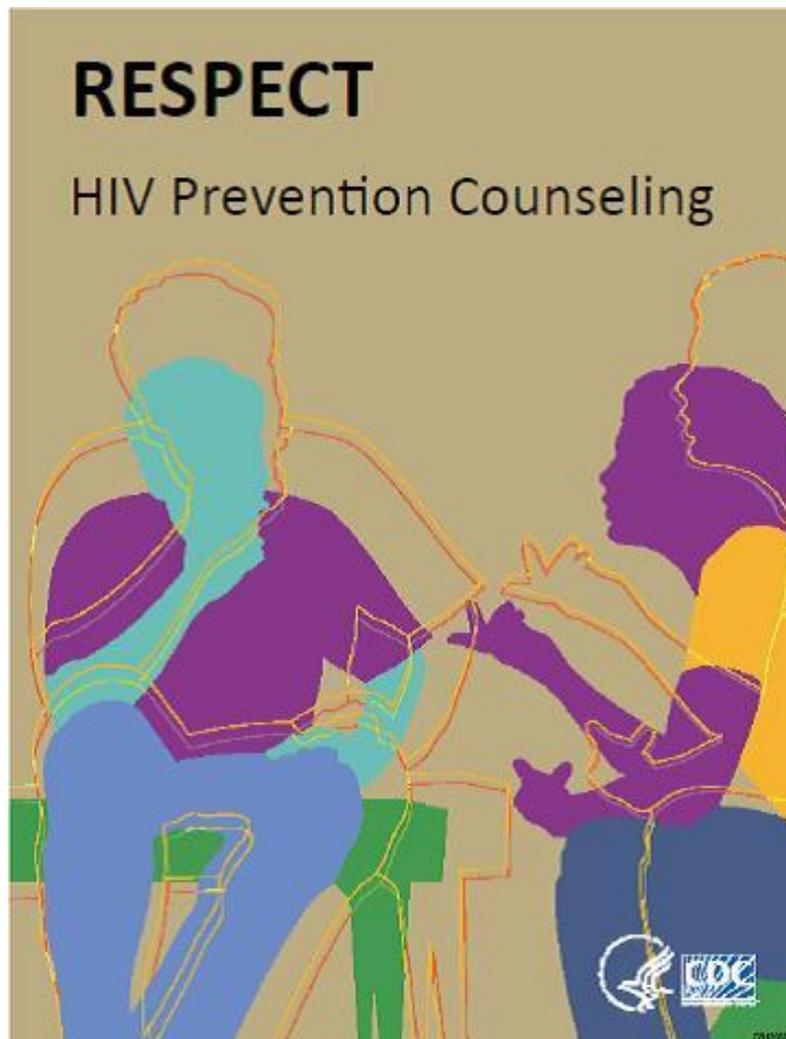


RESPECT

HIV Prevention Counseling

Manual



The RESPECT Counseling model is an individual level HIV prevention counseling model focusing on a client's unique, personal risk. It is designed to support individuals in reducing a client's HIV risk by increasing the client's sense of personal risk and developing incremental risk-reduction strategies.

Acknowledgments

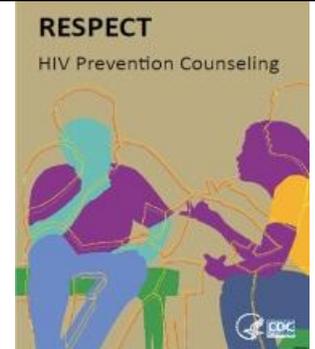
Many individuals collaborated on the development of the training curriculum, and the authors are indebted to each of them. The original iteration of this curriculum was developed with RTI International, the team included Elizabeth Frentzel Jaël, M.P.H., William Zule, Dr.P.H., Molissa Polier, M.Ed., Rachel Ellerson, and Sharon Barrell.

This training curriculum was significantly updated and revised with the team from the California STD/HIV Prevention Training Center. Specifically, we would like to thank Greg Mehlhaff, Linda DeSantis, M.Ed., Alice Gandelman, M.P.H., Miriam Garfinkel, M.A. M.F.T., and Stacy Vogan, M.P.H. who provided extensive input and expertise into the development of the materials. We would also like to thank Ed Wolf and the San Francisco AIDS Health Project, who provided additional materials.

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OVERVIEW OF THE RESPECT IMPLEMENTATION GUIDE

The purpose of the *RESPECT Implementation Guide* is to establish the guidelines and procedures necessary to implement and deliver the intervention with fidelity. This manual will help Health Departments, community-based organizations (CBOs) and other agencies devise an appropriate plan of action for delivering the intervention effectively. This manual contains all of the instructional information needed to deliver, and conduct quality assurance procedures. However, agencies will need to purchase and generate additional resources required for the intervention that are not immediately included in this manual (such as all of the materials and supplies for conducting *RESPECT* with rapid testing as outlined in the Agency Capacity Check List, and an *Area Resources List* of local services for high-risk and HIV-positive clients). The Centers for Disease Control and Prevention (CDC) will provide health department and CBO staff with training for the intervention and technical assistance, as needed. CBOs also should seek technical assistance for implementing *RESPECT* from their local health departments. Information about CDC's training schedule for the *RESPECT* intervention can be found at www.effectiveinterventions.org.

INTENDED AUDIENCE

The intended audience for this manual is CBO, health department, and agency staff who plan to implement the *RESPECT* intervention. The manual is distributed as part of CDC's *RESPECT Training of Facilitators* course and assumes that the users of the manual have completed the training.

ORGANIZATION OF THE MANUAL

The manual contains the following documents:

- 1. RESPECT Implementation Guide:** This Participant Manual has been adapted for the Single-session *RESPECT* with rapid testing. It includes information on the *RESPECT* counseling and behavior change logic model, core elements, key characteristics, and theoretical foundation. It outlines each session and the stages for carrying out the counseling objectives of the intervention for implementing 2-Session *RESPECT* for those agencies that continue to implement 2-Session *RESPECT*, and the Single-Session *RESPECT* with rapid testing. It also contains slides for both 2-Session and Single Session with rapid testing.
- 2. Single-Session Provider Cards & 2-Session Provider Cards:** The Provider Cards contain information to carry out each protocol stage effectively. It describes the purpose or rationale for each specific stage, and what needs to be accomplished. A table with protocol prompts and example dialogue outlines the activities and the order to follow for each stage, and gives examples for delivering them. For those who need the 2-Session Provider cards, they are also included on the participants cd and can be downloaded from the www.effectiveinterventions.org.

3. **RESPECT Behavior Change Logic Model:** provides a systematic and visual representation of the internal logic of the *RESPECT* intervention.
4. **Appendices:** This section contains quality assurance forms to ensure that *RESPECT* is implemented with fidelity; website addresses for retrieving the latest versions of CDC guidelines; DEBI required materials recommended by CDC; examples of tools; a sample budget and an agency readiness tool that should be reviewed before beginning implementation of *RESPECT*. The manual also contains a “Resources” section of supplemental information and materials for the counselors/implementers to read and explore to enhance their knowledge and skills in relevant areas. These include:

Appendix A: RESPECT & RESPECT 2 Studies

Appendix B: CDC Procedural Guidance and Fact Sheet

Appendix C: PWP (Prevention with Positives) Information

Appendix D: Cognitive Dissonance Theory

Appendix E: Quality Assurance Forms
Quality Assurance Observation Protocol
Quality Assurance Direct Observation: RESPECT with Rapid Testing Form
RESPECT Counseling Session Notes Form

Appendix F: Resources: Websites for retrieving the latest versions of the following:
Revised Guidelines for HIV Counseling, Testing and Referral MMWR
Quality Assurance for HIV Prevention Counseling in a Multi-Center
Randomized Controlled Trial
Partner Counseling and Referral Services Guidelines
Revised Guidelines for HIV Counseling, Testing and Referral and Revised
Recommendations for HIV
Screening of Pregnant Women
Rapid Testing QA Guidelines

Appendix G: DEBI Required Materials
MMWR Nonoxynol-9 Spermicide Contraception Use ---United States, 1999
Fact Sheet for Public Health Personnel: Male Latex Condoms and Sexually
Transmitted Diseases
Content of AIDS-related written materials, pictorials, audiovisuals,
questionnaire, survey instruments, and educational sessions in CDC assistance
programs
The ABCs of Smart Behavior
Notice to Readers: CDC Statement on Study: Results of Product Containing
Nonoxynol-9

Appendix H: Cost to Implement RESPECT HIV Prevention Counseling

Appendix I: Agency Readiness Tool

Appendix J: A CD of entire implementation package

RESPECT Models of HIV Prevention Counseling

Introduction

A great deal of progress has been made in the development and testing of programs to reduce higher risk behaviors. These efforts have produced a number of effective, evidence-based interventions, including the 2-Session RESPECT and the most recently adapted Single Session RESPECT with Rapid Testing.

This counseling model consists of one-on-one interactive counseling sessions. The sessions follow a structured protocol that guide the provider to elicit and discuss the clients' risk situations, to conduct personalized risk assessment, and encourage and assist clients to develop a risk-reduction step. The 2-Session RESPECT model was designed for use with HIV testing that followed the "standard" protocol, consisting of an enzyme immunoassay followed by confirmatory testing, if indicated.

In Session 1 (Pre-Results Session), the client's understanding of his or her personal risk for becoming HIV infected is increased and a realistic step toward risk reduction is developed and supported. If counseling is being conducted in a test setting, a specimen is taken for HIV testing at some time before, during or immediately after this session. In Session 2 (Post-Results Session), the client is guided by the provider to review and revise his or her risk-reduction step. If in a test setting, the results will be given at the beginning of this session.

The RESPECT model is consistent with the CDC recommendations for advancing HIV prevention (AHP) and the National HIV/AIDS Strategy, which emphasize that people learn their HIV status and are provided with support for reducing HIV transmission and for referral to care, treatment, and prevention services. This document focuses on training for Single-Session RESPECT

with Rapid Testing with support for 2-session RESPECT.

What is the 2-Session RESPECT Model?

The 2-Session RESPECT HIV Prevention Counseling model (2-Session RESPECT) focuses on the client's personal risk. It is designed to support individuals in reducing their risk of getting HIV and other STDs by increasing a client's perceptions of his or her personal risks, supporting incremental risk-reduction steps, and increasing self-efficacy of safer behaviors.

This counseling model consists of two, brief, one-on-one interactive counseling sessions. The sessions follow a structured protocol that guides the provider to elicit and discuss the client's risk situations by conducting a personalized risk assessment, and to encourage and assist the client to develop a risk-reduction step to support an overall risk-reduction goal. The 2-Session RESPECT model was designed for use with HIV testing that follows a "standard" protocol consisting of non-rapid HIV testing. It is also adaptable to a variety of HIV prevention settings such as CRCS (Comprehensive Risk Counseling and Services) and PCRS (Partner Counseling and Referral Services).

In Session 1, the client's understanding of his or her personal risk for becoming HIV infected is increased, and a realistic step toward risk-reduction is developed by the client with the support of the provider. In test settings, a specimen is taken for HIV testing after the first session. In Session 2, the client is guided by the provider to review and revise his or her risk-reduction step as needed. In a test setting, the result is given at the beginning of the session.

What is the Single-Session RESPECT Model with Rapid Testing?

- ◆ RESPECT can be delivered in a single-session, such as with RAPID HIV testing. The Single-Session RESPECT HIV Prevention Counseling model includes all the steps of the 2-session RESPECT in one sitting. In an HIV test setting, the test would be administered during Session 1 towards the beginning of the Pre-Results Session. The results would be given 20 minutes later during the Post-Result Session. The time while

the rapid test is running offers an opportunity to have a conversation with a client. In Single-Session test settings, stages 2 and 3 of the Post-Results Session would entail reviewing and revising the step based on the test result rather than the client's experience in implementing the step.

Why Use the RESPECT HIV Prevention Counseling Interventions?

Compared with information-giving, the RESPECT HIV Prevention Counseling model was more effective at reducing sexually transmitted diseases—study participants reported using condoms more and performing other risk-reduction behaviors. In addition, rates of STDs were significantly lower among study participants than those in the control group. Because the focus of the counseling is on risk behaviors, it is assumed that the counseling is also effective at preventing other sexually transmitted and blood borne diseases including HIV and hepatitis B and C.

Further, the 2-Session RESPECT model is recommended in the Centers for Disease Control and Prevention (CDC) guidelines for providing HIV counseling, testing, and referral. The model is also consistent with the CDC recommendations for advancing HIV prevention (AHP), which emphasizes the importance of learning HIV status in order to be supported in reducing HIV transmission and provided with referrals for care, treatment, and prevention services. The model can be used to work with HIV-positive clients in reducing acquisition of new STDs and/or transmission of HIV to others.

Who is the RESPECT Model Intended For?

The RESPECT HIV Prevention Counseling intervention was originally conducted with HIV-negative heterosexuals who came to a clinic for STD testing and whose main risk for HIV was sexual transmission (see **Appendix A**).

Because it uses a client-focused counseling approach and includes a personalized risk assessment and development of personalized risk-reduction steps, it can be easily adapted and tailored to different HIV prevention settings for a variety of populations. In other words, it can be offered to all persons at risk for acquiring or transmitting HIV who seek services in any setting, including testing and traditional clinic settings and nontraditional settings, such as community-based or outreach venues.

Similarly, because the model includes a protocol with specific prompts, it helps the provider cover all important pieces of the protocol while ensuring that the counseling will be acceptable to target populations.

About this Implementation Manual

This Implementation Manual is part of an integrated, multimedia curriculum package developed by the California STD/HIV Prevention Training Center (CA PTC) for the Centers for Disease Control and Prevention (CDC) to support providers in implementing the 2-Session and Single-Session RESPECT HIV Prevention Counseling model. This Implementation Manual is intended to support HIV prevention providers and supervisors to deliver the 2-Session and Single-Session RESPECT model after they have been trained.

The Project RESPECT research, found that, compared with the standard practice of human immunodeficiency virus (HIV) counseling, this model of HIV prevention counseling was more effective at reducing sexually transmitted diseases (STDs). Study participants reported increased condom use and increased risk-reduction behaviors. Because it is the behaviors that enable the transmission of infection, we can assume that this intervention is also effective at preventing other sexually transmitted and blood-borne diseases, including HIV.

The 2-Session and Single-Session RESPECT HIV Prevention Counseling model focuses on the client's personal risk. It is designed to support individuals in reducing their risk of acquiring or transmitting HIV and other STDs by increasing a client's perceptions of his or her personal risks and supporting incremental risk-reduction steps. While the model was researched in an HIV test setting, it can also be effective in other settings whenever prevention efforts are implemented.

This counseling model consists of two 20-minute one-on-one interactive counseling sessions. The sessions follow a structured protocol that guide the provider to elicit and discuss the clients' risk situations, to conduct personalized risk assessment, and encourage and assist clients to develop a risk-reduction step. The 2-Session RESPECT model was designed for use with HIV testing that follows a "standard" protocol consisting of an enzyme immunoassay followed by confirmatory testing, if indicated. It has been adapted to single session HIV test settings as well as settings outside of HIV testing situations.

In Session 1, the client's understanding of his or her personal risk for becoming HIV infected is increased and a realistic step toward risk reduction is developed and supported. If counseling is being conducted in a test setting, a specimen is taken for HIV testing. In Session 2, the client is guided by the provider to review and revise his or her risk-reduction step. If in a test setting, the results will be given at the beginning of the session.

If conducting Single-Session RESPECT, both sessions are offered in the same sitting. The test is conducted early in session-1 and the results are provided to the client at the beginning of Session 2,

The RESPECT model is recommended by the CDC for providing HIV counseling, testing, and referral. The model is also consistent with the CDC recommendations for advancing HIV prevention (AHP), which emphasize that people learn their HIV status and are provided with support for reducing HIV transmission and for referral to care, treatment, and prevention services.

Key Objectives for this Implementation Manual

This Implementation Manual serves as a supplement to the Training of Facilitators curriculum. It provides participants with an understanding of the RESPECT research study; it reviews the skills and knowledge covered in the Training of Facilitators (TOF), necessary to successfully implement the RESPECT counseling model in their prevention work.

After receiving the TOF and reviewing the IP, participants will be able to:

1. Understand the 5 core elements of the RESPECT intervention;
2. Understand the role dissonance plays in the RESPECT model;
3. Describe the stages in Session 1 and 2 of the RESPECT model; and the stages in the Single –Session combined model
4. Enhance client's accurate perception of his/her risk for STD/HIV;
5. Negotiate a realistic and incremental plan for reducing client's risk.

