV Counseling, Testing, and Referral.[1]) Counselors should also discuss the importance of continued commitment to risk reduction.

For clients whose test results are negative, counselors should address personal HIV risk reduction, including reviewing progress on goals set at the previous counseling session.
For clients whose test results are positive, counselors should

- provide psychological support, refer the client for additional counseling (if needed), or both
- ensure that the client knows where and how to obtain more information and services
- refer the client for medical evaluation, care, and treatment (including screening or care for sexually transmitted diseases, vaccination or treatment for viral hepatitis, and referral to reproductive health services)
- assess the need for and provide, or make referrals for, other prevention services (individual- or group-level interventions or comprehensive risk counseling and services)
- ensure that the client has accurate information about steps necessary to prevent transmission
- elicit and correct misperceptions about HIV transmission risk and address strategies for prevention of other sexually transmitted diseases or bloodborne infections
- counsel the client about who to notify of his or her positive test result
- discuss and provide or refer the client to partner counseling and referral services

Referring

Referrals for additional services may be made at any point in the CTR process. Services include

- screening and care for sexually transmitted diseases
- viral hepatitis screening, vaccination, and treatment
- housing
- food
- transportation
- domestic violence services
- reproductive health services
- chemical dependency prevention and treatment
- mental health services
- legal services
- other support services

CTR sites should

- develop and maintain a referral resource guide
- nurture strong working relationships with the agencies providing the services
- identify key contacts from these agencies
- have formal, written agreements to delineate the roles and responsibilities of each agency
- review referral agreements periodically and modify them as appropriate
- track referrals made and completed
- address barriers to successful referrals, initially and on an ongoing basis

Counselors must consider the most appropriate service provider for each client, considering such things as the client’s culture, language, sex, sexual orientation, age, or developmental level. The counselor should work with the client to identify barriers to completing the referral and find ways to overcome those barriers. Referrals are most likely to be completed if they match the priority needs identified by the client and if the counselor is able to provide some personalized information about the agency, including a contact name, eligibility requirements, location, hours of operation, and the telephone number. More than 1 referral option should be provided, if possible. The referral may be also facilitated if the counselor can phone the service provider for the client; however, the counselor must first have a signed informed consent form to share private information from the client.

Information obtained through follow-up of referrals can identify barriers to completing the referral, responsiveness of referral services in addressing client needs, and gaps in the referral system. All referrals should be documented and tracked to determine if they were completed.

- **If not completed,** barriers should be addressed.
- **If completed,** satisfaction should be assessed and recorded in the referral resource guide.
- **If unsatisfactory,** new referrals should be made, if possible.

RESOURCE REQUIREMENTS

People

CTR needs paid or volunteer staff members who are trained in HIV CTR. If rapid HIV testing will be used, involved staff members must also be trained to perform rapid HIV tests. All polices, quality assurance requirements, and local and state requirements related to rapid HIV testing must be followed. The number of staff needed depends on the number of tests to be done and the type of test used (rapid or conventional). The number of tests completed per hour depends on the needs of the clients, the abilities of the counselor, and the type of test used.

Space

CTR can be implemented at any location where confidentiality of clients can be assured (e.g., private area or room) and where a specimen can be collected according to minimal standards as outlined by the Occupational Safety and Health Administration. Additionally, if rapid testing is used, the setting must have a flat surface, acceptable lighting, and ability to maintain temperature in the range recommended by the test manufacturer for performing the test.

RECRUITMENT

The following recruitment strategies can be used to reach clients for CTR:

- Recruit from HIV prevention counseling, Comprehensive Risk Counseling and Services, or other agency services.
- Recruit from other CBOs or agencies that serve populations at high risk for HIV (e.g., substance abuse treatment facilities, correctional facilities, shelters).
- Send press releases and public service announcements to radio stations and TV stations that serve specific populations at high risk for HIV.
- Advertise in local newspapers (e.g., neighborhood, gay, alternative).
- Post announcements on the Internet.

Review Recruitment in this document to choose a recruitment strategy that will work in the setting in which the CBO plans to implement CTR.

POLICIES AND STANDARDS

Before a CBO attempts to implement CTR, following policies and standards should be in place to protect clients, CTR providers, and the CBO:

Confidentiality

A system (e.g., a written protocol) must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed permission from the client or his or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire and train all staff to be representative of or sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available. CBOs should involve clients and the community in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements. CBOs should have written protocols on how to collect, document, analyze, and use CTR data according to state and local policies.

Informed Consent

CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO’s responsibility and the clients’ rights. Client participation must always be voluntary, and documentation of this informed consent must be maintained in the CBO’s client records. Individual state laws apply to consent procedures for minors; if necessary, consent should be obtained from a legal guardian if the client is a minor or unable to give legal consent.

Legal and Ethical Policies

It is important to keep in mind that CTR deals with the provision of services that require specialized training and deals with private client medical information. CBOs must know their state laws regarding who may implement CTR procedures and about disclosure of a client’s HIV status (whether positive or negative) to sex partners and other third parties. CBOs must know and follow all applicable state and local laws, regulations, and policies related to reporting of HIV test results to the health department. CBOs must inform clients about state laws regarding the reporting of child abuse, sexual abuse of minors, and elder abuse.

Referrals

CBOs must be prepared to refer clients as needed. For clients who need additional help decreasing risk behavior, providers must know about referral sources for prevention interventions and counseling, such as partner counseling and referral services and health department and CBO prevention programs for persons living with HIV.

Safety

CTR provided in nonconventional settings may pose potentially unsafe situations (e.g., the risk of transmitting bloodborne pathogens). CBOs should develop and maintain written detailed guidelines for personal safety and security; for assuring minimal safety standards (including biohazard waste disposal) as outlined by the Occupational Safety and Health Administration; and for safeguarding the security of the data collected, client confidentiality, and the chain of custody for testing supplies and collected client specimens. CBOs must ensure that CTR providers are aware of and comply with safety guidelines.

Volunteers

If the CBO uses volunteers to assist with or conduct this intervention, then the CBO should know and disclose how their liability insurance and worker's compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing CTR:

Counselors

Qualifications

Providers of CTR should have the following skills and characteristics:

- Completion of standard training courses in client-centered HIV prevention counseling or other risk-reduction counseling models
- Belief that counseling can make a difference
- Genuine interest in the counseling process
- Active listening skills
- Ability to use open-ended rather than closed-ended questions
- Ability and comfort with an interactive negotiating style rather than a persuasive approach
- Ability to engender a supportive atmosphere and build trust with the client
- Interest in learning new counseling and skill-building techniques
- Being informed regarding specific HIV transmission risks

- Comfort in discussing specific HIV risk behaviors (i.e., explicit sex or drug behaviors)
- Ability to remain focused on risk-reduction goals
- Support for routine, periodic, quality assurance measures

Training

A training program should be in place for all new employees, existing employees, and volunteers who will be providing CTR. This program should ensure that all CTR providers receive

- adequate training
- competency assessment
- annual training updates
- continuing education
- adequate supervision to implement CTR and, if performed, the rapid HIV test

The program should also ensure that CTR providers are skilled and competent in the provision of services (by using observed practice of CTR sessions with feedback to counselors and of rapid HIV test procedures, if needed).

Supervision

A review mechanism should be in place to assure that all testing protocols are followed as written. Quality assurance activities can include observation as well as role-playing demonstration of skills. The review should focus on ensuring that the protocol is delivered with consistency and responsiveness to expressed client needs and should help counselors develop skills for delivering the intervention.

Records

Selected intervention record reviews should focus on assuring that consent was obtained or documented for all clients and that all process and outcome measures were completed as required. Records should be securely stored, periodically reviewed, and destroyed when outdated (how long test result records are kept as part of a medical record may be subject to state or other requirements).

Clients

Clients' satisfaction with the services and their comfort should be assessed periodically.

Setting

Supervisors should periodically review the setting to ensure that it is private and confidential and that the waiting time for a test at this setting does not create a barrier to testing.

Troubleshooting

The CBO should have a method to detect and resolve problems that occur. This should specify how to document problems and actions taken (such as having a logbook where problems and corrective actions taken can be recorded) and how to verify that corrective actions taken addressed the problem.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

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KEY ARTICLES AND RESOURCES

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INCORPORATING HIV PREVENTION INTO THE MEDICAL CARE OF PERSONS LIVING WITH HIV

DESCRIPTION

Incorporating HIV Prevention into the Medical Care of Persons Living with HIV is a set of recommendations recently published by CDC, the Health Resources and Services Administration, the National Institutes for Health, and the HIV Medicine Association of the Infectious Diseases Society of America.[5] Prevention in the care setting uses the outpatient clinic and health care providers to screen for HIV transmission risk behaviors and sexually transmitted diseases, provide brief behavioral prevention interventions, and facilitate partner notification and counseling.

Goals

- Reach a large number of HIV-infected persons who regularly visit the clinic for treatment.
- Implement a safer-sex prevention program to instill self-protective and partner-protective motivations for reducing risk behaviors across time.
- Integrate prevention into routine medical care.
- Involve clinic staff (especially physicians, physician assistants, nurses, nurse practitioners, and counselors) in prevention counseling.

How It Works

The recommendations state that medical care providers can greatly affect patients’ risks for transmission of HIV to others by

- performing a brief screening for HIV transmission risk behaviors
- communicating prevention messages
- discussing sexual and drug-use behavior
- positively reinforcing changes to safer behaviors
- referring patients for services such as substance abuse treatment
- facilitating partner notification, counseling, and testing
- identifying and treating other sexually transmitted diseases[5]

These recommendations are integrated into 3 major components.[5]

- Screening for HIV transmission risk behaviors and for sexually transmitted diseases
- Providing brief behavioral risk-reduction interventions in the office setting and referring selected patients for additional prevention interventions and other related services
- Facilitating notification and counseling of sex partners and needle-sharing partners of infected persons

The recommendations are intended for all persons who provide medical care services to persons living with HIV (e.g., physicians, nurse practitioners, nurses, physician assistants). They are also appropriate for CBOs that provide medical care services; however, CBOs that do not provide care may choose to partner with medical care providers to offer a range of services, including brief prevention messages delivered by the medical care provider as well as more conventional prevention services (e.g., comprehensive risk counseling and services, partner counseling and referral services, counseling testing and referral for partners) that could be available on site at the clinic.

Research Findings

After receiving a positive HIV test result, many persons decrease behaviors that may transmit HIV to others.[1,2] However, recent studies suggest that not all HIV-infected persons maintain such behavioral changes and that some continue to engage in behaviors that place others at risk for HIV infection.[3,4] Thus, the recommendations were published in recognition of the importance of including HIV prevention in the medical care setting.[5]

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. **Core elements are essential and cannot be ignored, added to, or changed.**

Incorporating HIV Prevention into the Medical Care of HIV-infected Persons has the following 7 core elements:

- Adopt prevention as a standard part of clinical practice.
- Conduct a brief assessment (risk screening) of behavioral and clinical factors associated with transmission of HIV and other sexually transmitted diseases.
- Identify patients who are at greatest risk for transmission of HIV and who should receive more in-depth risk assessment and HIV risk-reduction counseling, other risk-reduction interventions, or referral for other services.
- Deliver to every patient at every clinic visit a brief (3–5 minute) prevention message focused on HIV prevention for the patient, the partner, or both and disclosure of HIV serostatus.
- Screen for and treat sexually transmitted diseases, as appropriate.
- Discuss reproductive health options with female patients of childbearing age.
- Hang posters in waiting and examination rooms, and hand out patient brochures that present education and prevention messages and reinforce messages delivered by the medical care provider.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

Incorporating HIV Prevention into the Medical Care of HIV-infected Persons has the following key characteristics:

- Train all clinic staff about using open-ended questions, demonstrating empathy, and remaining nonjudgmental.
- Base session length on the needs of the patient (counseling sessions can last more than 5 minutes, and follow-up reminders may last less than 3 minutes) Repeat the message over time during subsequent visits.
- Make condoms available in a way that patients can feel comfortable taking some home, as needed.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and characteristics.