Core Elements of the RESPECT HIV Prevention Counseling Model

What Are The Core Elements Of The RESPECT Model?

Core elements are critical features of an intervention's intent and design that must be maintained without change to ensure the intervention's effectiveness. To ensure the effectiveness of the RESPECT model, it is essential that all core elements are followed. The RESPECT HIV Prevention Counseling model has five core elements:

1. Conduct one-on-one counseling, using the RESPECT protocol prompts.
2. Utilize a "teachable moment" to motivate clients to change risk-taking behaviors.
3. Explore circumstances and context of a recent risk behavior to increase perception of susceptibility.
4. Negotiate an achievable step which supports the larger risk-reduction goal.
5. Implement and maintain quality assurance procedures.

The Project RESPECT research resulted in both behavioral and biologic changes in study participants, including increased risk-reduction behaviors, such as condom use, and reduced rates of HIV and other STDs. To maximize

the effectiveness of RESPECT counseling, it is essential that the intervention be implemented faithfully by maintaining all five core elements. By following all of the core elements, you are more likely to see results similar to the study and thus see an increase in STD and/or HIV risk-reduction behaviors, and decrease in STD rates, including HIV. Each of the core elements is described in more detail below.

1. Conduct one-on-one counseling, using the RESPECT protocol prompts. Conduct the sessions with only one client at a time. The RESPECT model is not applicable to group settings.
2. Utilize a “teachable moment” to motivate clients to change risk-taking behaviors. Moments of heightened emotion or cognitive dissonance often allow people the opportunity to think differently about themselves or their behavior. This model emphasizes the use or creation of teachable moments in order to create openings for new behavior.
3. Explore circumstances and context of a recent risk behavior to increase perception of susceptibility. This model focuses on the client’s specific and recent risk behavior and related circumstances. One of the main strengths of the counseling is its continuous focus on the client’s risk for acquiring or transmitting HIV. Similar to other crisis intervention models, this model avoids discussion of topics unrelated to the client’s risk for HIV. Rather than using the session for HIV education, the focus is on the client’s specific risk behavior. This counseling model requires that the provider use information only to clarify misconceptions related to the client’s personal risk.
4. Negotiate an achievable step which supports the larger risk-reduction goal. This counseling model supports and encourages the client to develop an achievable, realistic step that would reduce his or her risk of acquisition or transmission in each session. These steps should support an overarching risk-reduction goal.
5. Implement and maintain quality assurance procedures. To ensure high-quality counseling, providers should develop, implement, and maintain a quality assurance protocol that supports consistent delivery of the intervention.

Getting Started

What Resources Are Needed To Conduct The RESPECT Model?

To conduct the RESPECT HIV Prevention Counseling model in a manner consistent with the research on the model, providers will need the following resources and training:

1. Providers should receive training to deliver the RESPECT HIV Prevention Counseling model. As a prerequisite to the RESPECT training, providers should also be trained or be competent in the fundamentals of HIV counseling, counseling principles, and their local organizational requirements for HIV testing, counseling, referral, and related interventions.
2. Active involvement from supervisors who are trained and skilled in the counseling model and able to provide ongoing support, guidance, and quality assurance.
3. A private setting to comfortably speak with the client one-on-one in a confidential setting.
4. Sufficient time to conduct a session with each client.
5. Contact information for referrals (e.g., health care, mental health, and substance abuse resources, etc).
6. The RESPECT HIV Prevention Counseling intervention package containing information on the 2-session RESPECT and the Single-Session RESPECT model.
7. Written quality assurance protocols, monitoring and evaluation procedures and related forms (enclosed with the curriculum package.)

How Can The RESPECT Model Be Adapted?

Agency and clinic environments may differ from the research conditions under which the RESPECT model was tested. Therefore, providers may need to adapt the counseling model to meet client and agency needs while keeping the core elements of the model intact.

RESPECT Differs From Other Models

Many models of counseling are delivered to clients seeking HIV prevention services. Not all counseling models have the research foundation of the RESPECT model. Many models (for example, the CDC “Fundamentals of HIV Prevention Counseling”) are based on the RESPECT model, but do not replicate this intervention. The CDC’s “Fundamentals of HIV Prevention Counseling” course and similar provider training courses are recommended as prerequisites to the training, as the principles are similar and they complement the concepts and activities emphasized in the RESPECT training.

Merging This Model With Existing Service Systems And Programs

Because this counseling model was intended to be offered along with HIV testing, it is often imbedded within a service called “counseling and testing.” As recommended by CDC guidelines, these services often include additional components such as consenting processes, referral processes, partner notification services, linkage to care, treatment and navigation services, and individual or group education programs. In addition, local laws and organizational policies regulate provider programs. To effectively use this package, providers are encouraged to integrate the counseling protocol within their service or program in a way that minimizes disruption and any changes to the protocol.

Using RESPECT With Rapid HIV Testing

During the original Project RESPECT study, before rapid testing was available, the intervention was found to be effective when used in standard (i.e., non-rapid) HIV counseling and testing programs. In another research

study (RESPECT 2), it was modified for use with rapid HIV testing. Counseling using either the rapid or the standard HIV test had similar effects on STD incidence. Although the cumulative incidence of STDs at the 12-month follow-up was higher in the rapid test group than in the standard test group, the difference was not statistically significant. In the short term, and for some subgroups, such as gay men and other MSM, a rapid test intervention may be less effective in reducing high-risk behaviors and preventing STDs than the standard test. For some persons, returning for the second counseling session after a period of time (e.g., 1-2 weeks) to discuss experience in practicing steps from the risk-reduction plan, including possible revisions, may be beneficial. (2005, Metcalf et al. STDs).

What Is The Cost Of Using The 2-Session RESPECT HIV Prevention Counseling Model?

It is expected that any organization currently conducting HIV prevention services will be able to integrate RESPECT into its current services and programs easily. A cost sheet has been included for 2-Session RESPECT and Single-Session RESPECT to assist planning (see Appendix E).

The RESPECT HIV Prevention Counseling Model Materials

The counseling materials were packaged for HIV prevention providers to use when implementing the RESPECT model of HIV prevention counseling.

The RESPECT materials include:

1. An Implementation manual of the RESPECT model that includes information on implementing the 2-Session and Single-Session RESPECT.
2. Provider Cards
3. Risk-Reduction Step forms
4. Quality assurance recommendations and forms
5. Other Forms are provided for monitoring and evaluation purposes. These Forms are part of the RESPECT curriculum package and can be adapted for use by prevention providers.

How Are The Sessions Organized?

The RESPECT model is designed to be a brief and focused intervention, with each session lasting 10 to 28 minutes. Each session stage has several steps that help the provider carry out the counseling objectives. **Slides 1-3** show each stage for each session.

Standard 2 session RESPECT

Session 1 Stages

- 1. Introduce and orient client to session**
- 2. Enhance the client's sense of self risk**
- 3. Explore the specifics of the most recent risk incident**
- 4. Review previous risk-reduction experiences**
- 5. Summarize the risk incident and risk patterns**
- 6. Negotiate a risk-reduction step**
- 7. Identify sources of support and provide referrals**
- 8. Close the session**



- ◆ Based on adherence to protocols the model is linear with each stage building on the one before it. It is also expected that programs will eventually integrate and adapt the model according to their particular needs while adhering to the basic structure developed through the research.



Session 2 Stages

1. Frame the session and orient client
 - a. (Give test result)
2. Review the risk-reduction step
3. Revise the risk-reduction step
4. Identify sources of support
5. Provide referral
6. Close the session



- ◆ Built-in redundancy: Notice that there is built-in redundancy in different steps within the stages. The research was purposely designed with this repetition in mind. The repetition in the stages provides a reminder for providers to continually work towards enhancing a client's sense of self-risk and to notice opportunities at various points in the counseling process to do that.
- ◆ Different settings: In an HIV test setting, the test would be administered during Session 1. A standard test site might be likely to administer the test close to step 8 of the 2-Session Model.

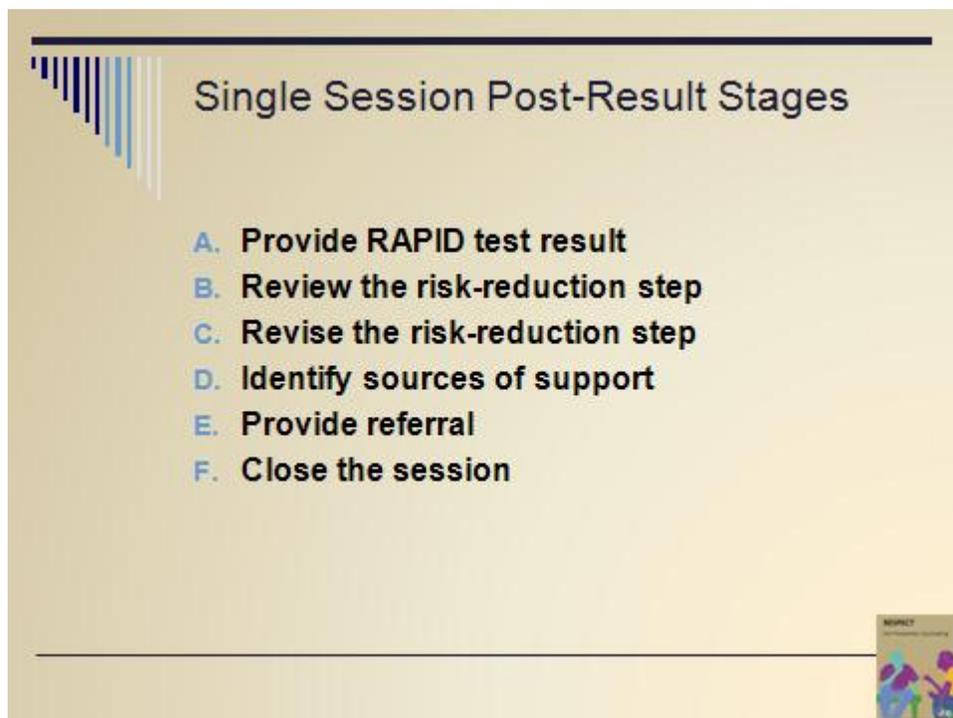


Single Session Pre-Result Stages

1. **Introduce and orient client to session, RAPID test procedures & results**
2. **Enhance the client's sense of self risk**
3. **Explore the specifics of the most recent risk incident**
4. **Review previous risk-reduction experiences**
5. **Summarize the risk incident and risk patterns**
6. **Negotiate a risk-reduction step**
7. **Identify sources of support and provide referrals**



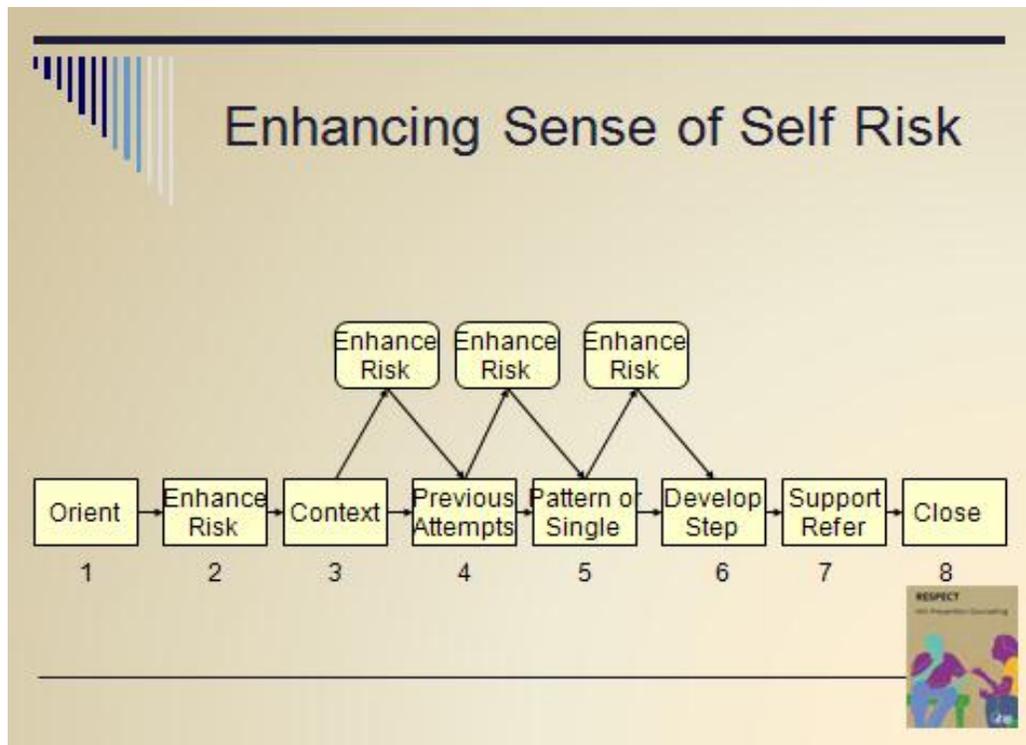
- ◆ The single-session Model: All the stages of 2-Session RESPECT are conducted. However, all stages are conducted in one sitting which also includes RAPID testing where the client is introduced and oriented to the RAPID test procedures, Pre-Results and Post Results Stages.
- ◆ In this model, the rapid HIV test would be administered at the beginning of the Pre-Results Session. While the rapid test is processing, the provider continues and completes the remaining stages and steps of the Pre-Result Session. After completing the Pre-Results Session, the provider transitions into the Post-Result Session and gives the results of the HIV test to the client. it also includes RAPID testing where the client is introduced and oriented to the RAPID test procedures, Pre-Results and Post Results Stages.



- ◆ In Single-Session test settings, stages B and C of the Post-Result Session would entail reviewing and revising the risk-reduction step based on the client's thoughts and feelings regarding the test result rather than the client's experience implementing the risk-reduction step.
- ◆ Notice that the stages of the Post-Result Session are referred to as letters A-F and not 1-6 as they are for the Session 2 of the 2-Session model.

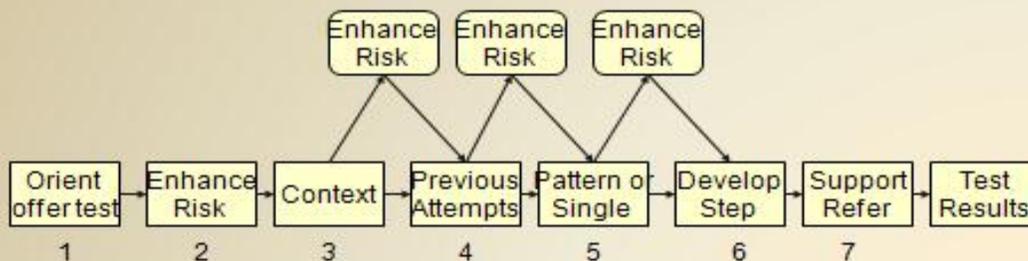
- ◆ It is helpful to refer to the banner illustrating Session 1/Pre-Result Session of the RESPECT model. The banner depicts how enhancing a client's sense of risk is inherent throughout the model. See Figures 1 & 2.

Figure 1: 2-Session RESPECT Model



It is helpful at this point to refer to the banner illustrating Session 1 or the Pre-Results Session of the RESPECT model. The banner depicts how enhancing a client's sense of risk is inherent throughout the model.

Enhancing Sense of Self Risk Single Session Pre-Results



How This Manual is Organized: Protocol Stages

For each protocol stage, this manual contains information to guide the provider in carrying out the protocol effectively. Each protocol stage is organized as follows:

Title of the protocol stage—introduces the stage.

Objective—describes what needs to be accomplished with the session stage.

Guidance—describes, in detail, the purpose or rationale for each specific stage of the session.

Table with protocol prompts and example dialogue—outlines the activities and the order to follow for each stage and gives examples for delivering them.

As shown in ***the slides above, the*** protocol stages are essential pieces of the counseling model that must be maintained by the provider. The protocol prompts and example dialogues are found in the “Provider Cards” which are part of the intervention package. However, the example dialogues are just that—examples. They are included to guide the provider in delivering the essential stages. The prompts also help keep the provider focused, thus increasing the likelihood that

he or she counsels clients in the same way as was done in the study. The provider may choose to use these examples or may choose to deliver the intervention stages using his or her own words, being careful to use words and language specifically tailored to the client.