Procedures for Incorporating HIV Prevention into the Medical Care of HIV-infected Persons are as follows:

Incorporating Prevention

Incorporating prevention into a busy clinic can be difficult but can be facilitated with some modification of the clinic structure and flow. Creating an atmosphere that endorses an integrated approach shows that HIV prevention is important to the medical care provider and staff. Posting prevention messages in the waiting and examination rooms and giving every patient printed material related to HIV prevention reminds the medical care provider and prepares the patient to discuss HIV prevention.

Behavioral Screening

Screening patients before they see the medical care provider (using pencil-and-paper, audio-, video-, or computer-assisted questionnaires or brief interviews with nonmedical staff) can help the medical care provider understand patients' risk factors and symptoms of sexually transmitted diseases, if present, and to initiate more in-depth discussions of HIV prevention during the medical visit.

Behavioral screening is a vital element. Many providers use a paper instrument to conduct behavioral screening. An example can be found under Prevention in Care Settings at CDC's National Prevention Information Network (800-458-5231 and www.cdcnpin.org/scripts/index.asp).

Providing Prevention Messages

If the patient reports engaging in risky behaviors (unsafe sex or injection practices), the medical care provider should provide an appropriate brief prevention message. This message may include

- a general prevention message
- a message that addresses behaviors or concerns specific for this patient
- correction of misconceptions about risk
- reinforcement of steps the patient has already taken to decrease risk for HIV transmission

Prevention messages should stress that the only way to ensure that HIV is not transmitted is abstinence or sex with a partner of concordant HIV status. However, patients should also know that sex with partners of concordant HIV status does not protect against other sexually transmitted diseases or reinfection with HIV. For sexually active patients, condom use is the safest way to prevent transmission or acquisition of HIV and other sexually transmitted diseases. Patients should also be made aware of the importance of disclosing their HIV status to potential sex partners.

Testing for Sexually Transmitted Diseases

Because the presence of a sexually transmitted disease can dramatically increase the transmissibility of HIV and the progression of HIV disease, the medical care provider should also recommend screening (for asymptomatic patients) or diagnostic testing (for symptomatic patients) and treatment, as appropriate, for sexually transmitted diseases for patients who engage in unsafe sexual behaviors. These tests should be recommended at the first visit for all patients, at least yearly for sexually active patients, and more frequently for patients at high risk. Patients should be tested for sexually transmitted diseases if they report any symptoms of infection, regardless of reported sexual behavior or other epidemiologic risk information.

Assessing Women’s Reproductive Status

Without appropriate intervention the risk for perinatal HIV transmission is high. Therefore, medical care providers should assess whether women of childbearing age might be pregnant, are interested in becoming pregnant, or are not specifically considering pregnancy but are sexually active and not using reliable contraception. Such women may need to be referred for reproductive health issues and counseling.

Referring Patients

The medical care provider should also refer the patient for more extensive prevention interventions or to other services that may benefit the patient, the partner, or both, as needed (e.g., substance abuse treatment services, mental health services, medication adherence counseling, partner counseling and referral services). Referral follow-up can provide the medical care provider with information about the success of the referral, patient satisfaction with the referral, or barriers to completing it. This information can be used to compile a referral guide for use by all providers in that clinic.

Following Up

Finally, medical care providers should recognize that risk is not static. Patients’ lives and circumstances change, and their risk of transmitting HIV may change from 1 medical encounter to another. Screening and providing risk-reduction messages should occur at every medical visit unless the client has other medical needs that take precedence.

Having Appropriate Materials

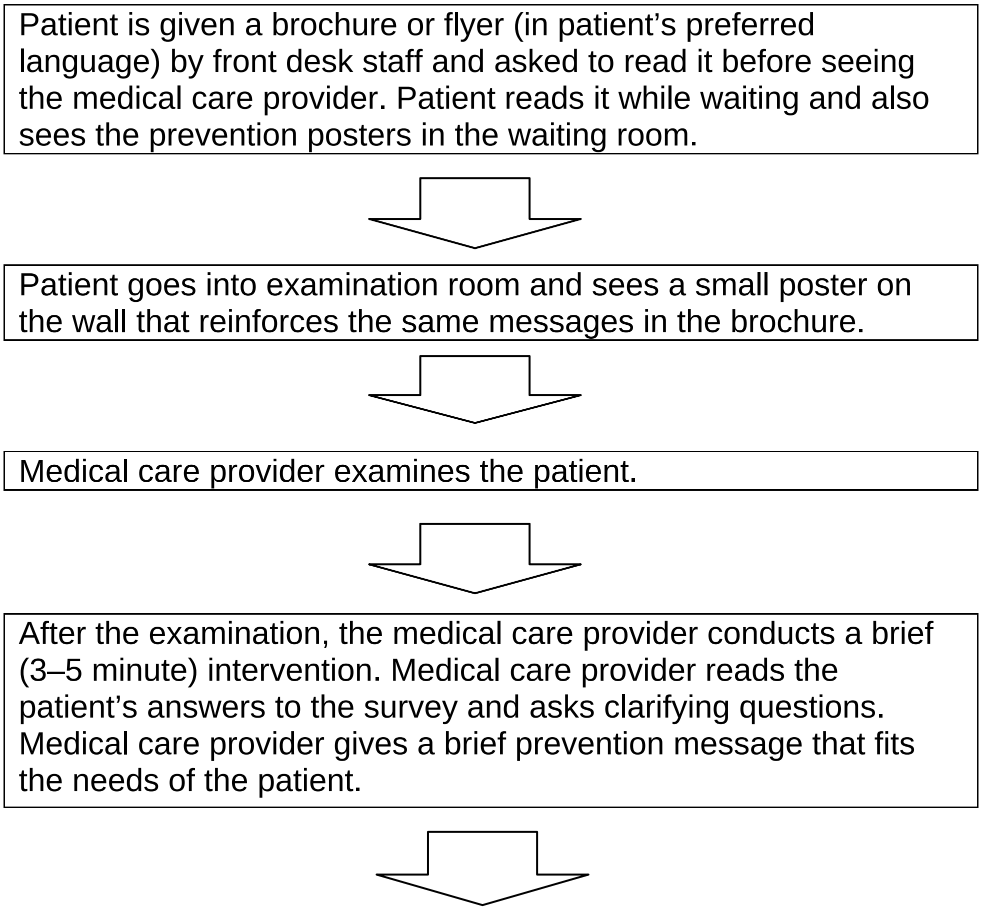
The following materials are helpful for introducing the concept of integrated prevention and care services:

- **Posters,** in languages appropriate to the populations served, displaying the general prevention messages, to hang in clinic waiting areas and hallways
- **Brochures,** in languages appropriate to the populations served, given to patients when they register at the front desk. The brochures should emphasize

  - the role of sexually transmitted diseases in HIV transmission and the need to be tested and treated at the first sign or suspicion of symptoms of sexually transmitted diseases
  - the potential role of drug use in increasing risky behaviors
  - the risks of unsafe sex or injection practices for patients and their partners, even in the presence of a low or undetectable viral load
  - the importance of disclosing HIV status
- **Posters to hang in examination rooms,** in languages appropriate to the populations served, that contain the same messages as the brochure
- **Documentation of patient counseling,** which may be done with a chart sticker, a stamp, or a check box in the printed or electronic medical record. The purpose is to remind the provider to do the counseling regularly.
- **Additional supportive materials,** given out as supplements to the brochure at subsequent visits. Materials can address additional prevention topics of interest and may include helpful information and testimonials related to changing behavior.

Examples of brochures, posters, and prevention prescription pads can be found at www.mpaetc.org. Go into the Positive Steps section.

One model for integrating prevention into care is diagrammed below.



Patient is given a brochure or flyer (in patient's preferred language) by front desk staff and asked to read it before seeing the medical care provider. Patient reads it while waiting and also sees the prevention posters in the waiting room.

Patient goes into examination room and sees a small poster on the wall that reinforces the same messages in the brochure.

Medical care provider examines the patient.

After the examination, the medical care provider conducts a brief (3–5 minute) intervention. Medical care provider reads the patient's answers to the survey and asks clarifying questions. Medical care provider gives a brief prevention message that fits the needs of the patient.

Medical care provider uses the brochure, poster, or other prevention materials to help with counseling. Medical care provider or patient places a check mark next to behaviors noted in the brochure and sets goals for behavior change. Medical care provider documents in the patient's chart that counseling was done.

If needed, the medical care provider refers the patient to other services. Medical care provider tells patient that he or she will be interested in hearing how the patient is doing at the next appointment.

Patient leaves feeling cared about, knowing more about safer sex and disclosure of HIV status, and ready to practice safer behaviors.

At follow-up visits, medical care provider asks about progress on goals and referrals, if given at last visit. Medical care provider offers reinforcement for healthy behavior and helps patient find ways to overcome obstacles. Medical care provider and patient set goals for next time.

Collaborating

CBOs that do not provide medical care can partner with a medical provider to help create prevention messages and materials that are appropriate for the clinic and to help with training and prevention strategies for clinics. Your AIDS Education and Training Center (http://www.aids-ed.org/) or Prevention Training Center (http://depts.washington.edu/nnptc/) is a good resource for materials. CBOs can also help clinics provide and facilitate referrals and can provide more extensive prevention services to those patients with additional prevention needs.

RESOURCE REQUIREMENTS

People

Incorporating HIV Prevention into the Medical Care of Persons Living with HIV uses existing providers and clinic staff, so no new staffing is required. Providers are asked to spend 3 to 5 minutes during each patient visit to discuss safer sexual behavior and disclosure of HIV status.

Providers and clinic staff will need half a day to attend training, plus another 2 hours for a booster training. Your AIDS Education and Training Center (http://www.aids-ed.org/) or Prevention Training Center (http://depts.washington.edu/nnptc/) can arrange these trainings.

A nurse, physician's assistant, or physician needs to be appointed as prevention coordinator. This person will

- set up training
- make sure that materials are on hand
- make sure that the intervention is being carried out

Clinics should have support and a commitment from all their staff to

- training
- talking with patients about sex and drug use
- understanding prevention interventions and factors related to risk behavior
- knowing what community resources are available by referral

Space

Incorporating HIV Prevention into the Medical Care of Persons Living with HIV is done at HIV outpatient health care clinics. Clinics should have private examination rooms where medical care providers and patients can talk privately about the patient's sexual behaviors.

Supplies

Incorporating HIV Prevention into the Medical Care of Persons Living with HIV needs

- training materials
- posters
- brochures
- chart stickers
- anatomical models
- condoms and lubricant

Along with staff time for training, these supplies are the major expenses for incorporating prevention into care.

RECRUITMENT

Agencies who choose to follow the recommendations will offer prevention services as the standard of care in their clinics; therefore, no specific recruitment strategy is endorsed for Incorporating HIV Prevention into the Medical Care of Persons Living with HIV. All clinic patients will receive counseling with appropriate messages at each appointment. However, all patients should be informed that the clinic has adopted a model of integrated service so that they may make an informed choice regarding their attendance at the clinic.

POLICIES AND STANDARDS

Before a clinic attempts to implement Incorporating HIV Prevention into the Medical Care of HIV-infected Persons, the following policies and procedures should be in place to protect clients and the clinic:

Clinic Support

Clinic management must demonstrate support for incorporating prevention into care by

- encouraging staff to attend 1 training related to providing prevention services (i.e., providing paid time off to attend)
- obtaining, distributing, and maintaining prevention materials
- committing to having primary care providers deliver patient counseling, and allowing providers the time to deliver prevention messages at every visit

Confidentiality

A system must be in place to ensure that the confidentiality is maintained for all clinic patients.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

Agencies must have a data handling policy that will ensure patient confidentiality and the confidentiality of chart notes and intervention reminders.

Informed Consent

All clinic patients should be informed that addressing issues of sexuality and HIV prevention is part of the standard of care at the clinic that incorporates HIV prevention into medical care. As with any patient care issues, they have the right to refuse treatment.

Legal and Ethical Policies

For clinics following these prevention guidelines, patients will be disclosing their HIV status. CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners; CBOs are obligated to inform clients of the organization's responsibilities and the organization's potential duty to warn. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Referrals

CBOs must be prepared to refer clients as needed. For clients who need additional assistance in decreasing risk behavior, providers must know about referral sources for prevention interventions and counseling, such as comprehensive risk counseling and services, partner counseling and referral services and health department and CBO prevention programs for persons living with HIV.

QUALITY ASSURANCE

The following quality assurance activities should be in place for Incorporating HIV Prevention into the Medical Care of HIV-infected Persons in CBOs that provide medical care.

Providers

The following are done to help ensure fidelity to the core elements:

Auditing

Audit charts to ensure that providers are delivering and noting the delivery of prevention messages.

Assessing

Assess providers’

- skill in eliciting behavioral information and providing prevention messages
- attitudes and beliefs about their role in delivering prevention messages
- frequency of message delivery
- satisfaction with the intervention

Observing

The clinic coordinator should ensure that materials are maintained in the waiting and examination rooms and that patient brochures and informational flyers are handed out to all patients.

Patients

Patients’ satisfaction with the services and their comfort should be assessed periodically.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

US Department of Health and Human Services, Office of Minority Health. National standards for culturally and linguistically appropriate services in health care. Washington, DC: US Department of Health and Human Services; 2001. Available at: http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf.

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1. Valleroy LA, MacKellar DA, Karon JM, et al. HIV prevalence and associated risk in young men who have sex with men. Journal of the American Medical Association. 2000;284:198–204.

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4. Crepaz N, Marks G. Towards an understanding of sexual risk behavior in people living with HIV: a review of social, psychological, and medical findings. AIDS. 2002;16:135–149.

5. CDC. Incorporating HIV prevention into the medical care of persons living with HIV: recommendations of CDC, the Health Resources and Services Administration, the National

Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR. 2003; 52(RR-12):1–24. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm.

PARTNER COUNSELING AND REFERRAL SERVICES

DESCRIPTION

Partner Counseling and Referral Services (PCRS) is a public health strategy to control and prevent the spread of HIV and other sexually transmitted diseases. Evidence suggests that a substantial number of new HIV infections in the United States originate from HIV-infected persons not yet aware of their infection.[1] PCRS helps HIV-infected persons notify their partners of exposure to HIV. It is part of a comprehensive array of services that begin when a person seeks HIV counseling and testing and continue after the client begins receiving care.

In most jurisdictions, health departments (local, state, or both) are legally responsible for ensuring the public health through the control of infectious diseases; PCRS is a strategy that most health departments use to fulfill this responsibility. For this reason, CBOs that wish to provide PCRS are required to collaborate with their health departments (local, state, or both). In some jurisdictions, state or local laws and regulations limit or prohibit PCRS being done outside the health department.

CDC is revising its guidelines for PCRS. The revised guidelines will replace the Partner Counseling and Referral Services guidelines published in 1998. Publication of the revised guidelines is expected in 2007. The guidance provided in this document may change, depending on the results of the guideline revision process; however, until that time, the recommendations in this document should be adhered to.

Goals

Voluntary PCRS, which includes partner notification, aims to identify HIV-infected persons and link them to medical, prevention, social, and other services as soon as possible after they become infected.[2–4] It also aims to inform current and past partners of HIV-infected persons of their risk so that they can seek HIV counseling, testing, and referral services, as appropriate.

How It Works

A key element of PCRS is informing current and past partners that a person who is HIV infected has identified them as a sex partner or partner who shares injection drug paraphernalia and advising them to seek HIV counseling and testing. Notified partners, who may not have suspected their risk or who may deny their risk, can then choose whether to be tested for HIV.

- **Those who choose to be tested and are found to be HIV infected** should receive early medical evaluation, treatment, social, and prevention services, including risk-reduction counseling and PCRS.
- **Those who choose to be tested and are found to be HIV negative** have the opportunity to receive primary HIV prevention interventions.

- **PCRS is confidential.** Partners are not told who reported their name or when the reported exposure occurred, and information about partners is not reported back to the original HIV-infected person.
- **PCRS is voluntary.** The infected person decides which names, if any, to reveal to the interviewer.

Research Findings

Evidence suggests that more than half of new HIV infections in the United States originate from HIV-infected persons who are not yet aware of their infection (unpublished data). PCRS has been shown to be an effective tool for reaching persons at very high risk for HIV infection. In studies of HIV PCRS, 8% to 39% of partners tested were found to have previously undiagnosed HIV infection.[5] However, a recently published survey found that, in 22 jurisdictions with HIV reporting, health departments interviewed only 32% of 20,353 persons with newly reported HIV.[6] Health department program data submitted to CDC also indicate that PCRS is highly underutilized (CDC, unpublished data). Surveys of persons seeking HIV testing, of HIV-infected persons, and of notified partners indicate acceptability of PCRS.[7–9] PCRS has been found to be cost-effective.[10–12]

In terms of which PCRS strategy is more effective, 1 observational study suggested that health department specialists were more successful than physicians at interviewing patients and locating partners.[13] Furthermore, results from a randomized trial showed that notification by health department staff was substantially more effective than notification by the infected person.[14]

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. **Core elements are essential and cannot be ignored, added to, or changed.**

PCRS has the following 6 core elements:

- Ensure that all services are voluntary and confidential.
- Identify and contact all persons with HIV (index clients) to offer them PCRS. Index clients may be persons with a new diagnosis of HIV or persons with a previous diagnosis of HIV who have ongoing risky sexual and injection drug use behaviors.
- Interview index clients who accept PCRS to elicit names of and locating information for sex partners and partners who share injection drug paraphernalia.
- Locate named partners, notify them of their exposure to HIV, provide HIV prevention counseling, and recommend HIV testing.
- Provide HIV counseling and testing to partners and ensure that they receive their test results.
- Link partners, especially those whose test results are positive, to appropriate medical evaluation, treatment, prevention, social, and other services.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

PCRS has the following key characteristics:

- Deliver PCRS through provider referral, client referral, or combined referral. (See Procedures for descriptions of referral types.)
- Deliver PCRS in a continuum of care that includes the capacity to refer sex partners and partners who share injection drug paraphernalia to HIV counseling, testing, and treatment, as well as to other services (e.g., treatment for sexually transmitted diseases, family planning, violence prevention, drug treatment, social support, housing).
- Provide client-centered counseling for HIV-infected persons and their partners to potentially reduce behavioral risks for acquiring or transmitting HIV infection. Client-centered counseling will also help the provider understand the readiness of the index client to notify partners and will enable the provider to offer services to help the index client successfully notify partners without adverse consequences.
- Offer PCRS as an ongoing service. PCRS should be offered as soon as an HIV-infected person learns his or her HIV status and should be made available throughout that person’s counseling and treatment. If new partners are later exposed, PCRS should again be made available. HIV-infected persons should be able to access PCRS whenever needed.

Procedures: Procedures are detailed descriptions of some of the above-listed elements and characteristics.

Procedures for PCRS are as follows:

Collaborating with Health Departments

PCRS is usually done by health departments; therefore, a CBO planning to provide any or all of PCRS should collaborate closely with its health department (state, local, or both) to avoid duplication of services and to ensure that all CBO procedures are consistent with health department policies and procedures. A written agreement with the health department outlining the roles and responsibilities of the CBO and the health department must be in place before a CBO implements PCRS. However, in some jurisdictions, state or local laws and regulations limit or prohibit PCRS being done outside the health department.

Addressing Core Elements

CBOs planning to provide PCRS must fully address all core elements or, if not possible, maintain formal written agreements with other agencies, organizations, or providers that will deliver the other elements. In addition, because most HIV diagnoses are made by private medical providers, CBOs should consider working with private providers as well as with other agencies and organizations involved in the care of persons living with HIV to improve their understanding of the value of PCRS and to integrate PCRS into their other services. At a minimum, CBOs providing PCRS should ensure that information about their services is easily accessible by health care providers in the public and private sectors and by other agencies and organizations responsible for providing diagnoses or services to persons living with HIV.

Interviewing Index Clients

During the interview, the PCRS provider should establish a plan for notifying partners and, if appropriate, arranging for follow-up to determine if contact was made. PCRS should be an ongoing process for index clients who have new sex partners or partners who share injection drug paraphernalia; therefore, index clients who remain sexually active or continue to use injection drugs should be counseled regarding self-disclosure of HIV status and provided opportunities to develop their disclosure skills.

Interviewing serves several functions.

- Providing client-centered HIV prevention counseling and information to the index client
- Assessing the index client's need for other services
- Making appropriate referrals
- Eliciting names of and locating information for sex partners and partners who share injection drug paraphernalia or children or infants who may have been exposed perinatally or through breastfeeding.

PCRS programs should have explicit procedures, developed in close collaboration with their health department(s), with regard to eliciting partner information, including, but not limited to

- determining the interview period (i.e., how far back in time, before the index client's diagnosis, to go to attempt to identify partners)
- following special considerations with regard to spouses
    - For example, federal legislation and related state laws and regulations may require that a good-faith effort be made to notify spouses.
    - Establish an approach for index clients who will not give consent and who will not allow the provider to notify current or past marriage partner(s).
- establishing an approach for index clients who decline to disclose partner names
- explaining to index clients all available options for notifying their partners (e.g., client referral, provider referral, contract referral, or dual referral), including advantages and disadvantages of each
- assessing and addressing potential for partner violence
    - PCRS workers should be aware of the potential for partner violence and be prepared to make appropriate referrals.
    - If the provider suspects a potentially violent situation for the index client or others, the provider must
        - make an assessment prior to notifying the partner
        - seek expert consultation before proceeding
        - comply with relevant state laws and local regulations
- Making plans for notifying partners of their exposure, including if, how, and when specific partners will be informed of their risk of exposure

Notifying Partners

Locating and notifying named partners should begin as soon as possible after the diagnosis of HIV in the index client. Partners should be informed of their possible exposure to HIV; provided with accurate information about transmission and prevention of HIV; informed of the benefit of knowing one's HIV status; assisted in accessing counseling, testing, and referral services; and cautioned about the possible negative consequences of disclosing one's own or another's HIV status.