Figure 1. Example Section of RESPECT Provider Cards

Protocol Steps (must be followed)	Example Dialogue (can be modified)
<p>1. Assess communication about HIV with partners</p>	<ul style="list-style-type: none"> • How did you decide to have sex/shoot drugs? Did you or your partner(s) suggest using condoms/new or clean needles or equipment or not sharing needles and equipment? Tell me about that. • Did you talk about whether either you or any of your partners had been tested for HIV? • Would you have engaged in the same behavior had you known this person had HIV? Tell me more. • What did you and your partner(s) talk about in terms of HIV risk or about being safe?

The example dialogue is designed to encourage the client to do most of the speaking, with the provider asking follow-up questions appropriate to the context. The provider is encouraged to avoid asking questions that are not relevant to the client’s risk circumstances and to use language (words and terminology) that the client would understand. If the client does not use terms that are specific enough, decide on terms both of you are comfortable using.

The example dialogue includes questions that are specific to clients whose main HIV risk is from sex and to clients whose risk is from injection drug use.

The example dialogue includes instructional text for the provider in brackets that is similar to the protocol prompts in font and color.

Session 1: Risk Assessment and Risk-Reduction Step

SESSION 1

Protocol Stages	Time (in minutes)
1. Introduce and orient client to the session	1-2
2. Enhance the client's sense of self-risk	2-3
3. Explore the specifics of the most recent risk incident	2-3
4. Review previous risk-reduction experiences	2-4
5. Summarize the risk incident and risk patterns	3-4
6. Negotiate a risk-reduction step	4-5
7. Identify sources of support and provide referrals	1-2
8. Close the session	3-5
Total Time	18-28

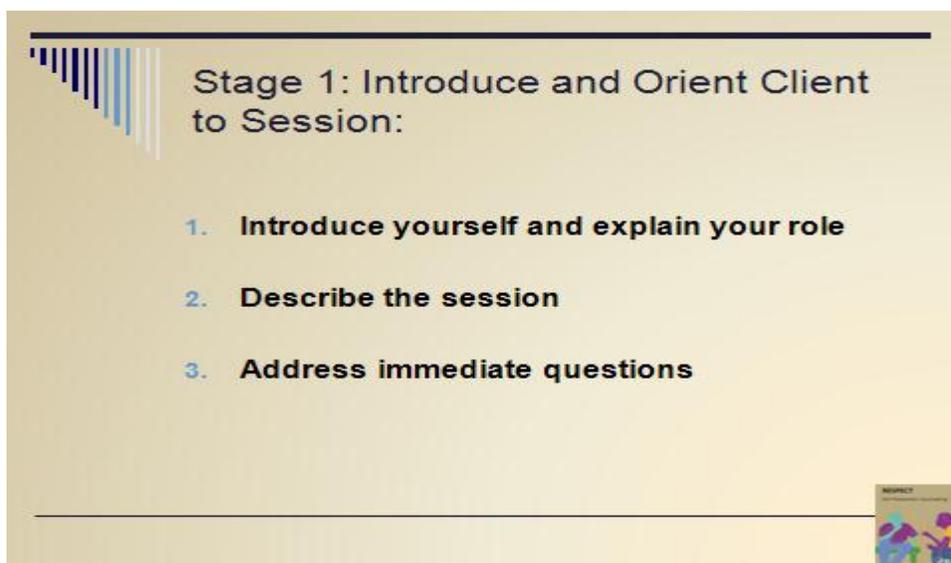
* Please see provider cards for suggestions of open-ended questions for each style.

Stage 1. Introduce and Orient Client to the Session

Objective

The purpose of this stage is to describe the session and the amount of time it will take to explain the roles and responsibilities of client and provider, and to establish consensus with the client about the overall objectives of the session.

Time: 1–2 minutes



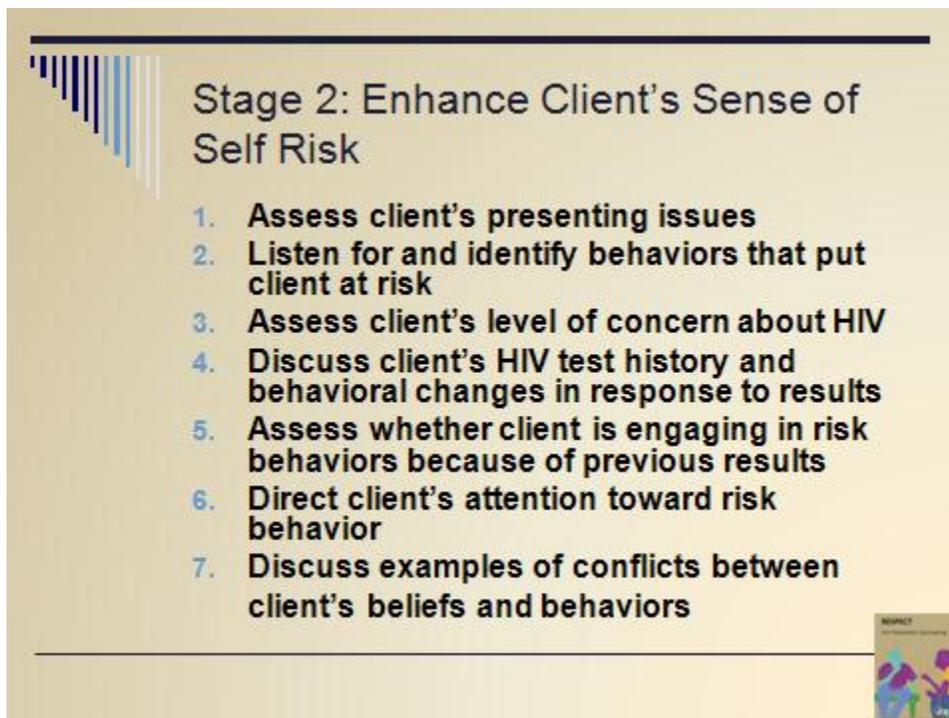
1. Introduce yourself and let the client know your role. This can include your role in the agency as well as your role in the session. Providers can help the client feel comfortable with the process, the provider's role, and the content and purpose of the session. If the client knows what to expect and understands the process, he or she will feel less anxious and will be able to focus better on the session. In an HIV test setting, this will increase the chances that the client will come back for the HIV test result.
2. Describe the session. Let the client know the length of the session and its purpose. Let the client know that you will be asking questions designed to address any specific risk related concerns the client may have. You may choose to let the client know that you will be using prompts or written guidelines to ensure that you address all the relevant issues.

-
3. Address immediate questions. By addressing immediate questions or concerns, the provider helps to ensure that the client is able to focus on the counseling session. Immediate questions or concerns may include distractions or the need for referrals to adjunct services. Focus on what is pertinent to the setting.
- *Repeat testers*: If this is an HIV testing setting and the client has been tested before, he or she may feel that the counseling is unnecessary and that he or she knows about all types of risk for HIV. The 2-Session RESPECT HIV Prevention Counseling model is not about educating a client about risk but about increasing the client's understanding about his or her own personal risks and taking a step to reduce those risks. Thus, it is very important to let repeat testers know that this counseling is different. It is not about risks per se, but about the client, his or her personal risks and his or her specific behaviors.
 - *Consent*: Providers will need to be sure that they obtain informed consent from the client, fill out any necessary forms, and complete any other State or agency requirements during the course of the session. This should occur according to individual agency policy.
 - *Additional information*: If a provider needs to include other pieces of information (such as discussions regarding test decisions), it may be helpful to consider doing it at either the beginning (in this stage) or at the end.

Stage 2. Enhance the Client's Sense of Self-Risk

The purpose of the activities in this stage are to focus on the client's attention on his or her risk behavior, increase his or her level of concern regarding these behaviors, and enhance his or her sense of personal risk.

Time: 2–3 minutes



Stage 2: Enhance Client's Sense of Self Risk

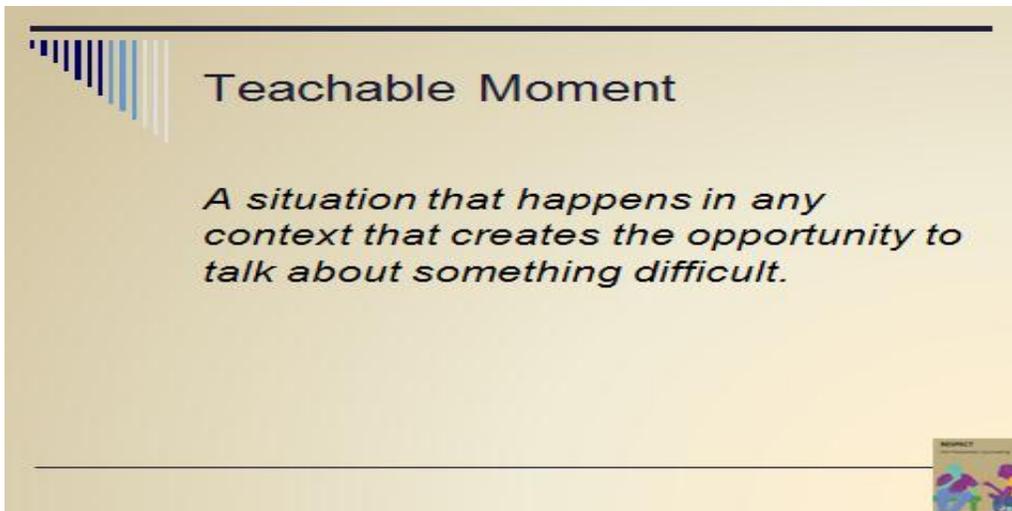
- 1. Assess client's presenting issues**
- 2. Listen for and identify behaviors that put client at risk**
- 3. Assess client's level of concern about HIV**
- 4. Discuss client's HIV test history and behavioral changes in response to results**
- 5. Assess whether client is engaging in risk behaviors because of previous results**
- 6. Direct client's attention toward risk behavior**
- 7. Discuss examples of conflicts between client's beliefs and behaviors**

Key Points

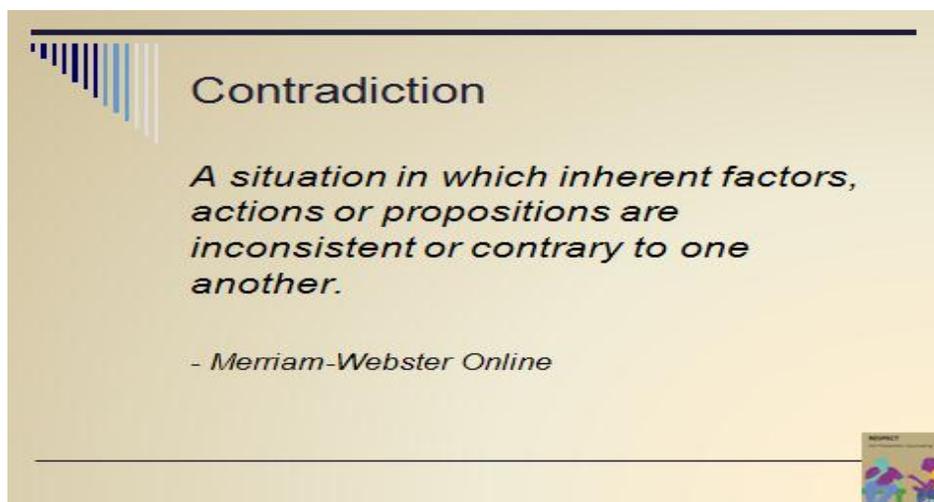
- 1. Assess client's presenting issues:** Use a client's request for STD/HIV services as the starting point. The client's presence in the clinic (or other organization) and request for STD/HIV services can be an opportunity for the provider to address the client's risk. It can provide a teachable moment. In a case management setting, the presenting issue may be a check-in for ongoing services. The provider can introduce prevention efforts as part of his or her agenda for the meeting.
- 2. Listen for risk behaviors:** Listen for any risk behaviors the client describes. Begin to identify the client's main risk behavior. Decide whether to identify behaviors for yourself or to point out the behavior(s)

to the client. For a person who is HIV negative, risk includes any behavior that has the potential to allow him or her to acquire HIV. Risk for a person who is HIV positive includes sexual or drug-using behavior that is likely to increase the likelihood that he or she will transmit HIV. This can include his or her choice of sexual act as well as his or her ability to disclose status to a partner. It may also include issues related to health and well-being such as receiving medical care or adhering to medications.

3. Assess client's level of concern about HIV: This discussion should help the provider and client understand the client's behaviors. Clients may understand which behaviors are risky but may not view their own behaviors as risky. One goal in this stage is to increase the client's sense of personal risk. A provider can look for and address comments in the session where the client's beliefs and behavior are at odds as well as any uncertainty or confusion about risk-reduction. This is not an educational model, but it can be appropriate and powerful to correct misinformation.
4. Discuss client's test history and behavioral changes in response to results: Explore the client's history with HIV or STD tests. This can include tests to ascertain positive or negative status as well as tests to measure known disease progression. Has the client tested negative in the past and therefore continued with risk behaviors? Has a positive test result caused the client to decrease their risk behavior or conversely abandon previous behaviors?
5. Assess whether client is engaging in risk behaviors because of previous test results: Has the client changed their behaviors because of previous test results? This can include increasing or decreasing their acceptable level of risk.
6. Direct client's attention toward risk behavior: If you have not done so already, state the risk behaviors that you have observed. Notice whether the client's perception of risk matches his or her objective susceptibility to risk. Notice any discomfort that the client may be having.
7. Listen for conflicts between client's beliefs and behaviors: When a provider asks questions that increase the client's sense of personal risk or discusses when the client's behavior and beliefs are at odds (also known as addressing contradictions), a provider may (or usually will) increase the client's realistic perception of risk. This may cause the client and the provider to feel uncomfortable. The provider may want to avoid increasing the client's sense of self-risk. However, when the provider increases the client's understanding of his or her risk, the provider and the client set the stage for development of a risk-reduction step that the client believes in and can successfully accomplish. This is a core element for conducting the 2-Session RESPECT model (using a teachable moment).

A slide with a light beige background. In the top left corner, there is a decorative graphic of vertical bars of varying heights, colored in shades of blue and grey. The title "Teachable Moment" is centered in a dark blue font. Below the title, a definition is written in italics: "A situation that happens in any context that creates the opportunity to talk about something difficult." A thin horizontal line is positioned below the text. In the bottom right corner, there is a small, colorful graphic of a globe with people icons.

These three components (teachable moment, contradictions and dissonance) are central to the RESPECT model and are often interrelated. Dissonance refers to a person's internal feeling whereas contradictions occur between a person's thought, speech or behavior. Dissonance can be uncomfortable for both the provider and/or client, it can also create a powerful opening for taking in new information (a teachable moment), thereby creating the foundation for different behavior.

A slide with a light beige background. In the top left corner, there is a decorative graphic of vertical bars of varying heights, colored in shades of blue and grey. The title "Contradiction" is centered in a dark blue font. Below the title, a definition is written in italics: "A situation in which inherent factors, actions or propositions are inconsistent or contrary to one another." Below the definition, the source is cited as "- Merriam-Webster Online". A thin horizontal line is positioned below the text. In the bottom right corner, there is a small, colorful graphic of a globe with people icons.

When one is faced with dissonance, there is an impulse to decrease or ease the dissonance. If dissonance occurs between a belief and a behavior, one may look at changing either the behavior or the belief. Our job as providers is to continue addressing contradictions to keep dissonance present and guide the client to focus on changing behavior.



Cognitive Dissonance

A condition of conflict or anxiety resulting from inconsistency between one's beliefs and one's actions.

- American Heritage Dictionary of English Language, 4th edition



Addressing contradictions is one way that providers can create dissonance. However, a provider may address a contradiction without the client experiencing dissonance. A person can have contradictions without having dissonance, but he or she is unlikely to experience dissonance without experiencing an inherent contradiction.