PCRS workers should help index clients determine, from the following, the best strategy for notifying each partner named. Regardless of which approach is chosen, the PCRS provider should ensure the partners are actually informed of the exposure.

- **Provider referral.** The medical care provider, health department staff, or other PCRS provider, with permission from the index client, informs the partner or partners, and refers them to counseling, testing, and other support services. Provider referral has been shown to be more effective than client referral.
- **Patient or client referral.** The HIV-infected person accepts full responsibility for informing his or her partners of their possible exposure to HIV and for referring them to HIV counseling and testing services. Index clients should receive information and coaching regarding
  - the best way to inform their partners
  - how to deal with the psychological and social effects of HIV status disclosure
  - how to deal with partner reactions (including violence)
  - how and where partners can access counseling and testing

  Although some persons initially prefer to inform their partners themselves, many often find this more difficult than anticipated.
- **Combined Referral.** Two strategies of combined referral include elements of each above strategy.
  - **Contract referral.** The index client has a specified number of days to notify partners. If, by the contract date, the partners have not come for counseling and testing, they are contacted by the PCRS provider.
  - **Dual referral.** The index client and the provider inform the partner together. Some reports of partner violence after notification suggest a need for caution, but violence seems to be rare.[15,16]

Many states and some cities or localities have laws and regulations about informing partners of their exposure to HIV. Some health departments require that even if an index client declines to report a partner, the PCRS provider must report to the health department any partner of whom he or she is aware. Some states also have laws requiring disclosure by providers to third parties known to be at significant risk for future HIV transmission from clients known to be infected. This is called duty to warn.[17] CBOs that choose to implement PCRS should familiarize themselves with local, state, and federal regulations about informing partners of potential exposure as well as potential duty to warn. Finally, the Ryan White Comprehensive AIDS Resource Emergency Reauthorization Act requires that health departments receiving Ryan White funds show good-faith efforts to notify marriage partners of HIV-infected persons.

Offering Services to Partners

All partners notified should receive appropriate client-centered counseling and should be offered anonymous or confidential testing (if not already known to be HIV infected) and referral services. Testing may be done at the time of notification (rapid testing and collection of specimens other than blood can facilitate this type of testing) or may be accomplished by escorting or referring the partner to a counseling and testing site. For partners who choose testing methods other than rapid testing, detailed locating information should be obtained to ensure that they receive their results; for those partners who were referred, follow-up should be arranged to ensure that they received counseling and testing. Regardless of how testing is accomplished, all aspects of counseling and testing should follow CDC's guidelines[18] and must be in accordance with federal, state, and local laws, regulations, and policies, including the Clinical Laboratory Improvement Amendment. PCRS workers should also maintain referral agreements and up-to-date resource guides to provide appropriate referrals.

Prioritizing PCRS Activities

Because PCRS may place a substantial burden on resources, CBO program managers may need to develop policies for prioritizing PCRS activities, such as the order in which persons living with HIV are offered PCRS or the order in which partners are located and offered counseling, testing, and referral and PCRS. These policies should be developed in close collaboration with the appropriate health department(s). The PCRS Guidance[18] suggests that the following partners be considered high priority:

- The partner who is most likely to transmit HIV to others (highest priority)
- Partners of a recently infected client who had contact in the prior 6 months (most likely to have been exposed)
- Partners who are unlikely to be aware of their exposure to HIV
- Current partners, who may be at continued risk for infection
- Partners with a history of other sexually transmitted diseases
- Partners of clients with resistant strains of HIV

RESOURCE REQUIREMENTS

People

PCRS staffing requirements vary according to the design of the program (e.g., 1 worker may perform all 3 components [eliciting, locating, notifying], or components may be divided among workers) and the number of clients to be served.

- CBOs could serve as many as 5 to 7 new clients per week for each full-time (or equivalent) PCRS provider on staff.
- A full-time (or equivalent) supervisor (per 5 to 7 PCRS providers) will be required to
    - oversee staff
    - maintain accurate records (ensuring that all clients are reached and partners are notified and provided with, or referred to, counseling, testing, and referral
    - work with the health department to coordinate delivery of services

Depending on the needs of the CBO and the skill level of the staff, 1 or more staff member will be needed to

- work with the HIV-infected client
- locate and notify partners, with time needed depending on
    - the number of partners to contact
    - the extent and accuracy of the locating information provided
    - whether counseling and testing will be provided on site
    - the type of referrals that the client wishes to pursue
- provide other services (e.g., counseling, testing, and referral services)

    - Elicitation of partner information may be done at the time of counseling for clients whose HIV test results are positive; however, elicitation will significantly increase the amount of time required for counseling.
    - If the client is not ready or if asking about partners does not fit within the logistics of the counseling, testing, and referral service, partner information can be elicited later; however, these clients may be lost to follow-up, thereby diminishing the success of PCRS as a prevention strategy.

Space

PCRS needs space for client interviews and partner notification.

Client interviews for PCRS can be done in several places, as long as the client is assured confidentiality and privacy.

- The CBO's office or clinic is the safest and most convenient space. The office location allows for greater control over the interview process and permits access to additional personnel and materials, including medical records.
- Clients' homes will be most comfortable for them and may facilitate the process; clients may have information at home (e.g., address books, photos) to help them remember and find partners.
- Other places (crack houses, bars, housing projects, cars) may be dangerous for staff members.
- Telephone interviews may be done when efforts to meet with a client in person have been unsuccessful or when the client is not in the same city as the PCRS worker. Telephone interviews do not allow client observation and should be used with discretion and in accordance with CDC's guidelines[18] and state and local policies and procedures. When interviewing by phone, certain privacy issues must be taken into account. Interviewers must be sure
    - they are speaking directly to the client
    - cellular phones are not being used
    - no one else is on the line

Partner notification should take place at the time and place that is most convenient to the partner being notified, while still assuring confidentiality and safety.

- **Notification in person** should be done whenever possible.
- **Notification by mail** may be acceptable in certain circumstances, but should always be followed by personal contact.

If a CBO is providing rapid testing with its PCRS services, the location should accommodate the requirements for rapid testing.

RECRUITMENT

Potential index clients may be identified from among persons already served by the CBO or may be identified by other agencies, organizations, or providers and referred to the CBO for PCRS.

CBOs planning to provide PCRS should have clearly defined strategies for identifying potential index clients, such as

- all persons with a new diagnosis of HIV
- other HIV-infected persons who in the past were not offered PCRS
- HIV-infected persons who now have new sex or drug-injecting partners
- persons with previously diagnosed HIV infection who are now seeking services for sexually transmitted diseases, substance abuse (injection drug use), or family planning
- HIV-infected persons who are receiving ongoing HIV medical care or other HIV prevention or care services and are identified as having new sex or drug-injecting partners or new sexually transmitted diseases
- persons who in the past declined or only partially participated in PCRS but have now decided to participate fully

Index clients should be offered PCRS at the earliest possible opportunity. However, for persons with a new diagnosis of HIV, reactions to learning that they are infected will vary and personal circumstances will differ. PCRS workers should recognize and accommodate clients who need to resolve other issues before they will be ready to participate in PCRS. CBOs providing PCRS should have clear guidelines for these situations to avoid inappropriate delays.

Two major sources of recruitment for PCRS are health care providers (who report HIV cases to the health department according to state regulations) and counseling and testing sites. CBOs can assist with referral into PCRS by helping health care providers understand the benefits of PCRS and by ensuring that all counseling sessions delivering HIV-positive test results at counseling and testing sites include referral to PCRS.

CBOs accepting referrals for PCRS from other agencies, organizations, or providers should do so only under a formal, written agreement (e.g., memorandum of agreement, contract) that clearly describes the roles and responsibilities of each party. Such agreements should be reviewed and approved by the health department and should ensure that appropriate consents for release of information have been signed by the referred client, to allow exchange of necessary information between the CBO and the referring entity.

CBOs providing PCRS should have explicit procedures for contacting potential index clients and offering them PCRS, including, but not limited to, the following:

- How to contact them (e.g., in person, by telephone, by mail)
- What steps to take before contacting them (e.g., ensuring that the person or organization making the diagnosis of HIV knows of, and agrees with, the CBO’s plan to contact their client for PCRS)
- When to contact them (i.e., the intervals between identifying the client, initiating contact, and establishing contact)
- What to do and say when contacting them
- What to do if unable to locate them or if they decline PCRS when it is offered (e.g., notifying the health department of the situation)

Review Recruitment in this document for any additional recruitment strategies that might be appropriate for the target population.

POLICIES AND STANDARDS

Before a CBO attempts to implement PCRS, the following policies and standards should be in place to protect clients, the CBO, and the PCRS provider:

Confidentiality and Voluntary Participation

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from a client or his or her legal guardian must be obtained. In addition, persons testing anonymously must not be required to disclose their identity to receive PCRS. Finally, participation in PCRS is always voluntary, and PCRS providers should ensure that clients are aware of their right to refuse or delay participation in PCRS.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected, managed, and reported according to CDC requirements.

Informed Consent

All clients tested at CDC-funded testing sites should be informed at the earliest opportunity that PCRS services are available. CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO’s responsibility and the client’s rights as well as options for serving partners. Individual state laws apply to consent procedures for minors; but at a minimum, consent should be obtained from each client and, if appropriate, a legal guardian if the client is a minor or unable to give legal consent. For anonymously tested clients a signature is not required, but documentation that the client’s rights were explained must be maintained in the client’s record.

Legal and Ethical Policies

PCRS is an intervention that deals with disclosure of HIV status, and PCRS workers must review with the client the legal and ethical reasons for informing partners. CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners; CBOs are obligated to inform clients of the potential duty to warn and the CBO's responsibility, especially with regard to a spouse. PCRS workers should help the HIV-infected client prioritize partners to be notified on the basis of the likelihood of past or future transmission. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Referrals

CBOs must be prepared to refer clients and partners, as needed. For clients who need additional assistance in decreasing risk behavior, providers must know about referral sources for care, counseling and testing, and prevention interventions such as comprehensive risk counseling and services and health department and CBO prevention programs for persons living with HIV.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing PCRS.

Providers

Training is critical for successful PCRS. Training for PCRS workers is provided by CDC and includes

- initial training plus periodic updates on standards, objectives, and specific guidelines for PCRS
- knowledge of HIV infection, transmission, and treatment
- cultural competence with regard to eliciting information about partners
- client-centered counseling
- protecting persons' rights to privacy
- how to use scientific information for prioritizing partners
- how to administer HIV tests
- how to defuse potentially violent situations involving clients, partners, or staff
- understanding local, state, and federal laws regarding PCRS as well as health care issues, including the right to privacy and confidentiality

Quality assurance methods should be in place to ensure that appropriate standardized methods are used for

- counseling HIV-infected clients about notification of their partners
- developing a PCRS plan with HIV-infected clients
- prioritizing which partners are to be reached
- locating and informing those partners of their possible exposure to HIV
- providing immediate counseling and testing services to informed partners, referring them to other service providers, or both
- collecting, analyzing, using, and storing PCRS data

These methods should include

- written job descriptions
- periodic direct observation of PCRS workers
- peer review of selected cases
- consumer satisfaction surveys

Clients

Clients should be assured of their right to privacy and that PCRS is always voluntary.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

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RAPID HIV TESTING IN NONCLINICAL SETTINGS

DESCRIPTION

Rapid HIV Testing in Nonclinical Settings is HIV antibody testing performed on a sample of fingerstick whole blood or oral fluid. Rapid testing can be done in locations typically accessed by outreach. It offers an opportunity to take advantage of the benefits of outreach testing and ensure that tested persons receive their results. Two rapid tests—the OraQuick Advance Rapid HIV-1/2 Antibody Test and the Uni-Gold Recombigen HIV Test—can be used in selected nonclinical settings and can provide results in 10 to 20 minutes (so clients do not need to schedule a separate visit to get results). It is important to realize that reactive rapid test results must always be confirmed using a second, more specific test (e.g., the Western blot). Therefore, until the reactive result is confirmed, the result is interpreted as preliminary positive.

Background

Outreach efforts for HIV prevention activities provide access to hard-to-reach populations at high risk for HIV. Bringing HIV prevention counseling, testing, and referral to these outreach sites through the use of mobile vans and HIV tests designed for whole blood and oral fluid has helped to increase knowledge of HIV status among many groups.

CDC is revising its HIV counseling and testing guidelines. Separate guidelines are being developed for HIV testing in health care settings and HIV counseling, testing, and referral in non-healthcare settings. The guidance provided in this document may change, depending on the results of the guideline revision process; however, until that time, the recommendations in this document should be adhered to.

Specifically, Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings will be published later in 2006. They will replace CDC's 1993 Recommendations for HIV Testing Services for Inpatients and Outpatients in Acute-Care Hospital Settings; and they will update aspects of CDC's 2001 Revised Guidelines for HIV Counseling, Testing, and Referral that apply to health care settings and the 2001 Revised Recommendations for HIV Screening of Pregnant Women. In addition, the process for updating recommendations for HIV testing in non-healthcare settings is under way, with publication expected in 2007.

Goals

Rapid HIV Testing in Nonclinical Settings aims to increase knowledge of HIV status among many groups.

How It Works

By bringing testing into the community and providing test results quickly, rapid HIV tests can be used to reach groups in which HIV infection has been underdiagnosed. HIV infection is underdiagnosed when people do not recognize that they are at risk for HIV infection or they do not use conventional HIV counseling, testing, and referral services. Testing programs in nonclinical settings are more likely to reach members of some racial and ethnic minorities and persons at increased risk for HIV.

Research Findings

Studies at CDC-funded sites showed that persons tested at nonclinical (outreach) sites were 2 times as likely as persons tested at conventional (CDC-funded) testing sites to report high-risk heterosexual contacts and 3 to 4 times as likely to report injection drug use or male-to-male sex.[1]

In addition, the rate of HIV-positive test results in nonclinical settings is generally high and consistently higher than at conventional testing sites.[1] Unfortunately, many persons tested in nonclinical settings do not return for their test results. CDC's national data from 2000 indicate that of all HIV-positive results from tests performed in nonclinical settings, nearly half were never received. With rapid testing in outreach programs, however, limited experience is encouraging. In a Minnesota program, an outreach worker regularly visited CBOs, homeless shelters, chemical dependency programs, and needle exchange programs to offer rapid HIV testing. When results were provided the same day, 99.9% of those tested received their HIV test results.[2]

Interviews of persons at nonclinical settings reveal features important to the success of this type of testing. For persons at high risk at a needle exchange program and gay bath houses, 36% of those who had never been tested and 28% of those who had delayed testing gave as their reason "not wanting to go to a clinic."[3] Participants in other testing initiatives cited a desire to receive HIV results immediately and a need for testing during expanded hours as important reasons to increase alternative testing opportunities.[4]

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. **Core elements are essential and cannot be ignored, added to, or changed.**

Rapid HIV Testing in Nonclinical Settings has the following 7 core elements:

- Assess the community to determine
    - in which populations HIV is likely to be underdiagnosed (because risk is underestimated or because conventional counseling, testing, and referral services are not used)
    - where and when to reach persons who are at risk, underdiagnosed, or both
- Collaborate (written agreement) with the state health department, a laboratory, or both to ensure compliance with the Clinical Laboratory Improvement Amendments (CLIA) and state and local regulations and policies.
- Delineate a clear supervisory structure to ensure responsibility for training and guidance, oversight for testing procedures, and coordination.

- Train, or ensure training of, providers in nonclinical settings to perform rapid HIV testing. Include the following essential elements on how to
    - perform the test, including procedures done before, during, and after testing
    - integrate rapid testing into the overall counseling and testing program
    - develop and implement a quality assurance program (Guidelines are available at www.cdc.gov/hiv/rapid_testing/materials/QA-Guide.htm#qc.)
    - collect and transport specimens for confirmatory testing
    - ensure specimen integrity
    - document and deliver confirmatory test results to persons whose rapid test results had been preliminary positive
    - comply with universal and biohazard safety precautions
    - ensure confidentiality and data security
    - ensure compliance with relevant state or local regulations
- In conjunction with health departments (state, local, or both) and community mental health providers, establish clear and easy guidelines and sobriety standards to help counselors determine when clients are not competent to provide consent. Although it is important to assess sobriety level, every person who has been drinking or using other substances should not be excluded from testing. Some persons will be active substance abusers who use substances on a daily basis; these persons are generally at high risk for infection and should not be excluded from testing if they are still capable of providing informed consent. In situations where a client's sobriety and ability to provide informed consent is questionable, some counselors have found it helpful to ask the client what he or she would do in the event of a preliminary positive result. This may be 1 of several questions that counselors could use to assess an individual's ability to provide informed consent.
- Ensure confirmatory testing of preliminary positive test results.
- Provide clients who have a confirmed HIV-positive diagnosis with, or refer them to, medical evaluation, partner counseling and referral services, and other appropriate prevention services.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

Rapid HIV Testing in Nonclinical Settings has the following key characteristics:

- Arrange appropriate referral agreements (for medical and social services), and develop strategies for follow-up.
- Obtain detailed locating information for clients whose test results are preliminary positive so that the clients can be contacted and encouraged to come in for care if they fail to return for their follow-up appointment. The health department and the testing program should specify who is responsible for follow-up of clients who fail to return for confirmatory test results.
- Assemble the testing supplies for easy storage and transportation to each testing site. Individually packaged rapid test kits include all the supplies and materials needed to facilitate single-client testing in nonclinical settings.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and characteristics.

Procedures for providing Rapid HIV Testing in Nonclinical Settings are as follows:

Assessing the Community

CBOs considering the use of rapid testing in nonclinical settings should begin by assessing their community. They should seek input from community planning groups, other community-based service providers, staff from similar programs within the CBO (e.g., needle exchange or screening for sexually transmitted infections), and representatives of their target populations. They should find out where persons at high risk for HIV are likely to spend time and where rapid testing services could be delivered without an appointment, with little waiting time, and with no barriers such as transportation.

Ensuring Regulatory Compliance

If the needs assessment indicates that Rapid HIV Testing in Nonclinical Settings is both appropriate and feasible, the CBO must ensure an understanding of, and compliance with, CLIA and all state and local regulations and policies. This is done through a written agreement with the state or local health department, laboratory, or both.

The agreement delineates

- responsibility for training and guidance
- oversight for testing procedures
- coordination of services
- assurance that confirmatory testing of preliminary positive results is provided

Training Staff

Training on the essential elements of delivery of the HIV rapid test is available from CDC. CDC recommends that any persons who are responsible for the delivery of the rapid test should be trained in and familiar with

- client-centered HIV prevention counseling
- performing the rapid test
- providing and interpreting test results (including the meaning of negative, preliminary positive, and invalid test results)
- referring clients for services (social and medical)
- reporting positive test results to the state or local health department

Handling and Tracking Specimens and Materials

Rapid HIV Testing in Nonclinical Settings differs from standard counseling, testing, and referral in that rapid testing materials must be carried to the testing site. Individually packaged rapid test kits include all the supplies and materials necessary for single-client testing in nonclinical settings, but CBOs must devise a means for easy storage and transport of testing materials. In addition, specimens collected for confirmatory testing must be transported to a laboratory for analysis. Specimen handling and tracking procedures must be devised to ensure the safety and integrity of the specimen and to comply with Occupational Safety and Health Administration regulations for handling of infectious waste. An exposure control plan must be devised for potential occupational exposures.

Locating Clients
Detailed locating information must be obtained for all persons with a preliminary positive test result so that they can be contacted to come in for care should they fail to return for their follow-up appointment. The state or local health department and CBO must specify who is responsible for following up with clients who fail to return for confirmatory test results. In some states, preliminary positive results cannot be given to clients. Consideration should be given, where appropriate, to eliminating such barriers to rapid testing.

Staying Current
CBOs should frequently review the package insert for the rapid HIV test to note any recommended changes related to test delivery and use.

RESOURCE REQUIREMENTS

People

Rapid HIV Testing in Nonclinical Settings needs staff members who are trained in HIV counseling, testing, and referral and in the delivery of rapid HIV testing. Training should include all topics noted under Quality Assurance, below. The number of staff needed will vary according to the number of tests to be done. The number of tests completed per hour depends on the needs of the clients and the abilities of the counselor. Each counselor may provide between 1 and 3 tests per hour. Explaining positive results will take longer. CBOs should staff their programs according to the projected need for rapid testing in their area. This information can be obtained from an appropriate needs assessment and a review of the local epidemiologic profile (the HIV prevention community plan and other sources of relevant information).

Rapid HIV Testing in Nonclinical Settings also needs trained staff members to conduct outreach activities, follow-up and linkage to care activities, and to provide security (if testing is offered in unsafe areas or during the evening or nighttime hours).

Space

Rapid HIV Testing in Nonclinical Settings can be done anywhere that confidentiality of clients can be assured (e.g., private area or room) and where a specimen can be collected according to minimal standards as outlined by the Occupational Safety and Health Administration. The setting must have a flat surface, acceptable lighting, and ability to maintain temperature in the range recommended by the test manufacturer for performing the test. Clients must be able to stay long enough to be counseled and tested and to receive their results.

RECRUITMENT

Review Recruitment in this document to choose a recruitment strategy that will work in the setting in which the CBO plans to implement Rapid HIV Testing in Nonclinical Settings.