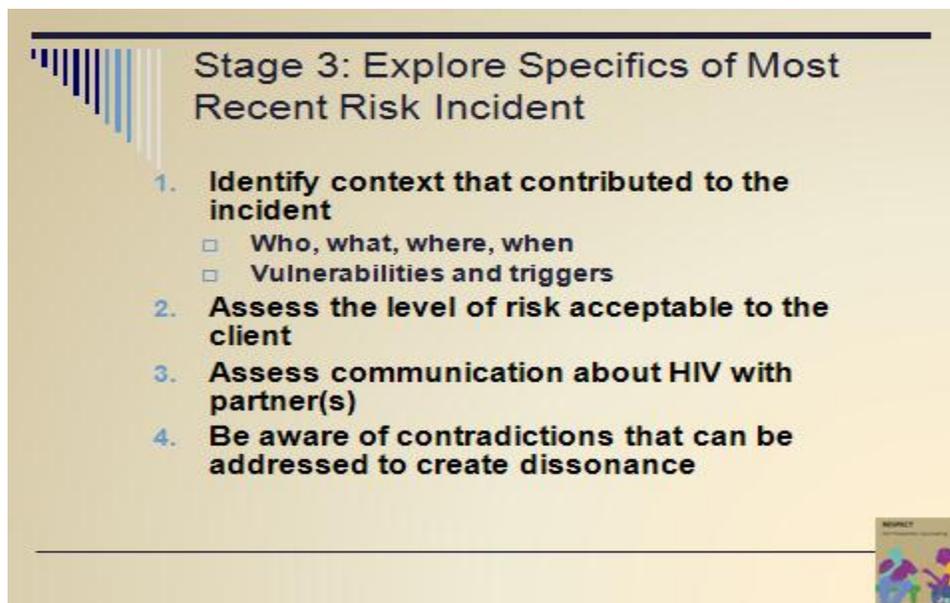
Please refer to the Festingers resource (Appendix D).

Stage 3. Explore the Specifics of the Most Recent Risk Incident

Objective

The purpose of this stage is to help the client understand the issues and circumstances that contribute to his or her most recent incident.

Time: 2–3 minutes



Stage 3: Explore Specifics of Most Recent Risk Incident

- 1. Identify context that contributed to the incident**
 - Who, what, where, when
 - Vulnerabilities and triggers
- 2. Assess the level of risk acceptable to the client**
- 3. Assess communication about HIV with partner(s)**
- 4. Be aware of contradictions that can be addressed to create dissonance**

1. Identify context that contributed to the incident. Context includes issues such as the underlying circumstances that may have contributed to the client’s decision to engage in risky behavior, who it was with, where the behavior occurred, when it happened, and how it happened. Contextual issues are important whether the behavior is a pattern, is unusual, or is “an accident.” Emotions, recent life events (e.g., divorce, relationship break-up, death of a loved one), substance abuse, low self-esteem, and other issues may influence behavior. A provider and the client can work together to understand the context and patterns of the risk behavior.
2. Assess the level of risk acceptable to the client. People have different levels of acceptable risks. It is most likely that a client will want to change a behavior that has involved a level of risk that has made him or her uncomfortable.
3. Assess communication about HIV with partner(s). The ability to talk with a partner about HIV is an important contextual issue that can have a significant impact on risk-reduction efforts.

Remember to ask clients if and how they talk to partners about HIV.

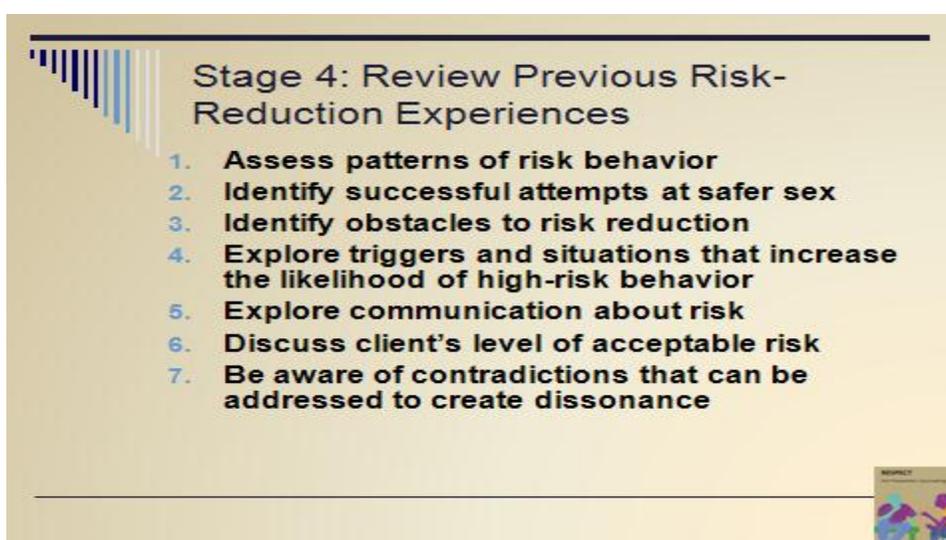
4. Be aware of contradictions that can be addressed to create dissonance. Discussions about context can provide opportunities to address contradictions. Listen for and address them as appropriate. Avoid blaming or being aggressive when addressing contradictions with clients.
5. Manage your feelings and discomfort. Discussing risk behavior may be difficult for both the provider and the client. Either may feel inclined to discuss something other than the client's risk incident. Discussions may be redirected by the client away from personal risk incidents to HIV risk in general (e.g., stating that unprotected receptive anal sex is very risky). Providers must remember to focus the conversation on exploring the client's specific behaviors and circumstances.
6. Remember to notice strengths and resiliencies as well as risks. Discussing risk behaviors can make the client feel vulnerable and ashamed. It is important for providers to notice times when clients have shown strength and resiliency.
7. This stage is key to helping the client decide what an appropriate risk-reduction step would be for him or her; thus, it is important to take time to go through the stage.

Stage 4. Review Previous Risk-Reduction Experiences

Objective

The purposes of this stage are to discover and acknowledge a client's positive steps to reducing his or her risk of becoming infected with HIV, explore barriers to other ways the client could reduce his or her risks, and provide support for and reinforce the client's efforts in risk-reduction.

Time: 2–4 minutes



1. Assess patterns of risk behavior. Is this behavior happening on a regular basis, occasionally, or was this a unique situation? Patterns may be harder to change.
2. Identify successful attempts at safer sex. Ask about any changes the client has begun to make to reduce his or her HIV risk. Support and reinforce any risk-reduction activities, no matter how small. Explore the different contextual issues.
3. Identify obstacles to risk-reduction. This discussion allows the client to talk about what he or she has done to reduce risk and the challenges he or she faced. It also provides the provider with insight about the client's strengths and difficulties in reducing risk for HIV.
4. Explore triggers and situations that increase the likelihood of high-risk behavior. Talk with the client about contextual issues that are more likely to result in his or her engaging in a high-risk behavior.

5. Explore communication about risk. Assess the client's comfort and ability to discuss HIV with partners or potential partners. Remember to validate ways that the client protects himself or herself as well as a partner. If the client has difficulty discussing or articulating his or her experiences with HIV risk-reduction, it may help to ask what the client's friends believe and do regarding HIV prevention.
6. Discuss client's level of acceptable risk. Check in with the client often to assess the level of risk that is acceptable to him or her. Do not assume that he or she has the same level of acceptable risk as you do.
7. Be aware of contradictions that can be addressed to create dissonance. These discussions may lead to the revelation of contradictory beliefs and/or behaviors by the client. Listen for them and point them out as appropriate.
8. Correct misconceptions as necessary. Provide information and correct critical misconceptions as needed to increase the client's sense of risk.

Reframing

Some key characteristics of reframing include:

- Helps a client feel empowered in their situation.
- Helps a client break out of self-defeating or constricting thought.
- Offers an alternative, positive way to view a situation.

Issues for Counselors to Keep in Mind:

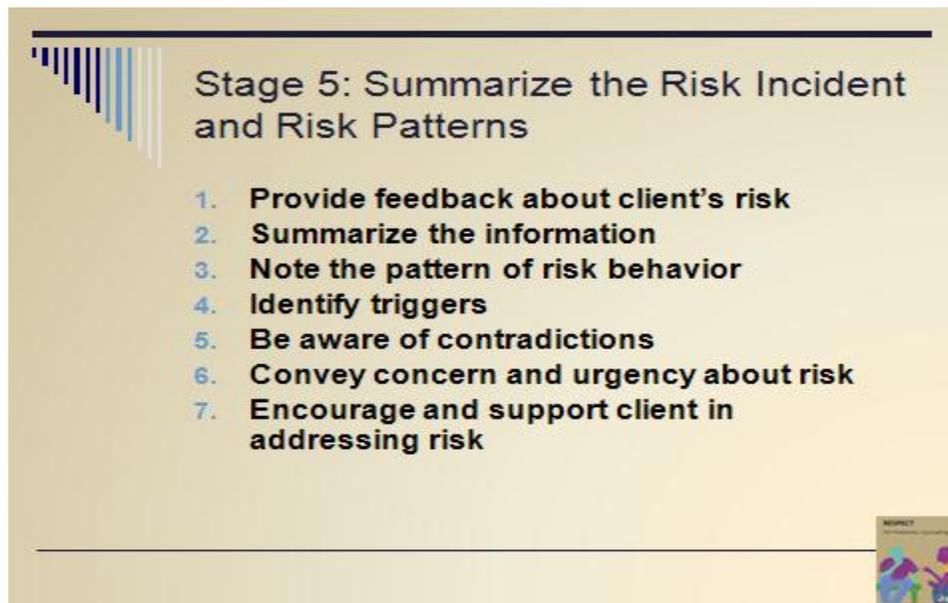
- Make sure clients are able to process/understand the idea.
- Offer the reframed idea in a tentative way.
- Ensure the reframe is plausible.
- Allow clients time to consider the idea.
- Avoid judgment (e.g. "it's great that you are using condoms some of the time, now all you have to do is use them all of the time.")
- Observe the client's body language in response to the reframe.

Stage 5. Summarize the Risk Incident and Risk Patterns

Objective

The purpose of this stage is to recap what has been said by the client about his or her risk behavior(s) as well as any contextual issues related to the risk behavior(s). This is also the time to address the client's risk(s), conveying a sense of concern or urgency as appropriate.

Time: 3–4 minutes



Stage 5: Summarize the Risk Incident and Risk Patterns

- 1. Provide feedback about client's risk**
- 2. Summarize the information**
- 3. Note the pattern of risk behavior**
- 4. Identify triggers**
- 5. Be aware of contradictions**
- 6. Convey concern and urgency about risk**
- 7. Encourage and support client in addressing risk**

Key Points

1. Provide feedback about client's risk. Acknowledge the reality of the client's risks.
2. Summarize the information. Review the risks you have heard and the contextual issues surrounding the risks. Summarize with empathy and without judgment. Ask for agreement or clarification about what you have heard and understood.
3. Note the pattern of risk behavior. Patterns can be important. A behavior that occurs regularly may present a greater risk than

something that has happened only once. Help the client see how the pattern may be changing, i.e., “From what you have told me, this seems to be happening more regularly than before. How does that concern you?”

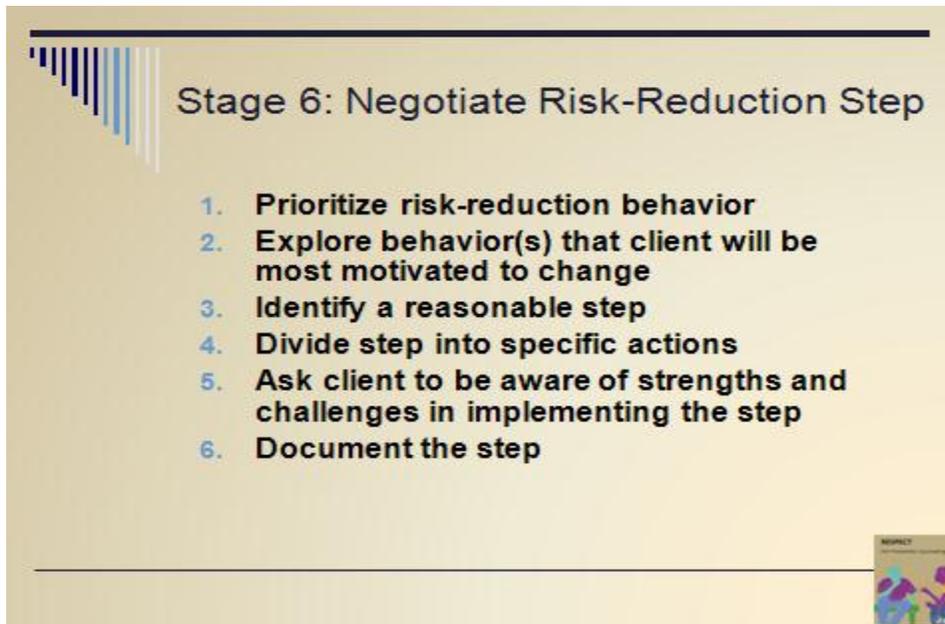
4. Identify triggers. Triggers contribute to risk taking. Avoiding or changing triggers may result in an increased ability to avoid or change risk behavior. Examples include “It seems that when you use alcohol, you’re more likely to have unprotected sex. Is that true?” or “It sounds like you tend to go to the baths when you feel depressed.”
5. Be aware of contradictions. This is another time in the session when clients may express contradictory thoughts or behaviors.
6. Convey a sense of concern and urgency about the risk and the consequences of the behavior. A provider who is able to convey an appropriate sense of urgency and concern about the risk can help clients to understand how his or her beliefs and actions affect risk. Some providers avoid communicating a sense of urgency because providers fear being perceived as judgmental. Providers can convey urgency while showing care. For example, a provider can say, “It sounds like you are doing a lot of risky things. I’m really concerned about that. From what you’ve told me, you are at real risk for getting HIV, this concerns me.”
7. Encourage and support the client in addressing the risk. This discussion not only gives an objective view of the client’s situation but also may increase the likelihood of the client working with you to develop an incremental step for reducing his or her risk for HIV. This activity forms the basis for developing a risk-reduction step.

Stage 6. Negotiate a Risk-Reduction Step

Objective

In this stage, you and the client will negotiate a specific and incremental HIV risk-reduction step that the client can take.

Time: 4–5 minutes



Stage 6: Negotiate Risk-Reduction Step

- 1. Prioritize risk-reduction behavior**
- 2. Explore behavior(s) that client will be most motivated to change**
- 3. Identify a reasonable step**
- 4. Divide step into specific actions**
- 5. Ask client to be aware of strengths and challenges in implementing the step**
- 6. Document the step**

1. Prioritize risk-reduction behavior. Clients may present with an array of problematic issues in their lives. Remember that your role is to help clients reduce their HIV risk. Identify the risk behaviors the client has described, including those that present the highest risk for HIV. Ask the client what behaviors he or she thinks are the most important to address.
2. Explore behavior(s) that client will be most motivated to change. Consider what behaviors the client is most concerned about. Develop an HIV risk-reduction behavioral goal. A behavioral goal can be defined as a behavior that in and of itself eliminates or reduces the risk of transmission.
3. Identify a reasonable step. Support the client in developing a risk-reduction step. This risk-reduction step is an important aspect of the prevention counseling session. Help the client select a single behavioral goal that he or she truly wants to change, is able to change, and is appropriate for his or her main risk. Provide support and encouragement to the client for developing a risk-reduction step.

-
4. Divide the step into specific actions. Ask the client to be specific about the step. The step must be stated in small, detailed actions to ensure that the client can do it before the next session. The step should also be specific to the behavioral goal. Avoid supporting a risk-reduction step that involves unreasonable or radical changes in the client's life. As a result of an increased awareness of the HIV risk, the client may desire to curtail all risky behaviors, which may not be realistic. Global changes—such as “always use condoms”—are often not appropriate. Changes such as “always carry condoms,” “talk to partner about being faithful,” or “call the drug treatment program” are appropriate.
 5. Ask client to be aware of strengths and challenges in implementing the step. It's important for a provider to discuss with the client potential problems or barriers and ways to overcome them. A provider may also role-play potential problems and develop a back-up or alternative step. This helps ensure that the client agrees with the step and is committed to it.
 6. Document the step. Write the client's risk-reduction step on the Risk-Reduction Step form, a blank piece of paper or appointment card. It is helpful to document the step in the provider's notes, so the provider can review it before the next visit. If the step puts the client's relationships or safety at risk (e.g., married and planning to use condoms with casual partners), consider cautioning the client about keeping the card in a safe place.

Risk-Reduction Step Form

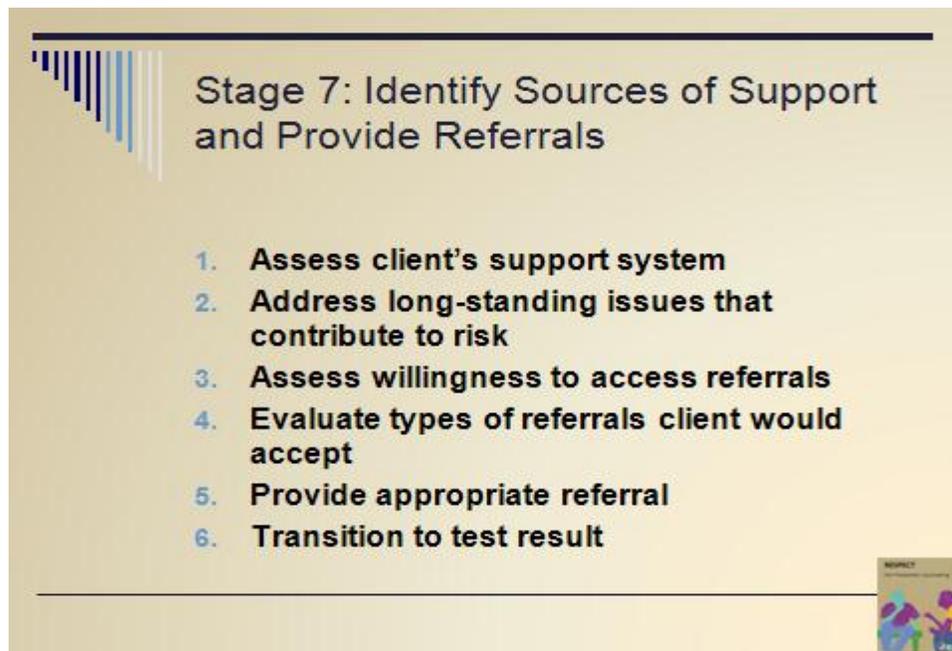
Front	Back
	<p data-bbox="834 657 1187 705">Space for counselor/agency to write down contact information</p>
	<p data-bbox="821 926 943 947"><i>Appointment</i></p>
	<p data-bbox="821 1024 1162 1052">Day Day (mm/dd/yyyy)</p>
	<p data-bbox="821 1081 1187 1108">Time: _____</p>
	<p data-bbox="821 1142 899 1163">Address:</p> <div data-bbox="818 1136 1203 1220" style="border: 1px solid black; height: 40px;"></div>

Stage 7. Identify Sources of Support and Provide Referrals

Objective

The purpose of this stage is to identify resources that will help increase the client's ability to reduce risk.

Time: 1–2 minutes



Stage 7: Identify Sources of Support and Provide Referrals

- 1. Assess client's support system**
- 2. Address long-standing issues that contribute to risk**
- 3. Assess willingness to access referrals**
- 4. Evaluate types of referrals client would accept**
- 5. Provide appropriate referral**
- 6. Transition to test result**

Key Points

1. Assess client's support system. The purpose of doing this is to identify peer, community, and professional support for HIV risk-reduction. Explore possible sources of support with the client.
2. Address long-standing issues that contribute to risk. Although the focus of the session is on the development of a small risk-reduction step, a client may have long-standing issues that contribute to that risk. For example, a client may go to clubs five nights a week. He knows that on evenings where he drinks more than three drinks, he is more likely to engage in riskier behavior than he otherwise feels comfortable with. The client may choose to limit his alcohol intake to one drink per night on week days. There may be a larger, long-standing issue about this client's alcohol use that could benefit from a referral.
3. Assess willingness to access referrals. Check in with the client

explicitly about her or his willingness to access referrals. It is not helpful to provide referrals for a client who is not ready. It may also be possible that there are logistical barriers to the client's accessing referrals that you can help alleviate.

4. Evaluate types of referrals client would be willing to accept: Ask the client if there are certain types of referrals he or she is more willing to accept. This can include issues such as kinds of services or locations of services.
5. Provide appropriate referral: Do this once the provider has assessed the client's willingness to accept referrals as well as the kinds of referrals the client is open to accepting. Avoid overwhelming the client with multiple referrals. A single, appropriate referral is often more effective than several referrals to multiple support services. The referral may be part of the risk-reduction step. However, a referral should not be the client's entire risk-reduction step unless no alternative is possible.

Components of effective referrals:

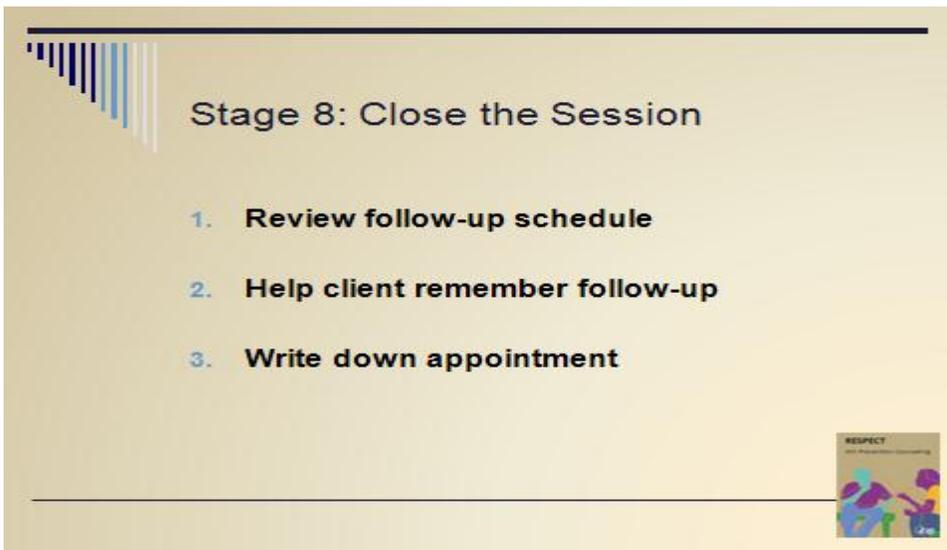
- Help client define priorities and desire to access other services
 - Offer options not directives
 - Refer to known, trusted, and appropriate services
 - Update your referrals frequently
 - Develop a follow-up plan
 - Give a name, if possible
 - Written with clear purpose
 - Assess client response to referral
6. Transition to Test Result: For the Single-Session RESPECT Model, this stage would also include step 6 (Transition to Test Result). During this step, the provider transitions into the Post-Result Session and gives the client their HIV test results. Transitioning to test results will look different at different test centers depending on their clinic protocol since some sites may have different procedures. Therefore, providers should be familiar with the protocol for their specific site. For example, some sites may transition to the Post-Result session if they collected the test sample during Stage 1 and others may transition the client to the test sample collection procedure and to another counselor for the Post-Results Session.

Stage 8. Close the Session

Objective

The purpose of this stage is to motivate the client to increase the likelihood that clients will work towards their risk-reduction step as well as return for follow-up appointments.

Time: 3–5 minutes



1. Review follow-up schedule. This stage should help ensure that the client returns for the second session.
2. Ways to remember follow-up. Ask the client how he or she best keeps appointments. This is a key opportunity to motivate the client to come back. If the client seems anxious about getting the result, encourage him or her to bring a friend or family member when he or she comes back for the next session.
3. Write down the appointment. Write the appointment day, date, time, and location on the back of the Risk-Reduction Step form. If your organization tracks clients for follow-up, ask for contact information.
4. Proceed with agency protocol to collect test sample and or close session. If implementing RESPECT in a testing setting, usual procedures will be followed. Thanking the client for his or her hard work and encouraging follow through with the plan are important while closing the session, as well as encouraging the client to return for follow-up appointments.

Common Stages

2-Session RESPECT Model: Session 2

Protocol Stages	Time (in minutes)
1. Frame the session and orient client a. (Provide test result)	2-10
2. Review the risk-reduction step	4-5
3. Revise the risk-reduction step	4-5
4. Identify sources of support for risk-reduction step	1-2
5. Provide referral	1-2
6. Close the session	1-2
Total Time	13-26

Single-Session RESPECT Model: Post-Result Session

Protocol Stages	Time (in minutes)
A. Deliver Test Results	2-3
B. Review the Risk-Reduction Step	4-5
C. Revise the Risk-Reduction Step	4-5
D. Identify Sources of Support for Risk-Reduction Step	1-2
E. Provide Referrals as necessary	1-2
F. Close the Session	1-2
Total Time	13-19

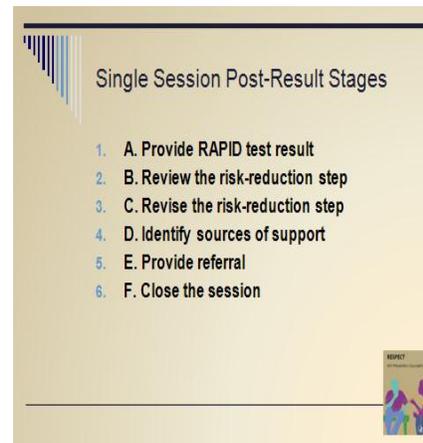
Before the session:

- Review the notes from Session 1/Pre-Result Session.
- Review the specific details of the risk-reduction step and the client's particular issues and vulnerabilities that may affect his or her attempt at changing HIV-related risk behaviors.
- Reminder: Although the 2-Session RESPECT Model has steps 1-6 and the Single-Session RESPECT Model has steps A-F, the components are the same. See example slides below.

2-Session RESPECT Model



Single-Session RESPECT Model



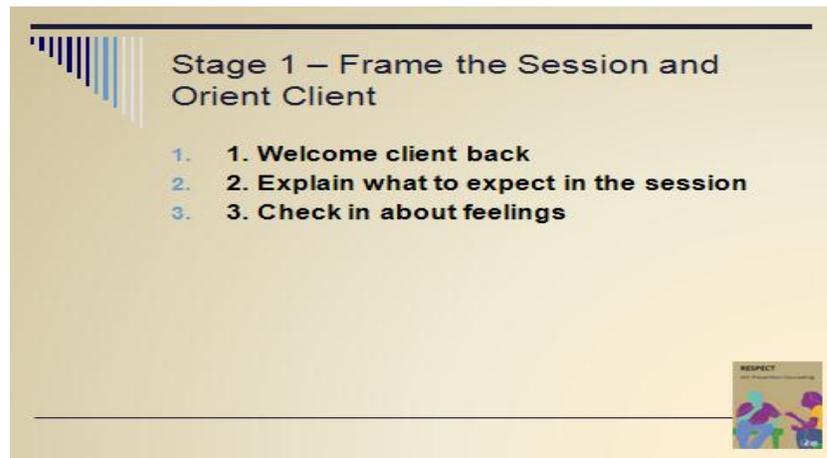
- ◆ These are the essential elements of the second session, regardless of setting. The only difference is giving a test result.
- ◆ The focus is on reviewing the previous risk-reduction step and creating revised or new steps designed to get closer to the larger prevention goal.
- ◆ Each provider will be best able to adapt the model to their setting.
- ◆ In settings where a provider has ongoing contact with a client, such as CRCS or a PWP intervention, the second session may be repeated more than once (i.e., there can be an ongoing process of reviewing and revising risk-reduction steps and looking for opportunities to enhance the client's self-perception of risk).

Stage 1: Frame the Session and Orient the Client: This stage is for the 2-Session RESPECT Model only

Objective

The purpose of this stage is to welcome the client back, let him or her know what to expect in the session, and check in about his or her feelings.

Time: 2–10 minutes

**Key Points**

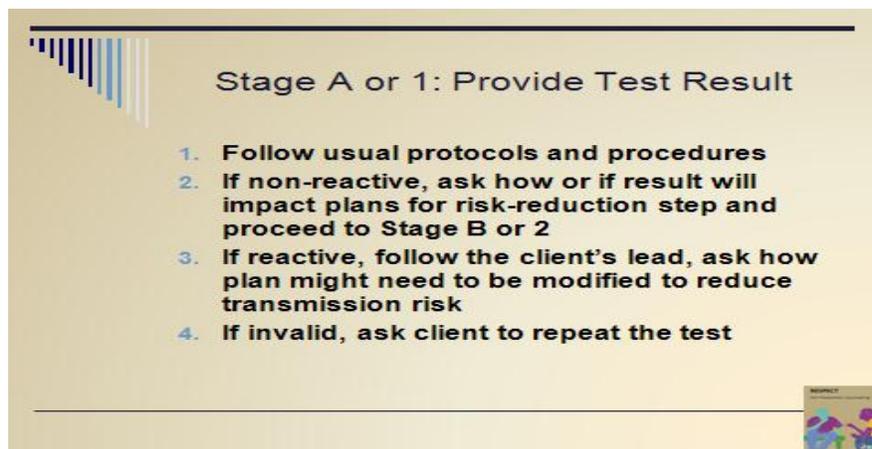
1. Welcome client back. Help the client feel comfortable. Positive feedback can begin now by acknowledging that he or she has returned.
2. Explain what to expect in the session. Clients may have less anxiety and be better able to focus in the session when they know what to expect.
3. Check in about feelings. Do not make assumptions about the client's state of mind. Ask how the client is feeling about your last session together. Ask how the client has been feeling since your last session together.

Stage 1(a): Provide Test Results for Test Settings; This would be Stage A in the Single-Session RESPECT Model

Objective

To provide the HIV results to the client

Time: For the 2-Session Model, within the 2-10 minutes allowed for Stage 1; For the Single-Session Model, 2-3 minutes



Key Points

1. Follow usual protocols and procedures. Providers should follow the standard protocols and procedures for their agency, local health jurisdiction, and state. It is our assumption that this includes basic counseling skills, such as preparing for giving the result, stating the result clearly and in a neutral tone, clarifying the meaning and assessing the client's reaction.
2. If non-reactive (negative), proceed to Stage 2 (stage 2 is referred to as stage B in the Single-Session RESPECT model). Once the client has processed the result, check in with him or her about the original risk reduction step and proceed through the remainder of the session as outlined in the common stages.
3. If reactive (positive), follow the client's lead. Don't assume that a client will or will not be able to revisit his or her previous risk-reduction step. Clients will have a wide variety of reactions to a positive test result. It is important to attend to the client's immediate needs such as support and medical referrals. Risk-reduction concerns may become more urgent or priorities may change, (i.e., clients may feel a need to

discuss how to talk to a previous partner about being positive and abandon a previous risk-reduction step that involves future actions).

4. If single session, ask how or if result will impact plans for risk-reduction step. The only difference in a single session or rapid test setting is that clients will not have had the opportunity to implement the risk-reduction step. When a provider chooses to proceed to Stage 2, the question will be whether the test result, negative or positive, changes the way he or she thinks about the agreed upon step.

Stage 2 or B: Review the Risk-Reduction Step

Objective

In this stage, you and the client review the step the client agreed to take to reduce his or her risk, and his or her experience with carrying out the risk-reduction step. Another objective is to support and reinforce attempts by the client to put the step into action.

Time: 4–5 minutes

- **Reminder: This stage is referred to as Stage B in the Single-Session RESPECT Model**

Stage B or 2: Review Risk Reduction Step

1. Assess efforts with risk reduction step
 - Assess impact of results on RR step
2. Provide encouragement and support
3. Identify strengths and barriers
4. Problem solve issues

Key Points

1. For 2-Session RESPECT, assess efforts with risk-reduction step. Check with the client about how he or she did with their prior risk-reduction step. For Single-Session RESPECT, ask how or if result will impact plans for risk-reduction step. The clients will not have had an opportunity to implement the risk-reduction step. When a provider chooses to proceed to Stage B, the question will be whether the test result, negative, or positive, changes the way the client thinks about the agreed upon step and their motivation to follow-through.
2. Provide encouragement and support. Remind the client of the continued importance of risk-reduction.
3. Identify strengths and barriers. Explicitly identify the ways in which the client will be able to move forward with the risk-reduction step. Helping the client to identify things that might present a challenge.
4. Identify sources of support. Ask the client where he or she gets support in his or her life. Can the client get support for risk-reduction efforts in the same places he or she gets support for other issues?
5. Problem-solve issues. Help the client to identify ways in which he or she can work through or around issues that might pose barriers to moving forward with the risk-reduction step.

Stage 3 or C: Revise the Risk-Reduction Step

Objective

The purpose of this stage is to renegotiate a new or revised risk-reduction step.