POLICIES AND STANDARDS

Before a CBO attempts to implement Rapid HIV Testing in Nonclinical Settings, the following policies and standards should be in place to protect clients, the agency, and the test provider:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent (for release of information) from a client or his or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Informed Consent

CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO’s responsibility and the client’s rights. In some states informed consent is not required to be written and can be given orally. Client participation must always be voluntary, and documentation of this informed consent must be maintained in the CBO’s records. Clients offered HIV testing at nonclinical settings may be under the influence of alcohol or drugs or may have chronic mental health conditions, any of which may interfere with their ability to provide informed consent for voluntary HIV testing and to understand test results. CBOs should work with their state or local health department and with community mental health providers to establish clear and easy guidelines and sobriety standards to help counselors determine when clients are not competent to provide consent. Because regulations vary by state, CBOs should be familiar with informed consent requirements in their state.

Legal and Ethical Policies

Rapid testing in nonclinical settings requires specialized training and deals with private client medical information. CBOs must know their state laws regarding who may implement counseling, testing, and referral and rapid testing and about disclosure of a client’s HIV status (whether positive or negative) to sex partners and other third parties. Additionally, some state laws prohibit the disclosure of preliminary positive test results. CBOs must also know, and adhere to all CLIA regulations for testing, documentation, and use of logs relating to test implementation. CBOs also must inform clients about state laws regarding the reporting of child abuse, sexual abuse of minors, and elder abuse, or imminent danger or harm to a specific person.

Referrals

CBOs must be prepared to refer clients as needed. Follow-up procedures for clients with preliminary positive rapid test results must be in place. A follow-up visit must be scheduled so these clients can receive confirmatory test results and referrals for care (within or outside the CBO). HIV counselors from the nonclinical setting may accompany clients to the medical center to provide support and ensure continuity of care. For clients who need additional help decreasing risk behavior, providers must know about referral sources for prevention interventions and counseling, such as partner counseling and referral services and health department and CBO prevention programs for persons living with HIV.

Safety

Counseling, testing, and referral and rapid testing services that are provided in outreach settings may pose potentially unsafe situations (e.g., the risk of transmitting bloodborne pathogens). CBOs should develop and maintain written detailed guidelines for ensuring personal safety and security in outreach settings; minimal safety standards with regard to specimen collection as outlined by the Occupational Safety and Health Administration; and the security of the data collected, client confidentiality, and the chain of custody for testing supplies and collected client specimens. Agreements with law enforcement agencies, owners of social locations such as bathhouses or sex clubs, neighborhood associations, and other key partners should be established before testing activities begin.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing Rapid HIV Testing in Nonclinical Settings:

Counselors

Training

CBOs should have a training program in place for all new and existing employees providing rapid HIV testing services. This program should ensure that all providers receive adequate training, annual training updates, continuing education, and appropriate supervision to implement rapid testing services, including training with regard to

- providing client-centered HIV prevention counseling
- providing information to persons before they are tested

- understanding HIV transmission and prevention of HIV and other sexually transmitted diseases
- understanding the history of HIV
- understanding partner counseling and referral services
- understanding comprehensive risk counseling and services
- knowing about prevention and support services in the area
- using gloves for personal protection
- disposing safely of biohazardous waste, including used lancets
- maintaining sufficient supplies and unexpired test kits and control kits (including proper storage and performance checks for new lots of test kits and shipments with external controls)
- maintaining and documenting the temperature of the room and refrigerator where the test and control kits are stored and testing is performed
- performing quality control testing and taking action (e.g., contacting the supervisor or manufacturer) if controls do not work
- collecting specimens
- performing the steps in the test procedure
- reporting results
- referring specimens or persons being tested for confirmatory testing and managing confirmatory test results
- recording test and quality control results
- conducting external quality assessment. (Please refer to www.cdc.gov/hiv/rapid_testing.)
- reviewing records and storing and destroying them when they are outdated (how long test result records are kept as part of a medical record may be subject to state or other requirements)
- troubleshooting and taking corrective action when things go wrong

Protocol Review
The training should ensure that providers are skilled and competent in the provision of services by watching them practice counseling skills integrating the rapid HIV test and watching them perform all steps of the rapid test. Quality assurance reviews can include direct observation of sessions as well as role-playing demonstration of skills. The reviews should focus on ensuring that the protocol is delivered with consistency and responsiveness to expressed client needs and should help counselors develop skills for delivering the intervention.

Control kits, available from the test kit manufacturer, should be used to ensure reliability and validity of the test process and materials. CDC also offers the Model Performance Evaluation Program to ensure accurate testing (available at www.phppo.cdc.gov/mpep/for_enrl_form.asp).

Record Review
Reviews of selected intervention records should focus on ensuring that consent is obtained and documented for all clients and that all process and outcome measures are completed as required.

Clients

Clients' satisfaction with the services and their comfort should be assessed periodically. Process monitoring systems should also track the number of referrals made and completed as well as responses to the service.

Setting

Supervisors should periodically review the settings to ensure that they are private and confidential, that the requirements of the test are met, and that the waiting time for a test at this setting does not create a barrier to testing.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

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ROUTINE HIV TESTING OF INMATES IN CORRECTIONAL FACILITIES

DESCRIPTION

Routine HIV Testing of Inmates in Correctional Facilities is a service in which HIV counseling and testing are routinely offered to all inmates as part of the standard medical intake evaluation.

Background

At the end of 2002, approximately 2 million persons were incarcerated in the United States.[1] And each year, many persons entering correctional facilities have a history of high-risk sexual behaviors, substance abuse, or both. As a result, high rates of HIV and other sexually transmitted diseases have been documented among persons entering the correctional system.[2] However, less than half of the prison systems, including 3 of the larger prison systems—California, New York, Florida— and few jails routinely provide HIV testing at time of entry.[3] Therefore, many persons who may be infected are not routinely offered HIV testing. Each year, approximately 7.5 million inmates are released back into their communities.

CDC is revising its HIV counseling and testing guidelines. Separate guidelines are being developed for HIV testing in health care settings and HIV counseling, testing, and referral in non-healthcare settings. The guidance provided in this document may change, depending on the results of the guideline revision process; however, until that time, the recommendations in this document should be adhered to.

Specifically, Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings will be published later in 2006. They will replace CDC's 1993 Recommendations for HIV Testing Services for Inpatients and Outpatients in Acute-Care Hospital Settings; and they will update aspects of CDC's 2001 Revised Guidelines for HIV Counseling, Testing, and Referral that apply to health care settings and the 2001 Revised Recommendations for HIV Screening of Pregnant Women. In addition, the process for updating recommendations for HIV testing in non-healthcare settings is under way, with publication expected in 2007.

Goals

Routine HIV Testing of Inmates in Correctional Facilities will identify HIV infection among those who are unaware of their HIV status or those who have had a previous negative test result and can confirm the HIV status of inmates who report that they are HIV infected. Prevention and care services can then be provided to those who need them, both while they are in the correctional system and after their release.

How It Works

Routine HIV testing can be either standard enzyme immunoassay and Western blot testing or rapid HIV testing with appropriate confirmatory testing. For persons incarcerated for fewer than 30 days, routinely providing rapid HIV counseling, testing, and referral services can greatly increase the proportion tested and notified of their test results before release. These persons can then access partner counseling and referral services, prevention, and care services while in the correctional system and after release.

To address the HIV prevention needs of inmates, CBOs must collaborate with the state or local health department, state and local justice and correctional departments, and officials for the individual correctional facility. If rapid testing will be implemented in the correctional setting, please see Rapid HIV Testing in Nonclinical Settings in this document for further guidance. Health departments or agencies approved to provide partner counseling and referral services should initiate this service for contacts of HIV-infected persons.

Research Findings

The RESPECT 2 study showed that HIV counseling, testing, and referral that used a rapid HIV screening test was as effective as conventional HIV counseling, testing, and referral.[4]

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. **Core elements are essential and cannot be ignored, added to, or changed.**

Routine Testing of Inmates in Correctional Facilities has the following 8 core elements:

- Adhere closely to all rules and regulations of the correctional facility to ensure the safety of CBO employees, inmates, and facility staff.
- Routinely offer HIV counseling and testing to all inmates who are provided a medical evaluation at intake.
- Provide all counseling, testing, and referral services consistent with CDC's *Revised Guidelines for HIV Counseling, Testing, and Referral.*
- When using the rapid HIV test, follow all standards and procedures related to its use, including guidelines for providing preliminary results and obtaining specimens for confirmatory testing.
- Notify all tested inmates of their HIV test result (whether positive or negative) confidentially and in person.
- Refer HIV-infected persons to partner counseling and referral services, medical care and treatment, and prevention services in the correctional facility, in the community, or both.
- Refer HIV-negative persons at high risk to prevention services in the facility, in the community, or both.

- Provide referral and linkage to care, treatment, and prevention services in the community for HIV-infected persons or HIV-negative persons at high risk being released from the correctional facility.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

Routine HIV Testing of Inmates in Correctional Facilities has the following key characteristics:

- Develop an information sheet with all relevant information about HIV prevention counseling, testing, and referral services; distribute it to all inmates in the orientation package, display posters that convey the information in the facility, or both.
- Establish a system to document consent for testing, record test results, and track specimens sent for confirmatory testing.
- Test inmates before, during, or shortly after the intake medical evaluation.
- Collaborate with the correctional facility to devise a strategy for reporting positive HIV test results to the state health department.
- Identify key contacts within the CBO and at the correctional facility to provide accountability and continuity in the collaboration.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and characteristics.

Procedures for Routine Testing of Inmates in Correctional Facilities are as follows:

Assessing

CBOs should initiate discussions with officials at correctional facilities that do not routinely offer HIV testing to inmates during the intake medical evaluation to determine their willingness to implement routine testing as a standard component of the medical intake evaluation. Additionally, CBOs, in collaboration with the medical staff at the facility, should assess whether rapid HIV testing should be offered by facilities implementing routine testing.

Collaborating

CBOs must collaborate with the state or local health department, state and local justice and correctional departments, and officials for the individual correctional facility (including correctional officers and medical staff) to develop policies and procedures that promote successful training for staff of CBOs and correctional facilities and that promote routine HIV screening and prevention services in correctional facilities.

CBOs should consider working with facility officials to promote the importance of routine testing. They should also address policies related to confidentiality and data security, documenting test results and providing inmates confidential notification of their HIV test results. Informed consent for the HIV test should be obtained in a manner consistent with state laws and facility requirements.

Relationships between the CBO, the correctional facility, health departments (state, local, or both), and other service providers inside and outside the facility should be formally documented. CBOs should document relationships and delineate the roles and responsibilities of each partner in a memorandum of understanding. The CBO and correctional facility officials should designate key contacts to provide accountability and continuity in the collaboration and referral process.

Providing Information

If the facility does not already have an information sheet that has been approved by the health department or Department of Corrections, the CBO should collaborate with medical personnel at the jail or prison to design one. This sheet can be given to all inmates prior to their intake medical evaluation. It should

- describe the risk factors for transmitting or acquiring HIV
- describe features of the HIV antibody test and possible results
- describe services for HIV prevention, support, and care available inside and outside the facility
- advise the inmate that HIV prevention counseling, testing, and referral is provided as a routine part of the intake medical evaluation

Testing

Prisons typically detain inmates for 1 year or longer, and jails typically detain inmates for less than 1 year. Therefore, the CBO should provide either conventional HIV testing with an enzyme immunoassay test followed by a Western blot test, or rapid HIV testing with Western blot confirmatory testing for preliminary positive diagnoses in prison inmates and rapid HIV testing with Western blot confirmatory testing for preliminary positive diagnoses in jails. Regardless of which strategy is used, testing must follow CDC's *Revised Guidelines for HIV Counseling, Testing, and Referral;* anyone providing this service should be trained in HIV prevention counseling, testing, and referral. In addition, if the rapid test is used, the CBO representative should have completed training in proper use of the test.