Time: 4–5 minutes

- **Reminder: This stage is referred to as Stage C in the Single-Session RESPECT Model**



Stage C or 3: Revise Risk Reduction Step

1. Develop new or more challenging step
2. Identify actions to achieve step
3. Identify strengths and barriers
4. Document revisions



Key Points

1. Develop new or more challenging step. Work with the client to develop a new risk-reduction step based on his or her feelings about their test result. Have his or her priorities changed for any reason? What are his or her concerns about becoming infected?
 2. Identify actions to achieve step. This will be similar to Session 1 (2-Session model) or the Pre-Result Session (Single-Session model). Talk with the client about specific ways in which he or she will move forward to achieve the step.
 3. Identify strengths and barriers. Use the client's experience with the previous risk-reduction step to highlight strengths he or she brings as well as potential barriers. Work with the client on strengths and problem-solve barriers.
 4. Document revisions. As in Session 1 / Pre-Result Session, document the revised risk-reduction step for your agency records. Write it down also for the client to use and reference efforts to move forward.
- ◆ It is important to follow the client's lead when raising the possibility of a new or challenging step. A new step should not be seen as the result of a client's "failure with the prior step but as an opportunity to get closer to his or her larger HIV prevention goals and build upon prior success.

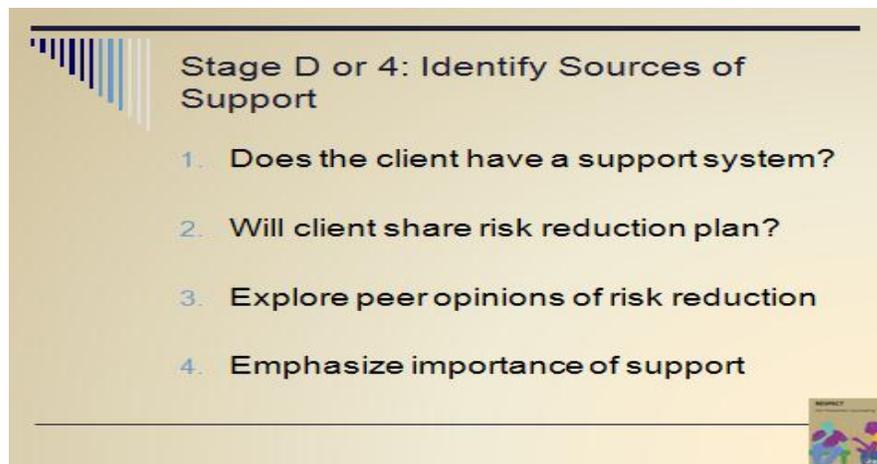
Stage 4 or D: Identify Sources of Support for Risk-Reduction Step

Objective

The objective of this stage is to identify resources that will help increase the client's ability to reduce risk.

Time: 1–2 minutes

- **Reminder: This stage is referred to as Stage D in the Single-Session RESPECT Model**



Stage D or 4: Identify Sources of Support

1. Does the client have a support system?
2. Will client share risk reduction plan?
3. Explore peer opinions of risk reduction
4. Emphasize importance of support

Key Points

1. Does the client have a support system? Ask the client who they consider, if anyone, to be their support system. Does he or she imagine the support system being able to support him or her in these efforts?
2. Will the client share the risk reduction plan? If so, ask the client with whom. If not, what prevented the client from sharing?
3. Peer opinions of risk reduction. Research has shown that peer opinion regarding prevention related behavior is an important factor in an individual's ability or willingness to change behavior.
4. Emphasize importance of support. Behavior change can be difficult. Discussing intentions with others can create both support and accountability.

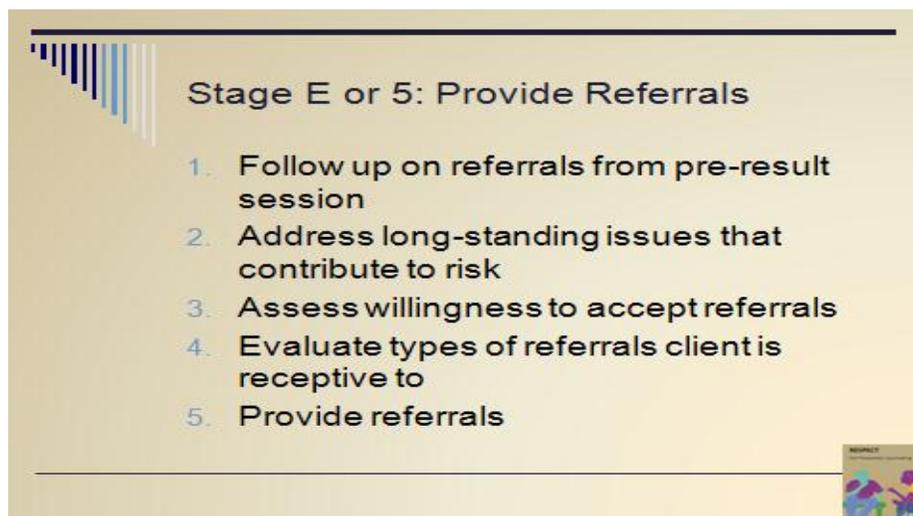
Stage 5 or E: Provide Referral (as necessary)

Objective

The objective of this stage is to ensure that the client knows where or to whom to go for help and intends to follow up.

Time: 1–2 minutes

- **Reminder: This stage is referred to as Stage E in the Single-Session RESPECT Model**



Stage E or 5: Provide Referrals

1. Follow up on referrals from pre-result session
2. Address long-standing issues that contribute to risk
3. Assess willingness to accept referrals
4. Evaluate types of referrals client is receptive to
5. Provide referrals

Key Points

1. Assess willingness to accept referrals. Check in with the client in non-judgmental way. Clients may be very eager to link with services or they may feel a need to apply the content of the session first. Make sure to leave the door open if a client is reluctant now.
2. Provide referrals directly related to step. If the client is willing to accept referrals, focus on referrals that will help the client make progress in accomplishing the specific step she or he has identified.
3. Address long-standing issues that contribute to risk. One client who has been struggling with a long history of substance use may feel a sense of urgency when addressing this risk rather than a sexual one. Another client with the same issues may not share the same priorities in the least.

4. Provide referrals related to long-standing risk. Clients who are ready to address long-standing issues will benefit from referrals to appropriate services.

- ◆ This stage may be very similar to the process already followed in many work settings. Session stages may not always progress in a linear fashion, and providers may have given clients referrals earlier in the session.

Stage 6 or F: Close the Session

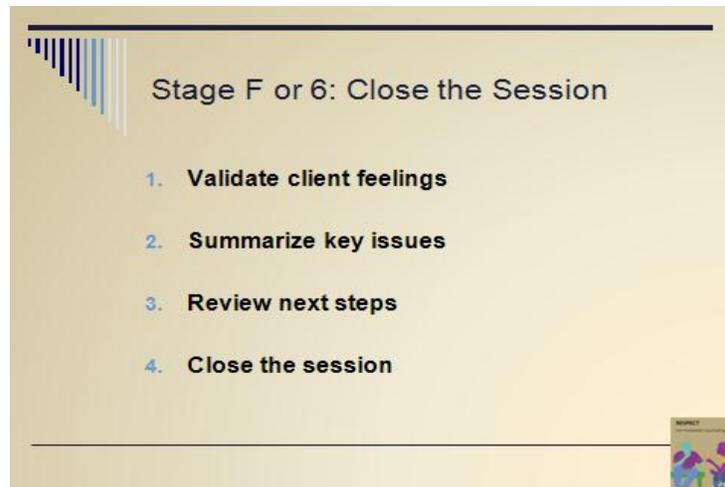
Objective

The objective of this stage is to provide closure to the session for the client.

Time: 1–2 minutes

- **Reminder: This stage is referred to as Stage F in the Single-RESPECT Model**
- **Notice:** The components of Stage 6 in the 2-Session RESPECT Model slightly differ from the components of Stage F in the Single Session RESPECT Model. See example slides below

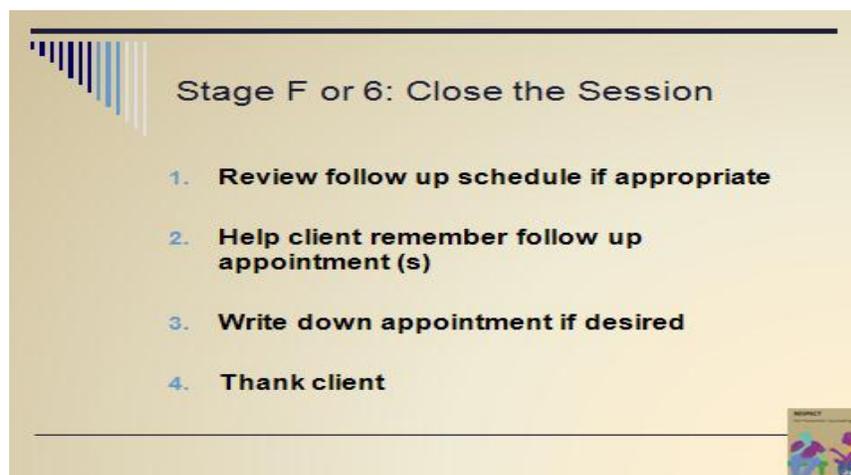
2-Session RESPECT Model



1. Validate client feelings. Reflect back to the client any feelings the client has been discussing. Normalize whatever he or she is going through.

2. Summarize key issues. Reiterate the important points you have discussed. Ask the client if he or she feels that you have missed anything.
3. Review next steps. Reflect the next steps that have been discussed in the session. Again, ask the client if you have missed anything or if he or she has any concerns about his ability to follow up.
4. Review contact information. Provide the client with any and all information needed to get in touch with you if appropriate. Review the contact information for any referrals given.
5. Close the session. Thank the client for coming in. Express genuine positive regard.

Single-Session RESPECT Model



Key Points

1. Review follow up schedule: Make note of need for retesting if non-reactive in window period, or if reactive for confirmatory test result.
2. Help client remember follow up appointment: Check in with client regarding best way to remember return appointment.
3. Write down appointment: Check appropriateness or utilize other personal options (i.e.: smart phone).
4. Thank client: Thank the client for coming in. Express genuine positive regard.

Quality Assurance Guidance

Introduction

Quality assurance is one of the core elements of the RESPECT HIV Prevention Counseling model and, as such, is critical to the integrity of this intervention. Quality assurance is an ongoing process that is intended to ensure that providers deliver the RESPECT HIV Prevention Counseling model with integrity as described in the intervention package.

The Project RESPECT study found that this intervention resulted in significant reductions in sexually transmitted disease (STD) rates and increases in use of condoms among study participants (see Appendix A). Although this research was conducted across multiple sites, comparable results were obtained across all of the sites because all sites followed quality assurance procedures.

This section provides recommendations on implementing and maintaining quality assurance in organizations that conduct HIV prevention counseling, testing, referral, and a range of other services where the RESPECT model may be used. It is included to assist these organizations with implementing this evidence-based intervention in a consistent manner.

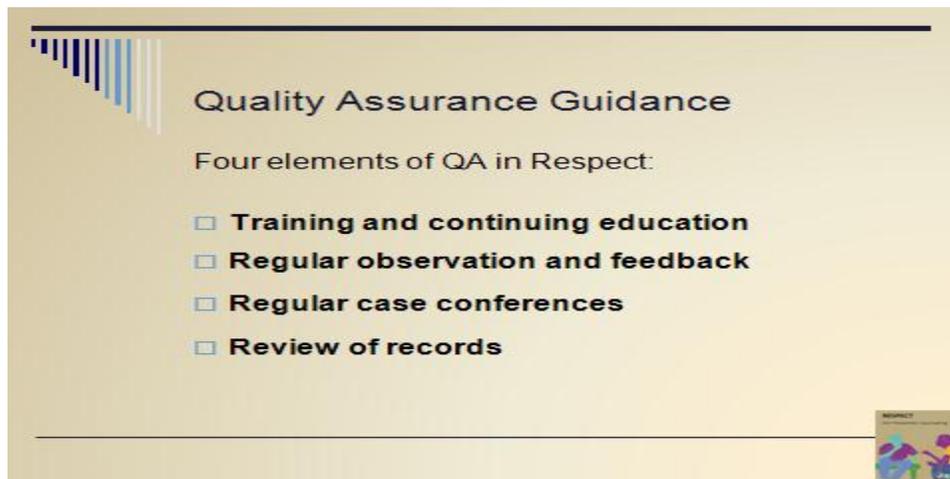
Quality Assurance for RESPECT

For the purposes of this RESPECT HIV Prevention Counseling package, the focus of quality assurance is on the delivery of the counseling intervention itself and does not include quality assurance protocol recommendations for other aspects of services such as testing, informed consent, or test decision counseling.

Quality assurance involves assessment, feedback, and strategizing. These tasks can be carried out through a variety of activities, including

- Training and continuing education (for both providers and supervisors).
- Regular observation, with follow-up feedback and support supervision, of providers delivering prevention counseling sessions.
- Review of records to ensure appropriate, accurate, and consistent documentation.
- Holding regular case conferences to discuss specific counseling sessions. Case conferences also serve as a means of developing staff skills and consistent delivery of the intervention

Strategies for Implementing and Maintaining Quality Assurance



Training

The training includes workshops on the RESPECT HIV Prevention Counseling Model. The training reviews basic HIV counseling concepts and skills, reviews each session in depth, provides an opportunity for participants to practice RESPECT counseling, and reviews quality assurance activities. Training for RESPECT HIV Prevention Counseling also provides a setting in which providers and supervisors can practice their skills.

Prior to taking the training on RESPECT HIV Prevention Counseling, providers and supervisors should be trained in counseling skills and concepts, HIV basics such as information on transmission routes, and information on state and local policies. This training ensures that all providers and supervisors have similar counseling background information and understand the basics of HIV counseling.

Regular Observation of Counseling Sessions

Observation of counseling sessions is the process in which a supervisor or senior provider directly observes a session or reviews one by listening to an audiotape of a session. To ensure quality counseling, adherence to protocol, and consistency in delivery of the intervention by all counseling staff, it is recommended that sessions be observed or taped on a regular basis. Observation and feedback by supervisors or other senior providers have proven effective in ensuring that providers understand how to conduct the counseling and maintain the integrity of the protocol.

By observing counseling sessions, a supervisor or lead provider can assess whether protocols are being followed. Observation may also help in assessing the provider's style of counseling and whether he or she is using key counseling concepts (e.g., open body language, nonjudgmental language). See Appendix for the quality assurance forms.

Observation Procedures

Providers can be observed by their supervisor in person or the session can be taped for later review. Either way, it is important that the client is aware of and agrees to the observation or recording of the session. Also, the client should understand that he or she can refuse to have the observer in the room and can ask the observer to leave at any time. If the provider will be observed directly, he or she should explain to the client that the observer will focus on the counseling skills during the session and not on the issues presented by the client.

To decrease any anxiety and help prepare the provider, it is recommended that the observer schedule the observation ahead of time and discuss any anxiety the provider may have concerning the observation process. It is also recommended that the observer attempt to sit in so that he or she is able to observe the provider without interfering with the provider-client interaction. The observer should avoid sitting in the client's or provider's line of sight. It is critical that the provider maintain control of the session; thus, it is recommended that the observer avoid any discussion during the session.

Agency policy/protocols must be taken into account when establishing observation schedule. It may be helpful for new providers to observe a given type of counseling session several times prior to being observed conducting that type of session. When a new provider begins conducting sessions, he or she should be observed by an experienced provider or supervisor until it is determined that he/she is sufficiently skilled in the intervention. If the entire agency is new to RESPECT HIV Prevention Counseling, supervisors and providers might take turns observing each other, or they may seek technical assistance.

After training, periodic observation of counseling sessions is usually helpful to ensure high-quality work. Based on the number of clients your agency sees, or your agency's requirements, your organization may choose to vary the frequency at which staff is observed.

Completing Quality Assurance Forms

Three quality assurance forms are enclosed for session assessments. The purpose of the observation is to evaluate adherence to intervention protocols. These forms will help provide feedback to providers. The forms are tailored to the specific protocol and content of each session.

The shaded rows of the form represent the protocol stages. The non-shaded rows are the specific tasks to be accomplished within each stage. The forms are designed for the observer to note whether the provider has or has not met the expectations for the stage. The forms follow the structure and flow of the protocol in the provider cards. Due to the nature of the counseling interaction, the client may present issues in a manner that does not follow the protocol order. Such a diversion from the flow of the protocol is not because the provider failed to follow the protocol. However, a skilled provider should be able to steer the session according to the protocol and get the discussion to follow the proper order.