Referring

The CBO should work with correctional officials to identify HIV-related services within the facility and in the community. They should work together to refer all persons with a positive test result and HIV-negative persons at high risk for infection to appropriate care, treatment, or prevention services, as appropriate. The services to which the inmate is referred will be determined by his or her needs and duration of incarceration. When possible, the initial care appointment should occur while the inmate is in the correctional facility, and a plan should be made for continuation of care after release. Inmates with positive test results should be offered and encouraged to participate in partner counseling and referral services, either by referral to the local or state health department or by the CBO, if appropriate. Other services, including discharge planning, should be available either from the correctional facility, the CBO, or by referral and should be initiated before release from the facility.

RESOURCE REQUIREMENTS

People

Routine Testing of Inmates in Correctional Facilities needs paid or volunteer staff members who are trained in HIV counseling, testing, and referral. If rapid HIV testing will be used, involved staff members must be trained in the delivery of rapid HIV testing. All polices, quality assurance requirements, and local and state requirements related to rapid HIV testing must be followed. The number of staff needed depends on the number of tests to be done and the type of test used (rapid or conventional). Each counselor may do 1 to 3 tests per hour. Explaining positive test results will take more time. CBOs should staff their programs according to the projected need for testing at the correctional facility. This information can be obtained by reviewing the facility's medical procedures and intake process.

Space

Routine HIV Testing of Inmates in Correctional Facilities can be done anywhere in the correctional facility that confidentiality of clients can be assured (e.g., private area or room) and where a specimen can be collected according to minimal standards as outlined by the Occupational Safety and Health Administration. Additionally, for rapid testing, the setting must have a flat surface, acceptable lighting, and ability to maintain temperature in the range recommended by the test manufacturer for performing the test.

RECRUITMENT

CBOs implementing Routine Testing of Inmates in Correctional Facilities should encourage medical providers at the facility to promote HIV testing during the intake medical evaluation. Posters displayed in the facility and information sheets distributed during the intake process can facilitate discussions about HIV risk and testing and can serve as a reminder for the care provider to discuss HIV risk with inmates and to refer them for counseling, testing, and referral services.

Due to the very short detention period for many inmates in jail settings many inmates may be released before an intake medical is provided. To reach this population, a mechanism should be developed so that these inmates can request and be provided with an HIV test prior to release

POLICIES AND STANDARDS

Before a CBO attempts to implement Routine Testing of Inmates in Correctional Facilities, the following policies and procedures should be in place to protect inmates, the correctional facility and staff, the CBO, and the test provider:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which an inmate is referred, signed informed consent from the inmate or his or her legal guardian must be obtained. If the referral is within the correctional facility, rules regarding communication between departments must be followed.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of inmates, if possible, or make translation available, if appropriate. CBOs should facilitate community and inmate involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competence in programs and services. Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements and state and federal statutes.

Facility Regulations

Regulations of correctional facilities are designed for the protection of inmates, staff, and visitors to the facility. It is essential that CBOs who wish to partner with a jail or prison understand and follow all rules of the facility.

Informed Consent

CBOs must have a consent form that is consistent with the state’s HIV testing requirements. In some states informed consent can be given in either oral or written form. Inmate participation must always be voluntary, and documentation of this informed consent must be maintained in the inmate’s medical record. Regulations vary by state; therefore, CBOs should be familiar with and adhere to informed consent requirements in their state.

Legal and Ethical Policies

Routine testing of inmates in correctional facilities requires specialized training and deals with private inmate medical information. CBOs must follow their state laws and prison policies regarding who may implement counseling, testing, and referral and rapid testing procedures and regarding disclosure of an inmate’s HIV status (whether positive or negative) to sex partners, correctional officers, and other third parties. Additionally, some state laws prohibit the disclosure of preliminary positive HIV test results. CBOs must also know and adhere to all Clinical Laboratory Improvement Amendments regulations for testing, documentation, and use of logs relating to test implementation. CBOs must inform inmates about state laws regarding the reporting of child abuse, sexual abuse of minors, elder abuse, or imminent danger or harm to a specific person.

Referrals

CBOs must be prepared to refer inmates as needed. Providers of HIV testing must know about and have linkage relationships with referral sources for care and prevention interventions and counseling, such as partner counseling and referral services, and health department and CBO prevention programs for persons living with HIV and for inmates who need additional assistance in decreasing risk behavior.

Safety

Counseling, testing, and referral and rapid testing services that are provided in correctional facilities may pose potentially unsafe situations (e.g., the risk of transmitting bloodborne pathogens or risk to personal safety). CBOs should collaborate with corrections officials to develop and maintain written detailed guidelines for ensuring personal safety and security in correctional facilities; for ensuring minimal safety standards regarding specimen collection as outlined by the Occupational Safety and Health Administration; and for safeguarding the security of the data collected, inmate confidentiality, and the chain of custody for testing supplies and specimens collected from inmates.

Volunteers

If the CBO uses volunteers to assist with or conduct counseling, testing, and referral services, then the CBO should know and disclose how their liability insurance and worker's compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing Routine Testing of Inmates in Correctional Facilities:

Counselors

Training

A training program should be in place for all new employees, existing employees, and volunteers who will be providing counseling, testing, and referral services. This program should ensure that all counseling, testing, and referral providers receive

- adequate training
- annual training updates
- continuing education
- adequate supervision to implement counseling, testing, and referral services and the rapid HIV test, if appropriate

The program should also ensure that providers of counseling, testing, and referral are skilled and competent in the provision of services (by using observed practice of counseling, testing, and referral sessions with feedback to counselors and of rapid HIV test procedures, if needed).

Protocol Review

A review mechanism should be in place to ensure that all testing protocols are followed as written. Quality assurance activities can include observation of sessions as well as role-playing demonstration of skills. The review should focus on ensuring that the protocol is delivered with consistency and responsiveness to expressed client needs and should help counselors develop skills for delivering the intervention.

Record Review

Selected medical record reviews should focus on assuring that consent was obtained or documented for all clients and all process and outcome measures are completed as required.

Inmates

Inmates’ satisfaction with the services and their comfort should be assessed periodically. Process monitoring systems should be used to track the number of referrals made, the number completed, and response to the service. Satisfaction with services may differ according to whether obtained while inside the correctional facility or after discharge. Both should be assessed, whenever possible.

Setting

Supervisors should periodically review the testing facility to ensure that a private and confidential setting is available for testing and that the waiting time for a test at this setting does not create a barrier to testing. Feedback should be solicited from correctional officers to ensure that test providers are adhering to the rules and regulations of the facility. Barriers to providing testing may be space available to conduct testing, availability of corrections officers to escort inmates, and the number of inmates being processed.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

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UNIVERSAL HIV TESTING OF PREGNANT WOMEN

DESCRIPTION

Universal HIV Testing of Pregnant Women is a service to identify women who are HIV infected during pregnancy. CBOs should consider providing referral services to medical providers who serve women to ensure that the HIV prevention and service needs of both HIV-infected and HIV-negative women at high risk and their children are met. CBOs who choose to partner with medical providers should document this relationship and delineate the roles and responsibilities of each partner in a memorandum of understanding.

Background

Since the first pediatric case of HIV infection was documented in 1984, tremendous medical and public health achievements have been made in preventing mother-to-child transmission of HIV. A key step toward ensuring that the perinatal HIV interventions offered are effective is making sure that care providers know the HIV status of the pregnant women in their care.

CDC is revising its HIV counseling and testing guidelines. Separate guidelines are being developed for HIV testing in health care settings and HIV counseling, testing, and referral in non-healthcare settings. The guidance provided in this document may change, depending on the results of the guideline revision process; however, until that time, the recommendations in this document should be adhered to.

Specifically, Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings will be published later in 2006. They will replace CDC’s 1993 Recommendations for HIV Testing Services for Inpatients and Outpatients in Acute-Care Hospital Settings; and they will update aspects of CDC’s 2001 Revised Guidelines for HIV Counseling, Testing, and Referral that apply to health care settings and the 2001 Revised Recommendations for HIV Screening of Pregnant Women. In addition, the process for updating recommendations for HIV testing in non-healthcare settings is under way, with publication expected in 2007.

Goal

The goal is reducing mother-to-child HIV transmission in the United States. This goal can be met by identifying pregnant women for whom antiretroviral and obstetric interventions can reduce the newborn’s risk for HIV infection.

How It Works

Maximal reduction of perinatal HIV transmission in the United States depends on ensuring that

- pregnant women receive prenatal care
- all pregnant women are routinely screened for HIV
- recommended antiretroviral regimens are used during pregnancy, labor, delivery, and after birth for HIV-infected women and their newborns, and obstetrical interventions are provided during labor and delivery when indicated
- routine HIV screening during labor and delivery, or to the newborn after birth, is available to women whose HIV status has not been previously determined[1]

Opt-in Approach
Pregnant women are given pretest counseling and must specifically consent, usually in writing, to an HIV test.

Opt-out Approach (recommended by CDC)
Pregnant women are notified that an HIV test will be included in the standard battery of prenatal tests and procedures and that they may decline testing.

Research Findings

When a woman is identified as being HIV-infected during pregnancy, antiretroviral and obstetrical interventions can reduce her risk for transmitting HIV to her child to 2% or less. When preventive antiretroviral treatment is not initiated until labor or birth, the risk for transmission is 9% to 13%.[2–4] In the United States, without any intervention, the risk for transmission is approximately 25%.[5]

Opt-in Approach
Among states in which the opt-in approach was used and in which data were collected from medical records during 1998–1999, testing rates ranged from 25% to 69%. Population-based data from Canada showed testing rates in 3 provinces using the opt-in approach to be 54% to 83%.

Opt-out Approach
In contrast, medical record data from Tennessee, which uses the opt-out approach, revealed a testing rate of 85%. Data from Canadian provinces using opt-out approaches showed a 98% testing rate in Alberta and a 94% testing rate in Newfoundland and Labrador. At the University of Alabama's 8 prenatal clinics, HIV testing rates rose from 75% to 88% after the opt-out approach was implemented.[6]

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. **Core elements are essential and cannot be ignored, added to, or changed.**

Universal HIV Testing of Pregnant Women has the following 6 core elements:

- Routinely offer universal prenatal HIV testing.

- Routinely offer rapid HIV testing during labor for women whose HIV status is still unknown.
- Offer rapid HIV testing postpartum for women of unknown HIV status or for their newborns when rapid testing at labor and delivery is not possible or has been previously refused. (Some states mandate screening of newborns in these circumstances.)
- Perform confirmatory testing for all preliminary positive rapid HIV test results.
- When using the rapid HIV test, follow all standards and procedures related to the use of the rapid test, including guidelines for providing preliminary results and obtaining specimens for confirmatory testing (see Procedural Guidance for Rapid HIV Testing in Nonclinical Settings in this document for additional information on the rapid HIV test).
- For pregnant women with positive HIV test results, facilitate access to appropriate obstetric, medical, and social services for prevention, care, and treatment and follow-up for their newborns.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the CBO or target population.