The quality assurance forms include three ratings: “Achieved,” “Not Achieved,” and “Not Applicable.” In general, each protocol stage is usually addressed in each session. A rating of “Achieved” reflects completion of a task and adherence to the protocol. If the task is missed or skipped entirely, the rating would be “Not Achieved.” The “Not Applicable” column is used when a stage of the session is not relevant to a particular client and when the built in redundancy of the model makes an item unnecessary. These forms may be modified by implementing agencies to suit their needs.

See Appendix for Quality Assurance Forms

Post-Observation Activities

At the end of the observed session, it is recommended that the observer carefully review the form content to ensure completion. Because immediate feedback will be most useful, it is recommended that observers provide feedback to the provider as soon as possible following the observed session. The assessment of the counseling skill is a joint activity by the supervisor or senior provider and the provider and should be conducted in a supportive manner. If kept as record, it is recommended that the observation forms are filed in a manner that ensures confidentiality and security.

The following tips are included to help the observing supervisor or senior provider provide feedback:

-
- Ask the provider for feedback on what he or she thought went well and what could have been better. This brings the provider into the process, clarifies what he or she perceives were the difficulties as well as the strengths of his or her observed session, facilitates agreement to the process, and expedites strategizing for staff development.
 - Be specific. Specifically identify content and intervention delivery issues by stage and, if possible, by the protocol prompt. The more specific feedback is, the more helpful it should be for the provider's development.
 - Identify aspects that need modification after discussing quality work. Focus on positive aspects first. Discuss quality work; relaying things that provider did well. Then in a supportive manner, discuss the "Not Achieved" aspects with minimal judgment or inference. This will help the provider explore the observation and discuss alternative approaches to the situation. Focus on things that the provider can do something about and not about things over which the provider has no control.
 - Focus on main areas that need strengthening. This is especially important if the issue has come up before with the provider. Focus on strengthening areas rather than on problems since it is easier to understand and use information on areas to strengthen. If a provider has difficulty following the protocol, he or she may benefit from additional one-on-one coaching or more frequent observation. A staff member overwhelmed with corrective feedback may be unable to make any changes. If a provider can improve in a number of areas, prioritize key issues rather than addressing all of them. This discussion should be done thoughtfully to ensure that it is collaborative and useful. Like the RESPECT counseling model, let the provider come up with a step or steps to assist him or her in developing the knowledge and skill to provide this counseling intervention as intended.
 - Use information from the observations for potential discussion topics during the case conferences. If the session was an especially interesting one, it might be useful to discuss it with a group.

Review of Records

Your agency may already include reviewing records as part of its ongoing quality assurance procedures. The purpose of reviewing records for RESPECT is to ensure consistent documentation of counseling sessions and to have some indication of the session content. In addition to key testing data requirements such as demographics, date, consent, return of test result, etc. when delivering the RESPECT counseling session, data collected might include indicators such as:

- Main risks and circumstances related to client's most recent risk incident (to determine if the session focused on most recent risk and circumstance).
- Date of most recent risk incident.
- The risk-reduction step (to determine if it's realistic, incremental, and achievable).
- Referrals and rationale for the referral (appropriateness of the referral).

Providing Feedback about the Record Review

Because immediate feedback is most useful, it is recommended that supervisors provide feedback to the provider as soon as possible following the record review.

Frequency of Record Reviews

For regular record reviews, follow your agency policies and procedures.

Regular Case Conferences and/or One-on-One Coaching

Case conferences are meetings among staff either in a group or one-on-one for coaching purposes. They provide a place for supervisors and providers to exchange constructive feedback. Case conferences also provide an opportunity to discuss important issues and create a collaborative and competent counseling team. They can also be an effective means for providing support of counseling staff and help prevent burnout.

Case conference activities can vary. The following is a list of possible activities for a group case review. All of these activities provide an opportunity for providers to learn from one another.

1. Present challenging, interesting, and especially effective sessions. When presenting a session, providers should provide a brief description of the client and his or her situation, any unique client issues or concerns, an account of the session's content and adherence to the protocol, and questions or concerns. Sessions should be conducted with respect to client confidentiality, minimizing specifics to protect client identification.
2. Role-play cases, particularly difficult cases, to strategize and practice new techniques.
3. Practice using package materials such as provider cards and observation forms.
4. Discuss and review stages of RESPECT counseling. For example, if providers find that they are having problems discussing risk reduction, the supervisor might lead a discussion to identify specific issues and come up with ways to overcome the discomfort of discussing a client's risks.
5. Problem-solve alternative approaches to dealing with challenging clients and issues.
6. Develop or enhance counseling skills. Discuss difficult and emotionally laden sessions in a supportive environment.

If you are a supervisor or one of the providers who is not presenting, provide feedback that is reinforcing and supportive. Discuss and review stages of the protocol and strategize alternative approaches to dealing with challenging clients and issues. It may help to role-play to practice alternative approaches.

Frequency of Case Conferences

Case conferencing can be a very powerful tool for staff development and support. Scheduling conferences monthly to meet staff needs will enhance agency ability to develop and sustain consistent delivery of this intervention.

RESPECT

Counseling Protocol for Rapid Testing



About Using the Provider Cards

The RESPECT session follows a structured protocol that guides the provider to conduct a personalized risk assessment, facilitate a discussion about client's risk situations, and encourage and assist clients to develop a realistic risk reduction step.

The basic structure of the provider cards needs to be practiced and followed to ensure the same degree of success that was demonstrated in the research. This tool is intended as a guide to help you follow the stages and steps of the intervention. Sample dialog is provided and you are encouraged to find your own words that are appropriate for your testing clients.

Use the RESPECT provider cards along with your client-centered counseling skills and techniques to focus on the client's specific behaviors that put them at risk for HIV. This is not an educational model, only give information to address gaps in knowledge or correct misunderstandings.

Using these provider cards to personalize risk for clients helps ensure an increased self-perception of risk and creates teachable moments to increase motivation to change. This is the major strength of the RESPECT model.

PRE-RESULT SESSION

PROTOCOL STAGES	TIME (In Minutes)	PAGE
1. Introduce and Orient Client to the Session	3-4	5
<i>The Rapid Test sample is taken, and test is started after the process is explained to the client and consent is acquired.</i>		
2. Enhance the Client's Sense of Self-Risk	2-3	8
3. Explore the Specifics of the Most Recent Risk Incident	2-3	11
4. Review Previous Risk Reduction Experiences	3-4	13
5. Summarize the Risk Incident and Risk Patterns	2-4	15
6. Negotiate a Risk Reduction Step	4-5	18
7. Identify Sources of Support and Provide Referrals	1-2	20
Total Time	17-25	

POST-RESULT SESSION-NEGATIVE

PROTOCOL STAGES	TIME (In Minutes)	PAGE
A. Deliver Test Result	2-3	22
B. Review the Risk Reduction Step	4-5	24
C. Revise the Risk Reduction Step	4-5	26
D. Identify Sources of Support for Risk Reduction Step	1-2	28
E. Provide Referrals as Necessary	1-2	30
F. Close the Session	1-2	32
Total Time	13-19	

POST-RESULT SESSION-POSITIVE

PROTOCOL STAGES	TIME (In Minutes)	PAGE
A. Deliver Test Result	2-10	34
B. Review the Risk Reduction Step	4-5	36
C. Revise the Risk Reduction Step	4-5	38
D. Identify Sources of Support for Risk Reduction Step	1-2	40
E. Provide Referrals as necessary	1-2	42
F. Close the Session	1-2	44
Total Time	13-26	

Stage 1: Introduce and Orient Client to the Session

3-4 Minutes

1. Introduce yourself and explain your role as a counselor

- *Hello, my name is [name]. I am going to be talking with you about your risk for acquiring HIV or contracting an STD and some of the concerns that you might have about that.*
- *My role as a counselor is to administer and interpret the RAPID HIV test and to help you explore those risks and look at ways that you might be able to do things differently to protect yourself and others.*
- *We use Rapid HIV testing which will give you a result in about 10-20 minutes. Would you like to continue? (Keep in mind consent may have already been given)*
- *I also wanted to let you know that I will be using these cards (Provider Cards) to help me remember to address all the important issues.*

2. Describe the session

(Briefly cover the following points. They will be explored in more detail through-out the session)

a. Indicate duration of the session

- *We will have about ___minutes to talk together. Everything we say here will be completely confidential.*

b. Explore HIV (and STD) risks

- *We will talk about your risks and concerns for acquiring HIV (and/or contracting STDs).*

(continued)

Stage 1: Introduce and Orient Client to the Session (cont.)

- c. Identify challenges to risk reduction
 - *We will look at how you have tried to reduce your risk in the past.*

- d. Discuss strategies to reduce risk
 - *We will talk about changes you could make to further reduce your risk and develop a plan for doing this.*

- e. Introduce and explain the Rapid Test (follow your clinic protocols and guidelines for describing the rapid test process and possible results)
 - *We will stop briefly to conduct the Rapid HIV test. You will have a result in 20 minutes or less. There are three possible results.*
 - **Non-Reactive (Negative)**, which means that HIV antibodies were not detected, and we will talk about the possible need for future testing.
 - **Reactive (Preliminary Positive)**, which means you are highly likely to be infected with HIV and we will need to run a confirmatory test. We would then talk about your next steps to take care of yourself and what you would do differently to avoid becoming infected with other STDs and to avoid exposing anyone else to HIV.
 - Rarely the result is **Invalid**, which means a result could not be interpreted. This can be caused by a problem with the individual test kit or with the sample collection. We would need to repeat the test with a new kit to provide you with an accurate result. We have measures in place to assure the tests are accurate and invalid results are rare.

(continued)

Stage 1: Introduce and Orient Client to the Session (cont.)

3. Address immediate questions

(Follow clinic protocol regarding consent and document if more than verbal consent is required)

- *Before we go any further, what concerns or questions do you have?*
- *If we identify issues we **cannot** address today, **I will offer referrals that might help you with these issues.***
- *Are you ready to get tested?*

Stage 2: Enhance the Client's Sense of Self-Risk

2-3 Minutes

1. Assess client's presenting issues

- *What brought you in today (for your test)?*
- *Can you tell me about what you think might be putting you at risk for HIV and other STDs?*

2. Listen for and identify behaviors that put client at risk

- *What do you think may have put you at risk for acquiring HIV or an STD?*
- *How do you define being careful? Safe?*

If client reports injection drug use, you may ask:

- *What does injecting safely mean to you?*
- *Can you tell me step-by-step what you do?*

3. Assess the client's level of concern about having or acquiring HIV (or STDs)

- *Which behaviors concern you the most?*
- *So, do you know that the same things that put you at risk for HIV can also put you at risk for STDs and Hepatitis?*
- *You say you are not concerned yet you are here to get a test, can you help me understand that?*

(continued)

Stage 2: Enhance the Client's Sense of Self-Risk

4. Discuss the client's HIV/STD test history and behavior changes in response to results

- *When was the last time you tested for [HIV/STD]?*
- *What was that experience like for you?*
- *How did the counseling or test results affect how you feel about the possibility of acquiring HIV or an STD?*

5. Assess whether the client is engaging in risk behavior because of previous results

- *When you were tested for _____, how did the counseling change your behavior?*
- *What have you done to keep from acquiring [HIV/STD] since the test?*

6. Direct the client's attention toward risk behavior

- *From what you have said about your behavior, you could be at some real risk for acquiring HIV [if appropriate].*
- *Some of the things you have told me about your risk behaviors put you at risk for acquiring HIV. That concerns me.*

(continued)

Stage 2: Enhance the Client's Sense of Self-Risk

7. Discuss examples of conflicts between the client's beliefs and behavior or examples of mixed feelings about risk reduction

- *We know that there is no cure for HIV so far and people respond differently to HIV treatment. I am wondering how would having HIV change your life?*
- **[If applicable]** *You have said how bad acquiring HIV would be, yet you continue to put yourself at risk with people whose status you don't know. Can you help me understand that?*

Stage 3: Explore the Specifics of the Most Recent Risk Incident

2-3 Minutes

1. Identify context that contributed to the incident

- *Tell me a little bit about the last time you put yourself at risk for acquiring HIV or getting STDs.*
- *Can you tell me what led up to having sex (or shooting drugs)?*

a. Who, what, where, when

- *Was that with someone you knew well?*
- *Where did you go to have sex (or inject)?*
- *Was it about where you were or who you were with that allowed you to take this risk?*

b. Vulnerabilities and triggers

- *What kept you from protecting yourself and your partner?*
- *How does drinking alcohol or using other drugs influence your decision to have sex or to have sex without a condom (or share needles)?*
- *What else is going on in your life that might be leading you to take risks?*
- *When you think of all the situations when you have had unprotected sex (shared needles) in the last three months or so, what was going on that made you take a risk? Was there anything common in all those situations?*

(continued)

Stage 3: Explore the Specifics of the Most Recent Risk Incident

2. Assess the level of risk acceptable to the client

- *How comfortable were you with what happened?*
- *What concerns do you have about having sex (or sharing needles) with this person?*
- *What behaviors do you draw the line at? Are too risky?*

3. Assess communication about HIV with partner(s)

- *What did you and your partner talk about in terms of HIV risk or about being safe?*
- *How did you make that decision (to have sex or shoot drugs)?*

4. Be aware of contradictions that can be addressed to create dissonance

- *If you knew beforehand that your partner had HIV, would you have had unprotected sex (shared needles) with him or her?*
- *Would knowing have made a difference?*
- *It sounds like not getting HIV is really important to you and something you have a lot of concern about, and yet you are putting yourself in situations where you are at risk. Can you help me understand that a little more?*

Stage 4: Review Previous Risk Reduction Experiences

3-4 Minutes

1. Assess the patterns of risk behavior (e.g., happening regularly, occasionally, an unusual incident)

- *How often do you have sex (share needles) with a partner?*
- *Did you have sex (or share needles) more than once with any of those partners, like with a boyfriend or regular partner?*
- *How often did you practice safer sex (or inject safely)?*

2. Identify successful attempts at safer sex

- *What have you done to reduce your risk in the past?*
- *Tell me about a time when you chose to protect yourself and your partner by asking someone to use a condom or else not have sex?*
- *What made it work for you?*
- *It is great to hear you say that you have... **[describe Risk Reduction effort]**. That reduces your chance of getting an STD or acquiring HIV.*

3. Identify obstacles to risk reduction

- *What is the difference between the times you have used condoms (clean needle) and the times you have not used condoms (clean needle)?*

(continued)

Stage 4: Review Previous Risk Reduction Experiences

- *What gets in the way of protecting yourself and your partner?*
- *What has been the most difficult part of reducing your risk?*

4. Explore triggers and situations that increase the likelihood of high-risk behavior (if appropriate)

- *Tell me about the things that make it more challenging for you to protect yourself?*
- *What is the difference between the times you are safe and the times you are unsafe?*
- *How do alcohol and other drugs affect your decision to have unprotected sex?*
- *What is it about some partners that makes it more difficult to protect yourself?*
- *Were there times in your life (e.g., when you've felt depressed, been unemployed, or recently broken up with someone) when you felt it was more difficult to practice safer sex (or inject safely)?*

5. Explore the client's communication about risk with friends and partners

- *What do you and your friends talk about concerning [HIV/STD] risks?*
- *When you talked about HIV risk reduction with a sex partner, who brought up the topic?*
- *How did you feel about how it went?*
- *What was the outcome?*

Stage 4: Review Previous Risk Reduction Experiences

6. Discuss the client's level of acceptable risk

- *Are you comfortable with the risks you have taken?*
- **[If yes]** *This involves the risk of getting [HIV/STD], and you say you feel comfortable with that? Can you help me understand that? [Said non-judgmentally]*
- *What would you be comfortable doing to avoid HIV?*
- *What do you consider too risky?*

7. Be aware of contradictions that can be addressed to create dissonance

- *The activities you say you feel comfortable with put you at some risk for acquiring HIV, and you have said that you don't want to get HIV. How do you explain this?*
- *You said you are always safe, yet you have had two STDs in the past six months. How did you get them?*
- *You said you "just know" when someone is positive to avoid them. How can you be certain when you don't ask them about their status?*