Universal HIV Testing of Pregnant Women has the following key characteristics:

- Develop an information sheet with all relevant information regarding HIV prevention counseling, testing, and referral services; distribute this sheet at gynecologic appointments or during labor.
- Offer testing on an opt-out basis.
- During the third trimester of pregnancy or during labor, rescreen all women who are seen in health care facilities in which HIV prevalence is high (> 0.5% prevalence among women of childbearing age) or who are seen in facilities in which prevalence is low but the women are at high risk for HIV infection.
- Establish a system to document test results and to track specimens sent for confirmatory testing.
- Develop a system to document and track refusal of HIV testing.
- Partner with care providers to provide information about the expected public health benefits of the opt-out approach to local representatives of national health care provider organizations, community groups that focus on maternal and child health issues, and state and local government officials.

Procedures

Procedures are detailed descriptions of some of the above-listed elements and characteristics.

Procedures for Universal HIV Testing of Pregnant Women are as follows:

Promoting Testing

CBOs should initiate discussions with care providers serving pregnant women about

- the benefits of routine testing for HIV
- the benefits of partnering to address routine testing of their patients
- the ability of the CBO to provide client-centered posttest counseling without disrupting the flow of the clinic
- ready access to services and referrals for women whose HIV test results are positive

Training

CBOs should work with the state or local health department and the AIDS Education and Training Centers of the Health Resources and Services Administration to facilitate the training of providers who choose to partner with the CBO. Training should ensure use of the opt-out approach, including documenting in a woman's medical chart her HIV test results or that she has declined testing.

Providing Information

In collaboration with medical providers, CBOs should design an information sheet to be given to all untested pregnant women during their medical appointments. Informational videos may also be used. The information should

- describe risk factors for transmitting or acquiring HIV
- describe features of the HIV antibody test and possible results
- describe the benefits to mother and child of knowing about and treating HIV
- list HIV prevention, support, and care services available within the community
- advise the women that HIV testing is provided as a routine part of prenatal care and that they have the right to decline the test

Testing During Prenatal Care

The HIV antibody test may be included in a standard battery of laboratory tests used. Although informed consent is required for HIV testing, if the provider has informed a woman that the HIV test is included in the standard battery and that she can decline testing, consent for the battery of tests may be sufficient; however, CBOs should be aware of their relevant state laws. HIV test results or the refusal to be tested should be documented in the woman's medical chart. Fact sheets on HIV testing for providers, an information sheet on HIV and other prenatal tests for women, and forms for documenting HIV test results or refusal have been developed by the American College of Obstetricians and Gynecologists and are available on their Web site.

Retesting

For women at health care facilities in which HIV prevalence is high (> 0.5% prevalence among women of childbearing age) or who are in facilities in which prevalence is low but the women are at high risk for HIV infection (e.g., women with HIV-infected partners), testing should be offered a second time if the test was initially declined or if the initial results were negative.

Testing at Labor and Delivery

If the woman's HIV status is unknown at the time of labor and delivery, rapid HIV testing should be offered. Working with key partners, CDC has developed a model protocol for implementing rapid HIV testing in labor and delivery settings. Again, the woman should be informed, as described above under Providing Information.

If the mother’s HIV status remains unknown after delivery, rapid HIV testing should be offered for the mother or the newborn as soon as possible. Some states mandate screening of the newborn in this circumstance. CBOs should be aware of their individual state laws.

Preventing Transmission

A woman who receives a positive HIV test result at any time during pregnancy or labor and delivery should be informed that medications can be given to her and to her child to reduce the chance that the child will become HIV infected. For some women, a scheduled cesarean section at 38 weeks gestation may be indicated. A woman whose rapid test results during labor and delivery are preliminary positive should immediately be offered medication for her and her child to reduce the chance that the child will become HIV infected. Preliminary positive results should be confirmed with a Western blot or immunofluorescence antibody test.

RESOURCE REQUIREMENTS

People

Universal HIV Testing of Pregnant Women needs paid or volunteer staff members who are trained in providing information about HIV testing and referral. If rapid HIV testing will be used, involved staff members must be trained in the delivery of rapid HIV testing. The number of staff needed depends on the number of tests needed and the type of test used. The number of tests completed per hour depends on the needs of the clients, the abilities of the counselor, and the type of test used (rapid or conventional).

Space

Universal HIV Testing of Pregnant Women can be done anywhere that confidentiality of clients can be assured (e.g., private area or room) and where a specimen can be collected according to minimal standards as outlined by the Occupational Safety and Health Administration. Additionally, for rapid testing, the setting must have a flat surface, acceptable lighting, and ability to maintain temperature ability in the range recommended by the test manufacturer for performing the test.

RECRUITMENT

CBOs implementing Universal HIV Testing of Pregnant Women should encourage medical providers at the partner clinics to promote HIV testing during prenatal care visits, during labor and delivery, or during the postpartum period. Information sheets or videos used during the prenatal visits can facilitate discussions about HIV risk and testing and can remind the provider to offer testing or refer women for counseling, testing, and referral.

POLICIES AND STANDARDS

Before a CBO attempts to implement Universal HIV Testing of Pregnant Women, the following policies and standards should be in place:

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client or her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to these different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, which should be used as a guide for ensuring cultural competence in programs and services. Please see Ensuring Cultural Competence in the Introduction of this document for standards for developing culturally and linguistically competent programs and services.

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Informed Consent

Women should be told that HIV testing will be included in the standard battery of prenatal tests and procedures and that they have the right to decline testing. This information may be included in a consent form that women sign for all prenatal care and services. Specific procedures regarding consent will depend on state and local laws, regulations, and policies. Refusal to be tested should be documented in the medical chart.

Legal and Ethical Policies

Universal HIV Testing of Pregnant Women requires specialized training and deals with private medical information. CBOs must know their state laws regarding who may offer HIV testing to clients, conduct rapid HIV testing, and provide results and referrals. Knowledge of the laws regarding disclosure of a client’s HIV status (whether positive or negative) to sex partners and other third parties is also important. Additionally, some state laws prohibit the disclosure of preliminary positive test results. CBOs must also know, and adhere to all Clinical Laboratory Improvement Amendments regulations for testing, documentation, and use of logs relating to test implementation. Some states require that newborns be screened for HIV if the mother's HIV status is unknown. CBOs and their medical provider partners should be familiar with state laws regarding this requirement. Finally, CBOs must inform clients about state laws regarding the reporting of child abuse, sexual abuse of minors, and elder abuse.

Referrals

CBOs must be prepared to refer clients as needed. In addition, CBOs must provide necessary referrals for newborns exposed to HIV. For clients who need additional assistance in decreasing risk behavior, providers must know about and have linkage relationships with referral sources for HIV and ongoing gynecologic care as well as prevention interventions and counseling, such as partner counseling and referral services and health department and CBO prevention programs for persons living with HIV.

Safety

HIV testing services may pose potentially unsafe situations (e.g., the risk of transmitting bloodborne pathogens). CBOs should develop and maintain written detailed guidelines for ensuring minimal safety standards with regard to specimen collection as outlined by the Occupational Safety and Health Administration and for safeguarding the security of the data collected, client confidentiality, and the chain of custody for testing supplies and collected client specimens.

Volunteers

If the CBO uses volunteers to assist with or conduct testing and referral services, then the CBO should know and disclose how their liability insurance and worker's compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing Universal HIV Testing of Pregnant Women:

Counselors

Training

CBOs should have a training program in place for all new employees, existing employees, and volunteers that will be providing counseling, testing, and referral services. This program should ensure that all providers of counseling, testing, and referral receive

- adequate training
- annual training updates

- continuing education
- adequate supervision to implement counseling, testing, and referral services and the rapid HIV test, if appropriate

The program should also ensure that counseling, testing, and referral providers are skilled and competent in the provision of services (by using observed practice of counseling, testing, and referral sessions with feedback to counselors and of rapid HIV test procedures, if needed).

Protocol Review
CBOs should have in place a review mechanism to ensure that all testing protocols are followed as written. Quality assurance activities can include observation as well as role-playing demonstration of skills. The review should focus on ensuring that the protocol is delivered with consistency and responsiveness to expressed client needs and should help counselors develop skills for delivering the intervention. Selected intervention record reviews should focus on assuring that consent was obtained or documented for all clients and all process and outcome measures are completed as required. For CBOs using rapid HIV test technology, control kits (available from the test kit manufacturer) should be used to ensure reliability and validity of the test process and materials. (For quality assurance activities related to rapid HIV testing, please review the Procedural Guidance for Rapid HIV Testing in Nonclinical Settings in this document.)

Clients
Women's satisfaction with the services and their comfort should be assessed periodically. Process monitoring systems should also track the number referrals made, the number of referrals completed, and response to the service.

Setting
Supervisors should periodically review the testing facility to ensure that a private and confidential setting is available for testing and that the waiting time for a test at this setting does not create a barrier to testing. Feedback should be solicited from medical providers to ensure that test providers are integrated appropriately into the clinic setting.

MONITORING AND EVALUATION

At this time, specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators is under review and will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management, data collection and evaluation guidance and training, and software implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC using PEMS. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies aimed at assessing the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

CDC. Dear Colleague letter. April 22, 2003. Available at: http://www.cdc.gov/hiv/projects/perinatal/2003/letter.htm.

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US Department of Health and Human Services, HIV/AIDS Bureau. AIDS Education Training Centers. Available at: http://hab.hrsa.gov/educating.htm.

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Glossary

Adapting—changing who receives the intervention or where it is delivered.

Appropriate—includes cultural and community values, gender, language, and age-related considerations.

Cultural competence—addressing the culturally relevant factors, risk behaviors, and risk determinants that place the population at risk for HIV infection. It is more than just having a member of the target population deliver an intervention.

> **Culture** refers to the patterns of behavior (language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups).
>
> **Competence** implies having the capacity to work within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

Feasible—includes human and fiscal resources as well as the level of skill attainment agency staff will need to implement the evidence-based intervention.

Formative evaluation—a series of activities through which you gather information needed to adapt and develop your intervention.

Community gatekeepers—people who can help or hinder delivery of an intervention in a particular community or with a particular population.

Logic model—a program plan that links an evidence-based problem statement to intervention activities that address the problem statement.

Recruitment—bringing members of a target population into HIV prevention interventions, programs, and services.

Risk determinants—things (behaviors, environment, circumstances) that put people at risk for HIV infection.

Risk for HIV infection—performing behaviors (in settings with high HIV prevalence or with HIV-infected persons) that put oneself at risk for HIV or other sexually transmitted diseases.

Very high risk for HIV infection—having, within the past 6 months had unprotected sex with a person who is living with HIV, unprotected sex in exchange for money or sex, unprotected sex with multiple (more than five) or anonymous partners, multiple or anonymous needle-sharing partners, or a diagnosis of a sexually transmitted disease.