Stage 5: Summarize the Risk Incident and Risk Patterns

2-4 Minutes

1. Provide feedback about the client's risk for acquiring HIV

- *It is great that you are thinking about what is risky.*
- *From what you have told me, there have been [quite a few, some, a couple of] risky situations that may have exposed you to HIV. It is really important that we work together to address this.*

2. Summarize the information

- *Here is how I understand your risks for acquiring HIV and getting STDs. First of all, you came in because [name reason for coming in. Retell the client's story as clearly as possible, making connections between issues and situations, and summarizing the key issues identified by the client].*
- *Does that sound right?*

3. Note the pattern of risk behavior

- *Let's talk about how often these risks happen. First, you have been able to protect yourself when [list circumstances that help the client reduce risk]. Is that right?*
- *However, when you [describe circumstance], you find yourself engaging in risky behaviors. It is important that we understand this.*

(continued)

Stage 5: Summarize the Risk Incident and Risk Patterns

4. Identify triggers

- *Several issues seem to affect your risk behavior: [list specific behavior, communication, or substance-use issues].*
- *Is this how you see your risk behavior?*
- *Does this make sense to you?*

5. Be aware of contradictions

- *You said that you would be less worried today if you had used condoms (or clean needles) more often in the past.*
- *How do you think you could make it happen?*

6. Convey concern and urgency about the client's risks (as appropriate)

- *You do not want to get HIV, and if you do not make some changes, you could be putting yourself at risk continually, and that really concerns me.*
- *I'm concerned the behaviors you describe are really putting you at risk for HIV.*

7. Encourage and support the client in addressing risk issues

- *Getting an HIV test and talking with me is a really great place to start because it shows you are taking care of yourself and doing something positive.*
- *Being willing to talk about this shows you care about yourself and others.*

Stage 6: Negotiate a Risk Reduction Step

4-5 Minutes

1. Prioritize Risk Reduction behavior

- *What do you think are the most important things to look at, or the most important circumstances to address to reduce your risk?*

2. Explore behavior(s) that the client will be most motivated to change

- *Realistically, what could you do to reduce your risk?*
- **[If the client selects a radical “always” or “never” approach]**
We know that change usually occurs in small steps. What would be the first step in reaching this goal?
- **[If the client is at a loss regarding how to reduce risk]** *I could suggest some options for reducing your risk: **[suggest some options]** but you are the only one who knows what will work for you.*

3. Identify a reasonable step toward changing the identified behavior

- *What step could you complete in the next week that would move you closer to reducing your risk?*

4. Divide the step into specific actions

- *You have identified something that you feel you can do. How are you going to make this happen?*

(continued)

Stage 6: Negotiate a Risk Reduction Step

- *What do you need to do first, second, third?*
- *When do you think you could do this?*

5. Ask the client to be aware of strengths and challenges in implementing the step

- *What might get in the way of doing this step?*
- *How could you plan for that challenge and work around it?*
- *What would be a good back-up step?*
- *How would you feel if you could complete this step?*
- *Changing behavior takes time and practice.*
- *You will really have done something good for yourself by trying out this step.*

6. Document the Risk Reduction step (get permission from client to give written documentation)

- *Let's write it down on this piece of paper so you will have a reference for when you leave today. Just a quick review, what is your step?*
- *We'll review this step after you get your results. You may think differently about your step depending on your result.*

Stage 7: Identify Sources of Support and Provide Referrals

1-2 Minutes

1. Assess the client's support system

- *Who in your life do you talk to about these things or who supports you?*
- *Is there someone who you feel you can talk with about your feelings and concerns?*
- *Who have you talked with about HIV risk already? How could they support you?*

2. Address the long-standing issues that contribute to risk

- *Your step sounds really good. We have identified some important bigger issues that lead to you taking risks, specifically [name issue].*
- *I can give you referrals to other services that might help with those issues.*

3. Assess the client's willingness to access referrals

- *Have you ever sought assistance for [name issue], such as counseling, a support group, or substance abuse treatment?*
- *How interested would you be in a referral to help you deal with this issue?*

(continued)

Stage 7: Identify Sources of Support and Provide Referrals

4. Evaluate the types of referral the client would accept

- *Would you be more comfortable in one-on-one counseling or in a group setting?*
- *Is there a particular type of support or service you would consider using?*

5. Provide appropriate referrals

- *Here is the name and phone number of the service you could call to get assistance.*
- *You can ask for _____ and tell him or her that I suggested you see _____.*
- **[If you have time and the referral service is open, offer to make the phone call for the client and set up an appointment now.]**

6. Transition (remind client of possible results and assess readiness to receive result)

- *We talked about a lot of things. Are you ready to get your results?*

Stage A: Deliver Test Results-NEGATIVE

2-3 Minutes

1. Assess whether client is ready to receive their test results. Deliver result in a clear calm manner

- *Are you ready to hear your test results?*
- *If you are ready, I will give you your result now.*

[Follow clinic protocols for giving results & transition to appropriate Post-Result Session Protocol]

- *Your result is **non-reactive (negative)**, which means no HIV antibodies were detected at this time.*

2. Allow client a moment to process the result as necessary

[Allow silence or other reaction.]

3. Check for understanding of result including window period and address any immediate reaction or questions.

- *Based on what you discussed as your most recent risk, you may need to retest in 3 months from your last risk.*
- *As we discussed earlier, you will need to test again since your most recent risk was less than 3 months ago.*
- *Remember the recommendation is 3 months from the date of last risk; your most recent risk may not be covered by this test.*

(continued)

Stage A: Deliver Test Results-NEGATIVE

4. Explicitly identify how a negative result affects the client's perception of risk

- *We discussed some of the things that concerned you about your risk for becoming infected with HIV. How do you feel about that now?*
- *As we discussed earlier some of the things you have been doing put you at high risk for getting HIV. Now that you have heard you are negative, how do you feel about them?*

Stage B: Review the Risk Reduction Step-NEGATIVE

4-5 Minutes

1. Assess the client's commitment to the step developed pre-result

(Remember to use any teachable moments and issues that concerned the client to keep awareness and focus on risky behaviors.)

- *Earlier we discussed some of your risks for [HIV/STD] [list risks].*
- *We came up with a Risk Reduction step for you to try after you leave here today. How do you feel about your step now that you have a negative result?*
- *Now that you have your result, how do you see your step and plan changing if at all?*
- *Remember earlier you were very concerned about some of the things you were doing that put you at high risk for getting HIV.*
- *Earlier we discussed how having an STD put you at higher risk for HIV and you were very concerned that you were exposing yourself.*

2. Provide encouragement and support for client's Risk Reduction step and plan (as appropriate)

- *Sounds like you are committed to protecting yourself and others in the future.*

(continued)

Stage B: Review the Risk Reduction Step-NEGATIVE

- *I am impressed with how you plan to handle that.*
- *You have really accomplished something for yourself by developing your plan.*

3. Identify strengths and barriers to the Risk Reduction step

- *How do you think it will feel when you take this step to reduce your risk?*
- *What parts of the step will be easiest?*
- *Which parts of the step might be challenging?*
- *What might stop you?*
- *What thoughts or feelings might support or challenge you?*
- *What would make it easier for you?*

4. Problem-solve issues concerning the step (if relevant)

- *How can we address the problems you might have with reducing your risk?*
- *What would help you get this done?*
- **[Offer options if client is at a loss. Be careful not to be directive]**
- *Some of my previous clients have tried _____, how do you think that might work for you?*

Stage C: Revise the Risk Reduction Step-NEGATIVE

4-5 Minutes

1. Develop a new or more challenging step with the client

(If necessary remind client of issues and concerns from the pre-result session)

- *You did an excellent job with developing this first Risk Reduction step. What else could you try to further reduce your risk of acquiring HIV? How do you feel about trying your step?*
- *Earlier you were very concerned about how the things you were doing put you at risk for HIV; this negative result doesn't mean those things are not risky.*
- *I am concerned that the things we talked about earlier that put you at risk will happen again.*
- *Remember that risk reduction and behavior change are best done in small, achievable steps. What do you need to do next to reduce your risk?*

2. Identify actions to achieve the step

- *Let us look at the issues that need to be addressed to reduce your risk and complete your new plan. [List issues] What do you need to do first, second, third?*
- *Try to think about how to improve or modify the step so it works better for you.*

(continued)

Stage C: Revise the Risk Reduction Step-NEGATIVE

3. Identify strengths and barriers

- *What do you think will allow you to make this step work for you?*
- *What might make it hard to do this step?*
- *When you try this step, think about what feels good and works for you, and which parts are hard or uncomfortable.*

4. Document the revised Risk Reduction step

- *Just as before, we will write your step on this piece of paper, and we will include all the actions needed to complete it. [Write out actions.]*
- *Sometimes just looking at the paper can help you remember the step and help you see yourself completing the step.*

Stage D: Identify Sources of Support-NEGATIVE

1-2 Minutes

1. Does the client have a support system?

- *As we discussed earlier it may be useful to share your step with someone who can support you in your efforts to reduce your risk. Who could you trust to tell about your visit here and talk with you about this step?*
- *Who knows you came for a test?*
- *It sounds like your (sibling, cousin, friend...) will be a good person to help you with this.*
- *Is there anyone else you would want to share this with and get support from? Someone who will help keep you on track?*

2. Discuss how client will go about discussing this with the people they have identified. Problem solve

- *How will you go about talking to [name]?*
- *What do you think might be difficult about talking to this person?*
- *If you have talked to them in the past about difficult things, what could you do next time to make sure you are able to talk to him or her about this?*
- *How do you feel about talking to [name] about your plan now?*
- *What will you say to [name]?*

(continued)

Stage D: Identify Sources of Support-NEGATIVE

3. [If client doesn't identify someone] Help identify a person to whom the client could comfortably disclose the step

- *Who in your life is supportive of you?*
- *Could you talk with him or her about the step?*
- *Who do you usually talk with about challenges you are facing?*
- *Do you and your friends ever talk about concerns about HIV?
Could you talk with any of them about this step?*
- *Who knows you came for a test? Might they be someone to talk to?*

4. Establish a concrete, specific approach for the client to use in sharing the step with a friend or relative

(If necessary remind client of issues and concerns from the pre-result session)

- *So, you believe you could tell [name] about this step?*
- *It is important to tell [name] about your intentions concerning the step and then to report to them on how it went.*
- *When and how will you tell [name]?*
- *What will you say? Would you like to practice?*

Stage E: Provide Referral-NEGATIVE

1-2 Minutes

1. If a referral was provided in the pre-result session, follow-up on the client's opinion of the referral post-result

- *(If a referral was provided in the pre-result session) When we talked earlier, I gave you a referral to [name]. How do you feel about calling to make an appointment now? Is there something I can do to facilitate this referral?*
- *Would you like to call and make an appointment right now?*
- *What might be more useful now?*

2. Address the long-standing or hard-to-manage issues that contribute to risk (optional)

- *Your step seems really good, and you've discussed some important issues that contribute to your risk and may best be handled with the help or assistance of professionals. How do you feel about that?*
- *Since we've talked about how [drug use and/or alcohol] affects your risk, have you considered getting help in dealing with this?*
- *Would some professional help to deal with [drug use and/or alcohol, mental health] be useful in keeping you from putting yourself at risk?*

3. Assess the client's willingness to seek professional help and use a referral (optional; repeat from pre-result session)

- *Some of the issues we talked about today are beyond my expertise and what we can deal with in this short time. How do you feel about seeking some additional support with these?*

(continued)

Stage E: Provide Referral-NEGATIVE

- *What about seeking assistance (e.g., counseling or a support group, methadone treatment, Narcotics Anonymous)? Have you (re)considered this?*
- *How interested would you be in getting a referral for services to deal with the issue?*
- *What would be the hardest thing about seeking support for [name the issue]?*

4. Evaluate the types of referral the client would be most receptive to (optional)

- *Would you be more comfortable talking to an individual provider or going to a support group?*
- *Is there a particular type of support or service you would be willing to consider using?*
- *What has been helpful in the past that might help with the issues you are dealing with now?*

5. Provide appropriate referral (optional)

- *Here is the name and phone number of the agency you can call to get assistance with the issue we discussed.*
- *How comfortable do you feel doing this?*
- *What questions do you have?*
- *Would you like to use my phone to call right now?*

Stage F: Close the Session-NEGATIVE

1-2 Minutes

1. Review the follow-up schedule if appropriate

(If no follow-up is being scheduled, skip to “Closing” in section 3 below.)

- *It's important that you come back for another test in ___months.*
- *Remember we talked about the window period and this test does not put you completely in the clear from some of the risks we discussed.*
- *If you want we can schedule a follow-up session to discuss how it went with your step/plan?*

2. Help client to remember follow-up appointment

- *What would help you remember to keep this appointment?*
- *Where do you usually record appointments so that you can remember?*

3. Write down appointment

(Get permission from client to give written documentation)

- *Is [day, date, time] okay?*
- *I am going to write your appointment down on the back of the piece of paper you wrote your step/plan on so you will have it for easy reference. (May ask client to write down appointment and step.)*

(continued)

Stage F: Close the Session-NEGATIVE

- *Let me make sure that you know how to contact me should you need to change the appointment.*

Closing

- *Thank you for coming in to talk with me today. You have done a lot of hard work. And I think you have made a step that will really work for you.*

Stage A: Deliver Test Results-POSITIVE

2-10 Minutes

1. Assess whether client is ready to receive their test results

Deliver Preliminary Positive result in a clear and calm manner following your clinic protocols

- *Are you ready to hear your test results?*
- *If you are ready, I will give you your result now.*

[Follow clinic protocols for giving results and transition to appropriate Post-Result Session Protocol]

- *Your result is **reactive (preliminary positive)**. This means it is highly likely that you are infected with HIV.*

2. Allow client a moment to process the result as necessary

- *Allow silence or other reaction.*

3. Check for understanding of result and address any immediate reaction or questions. Provide follow-up testing options and schedule confirmatory test

- *The rapid test is highly accurate and can detect HIV antibodies within a fairly short period after infection. The preliminary positive result from the rapid test will need to be confirmed with another test, but the result is very likely to be positive also.*
- *We will take a confirmatory sample before you leave today and have your results in a few days.*

(continued)

Stage A: Deliver Test Results-POSITIVE

4. Follow client's lead and assess for emotional and medical needs

- *I realize hearing that you are very likely infected with HIV may be difficult. (Unless client reaction indicates otherwise)*
- *Before you leave today I would like to put you in touch with a linkage counselor who can help you with the process of accessing care.*
- *I can connect you with referrals for emotional support and can make an appointment for you if you like.*

5. Assess client's readiness to move on to Stage B

- *One of the ways I can help right now is to talk with you about the risk reduction plan you developed earlier.*
- *Many of the things we discussed are still important to think about.*
- *How do you feel about spending a few minutes reviewing what you planned and talking about how it may change now that you have a preliminary positive result?*

Stage B: Review the Risk Reduction Step-POSITIVE

4-5 Minutes

1. Assess the client's commitment to the step developed pre-result

Remember to use any teachable moments and issues that concerned the client to keep awareness and focus on risky behaviors.

- *Earlier we discussed some of your risks for [HIV/STD] [list risks].*
- *We came up with a Risk Reduction step for you to try after you leave here today. How do you feel about your step now that you have a preliminary positive result?*
- *Now that you have your result, how do you see your step and plan changing if at all?*
- *Who knows you came for a test today? Who is the first person you will see when you leave here? Is anyone waiting for you?*
- *Earlier we discussed how having an STD put you at higher risk for HIV and you were very concerned that you were exposing yourself. How do you feel about possibly exposing others to HIV?*

2. Provide encouragement and support for client's Risk Reduction step and plan (as appropriate)

- *Sounds like you are committed to protecting yourself and others in the future.*
- *I am impressed with how you plan to handle that.*
- *You have really accomplished something for yourself by developing your plan.*

(continued)

Stage B: Review the Risk Reduction Step-POSITIVE

3. Identify strengths and barriers to the Risk Reduction step

(Disclosure of HIV status may be an issue, and may need to be supported)

- *How do you think it will feel when you take this step to reduce the risk of getting an STD or transmitting HIV?*
- *What parts of the step will be easiest?*
- *Which parts of the step might be challenging?*
- *What might stop you? What might make it more difficult?*
- *What thoughts or feelings might support or challenge you?*
- *What would make it easier for you?*

4. Problem-solve issues concerning the step (if relevant)

- *How can we address the problems you might have with reducing your risk? What would help you get this done?*
- *It sounds like telling partners about your status may be difficult. We can talk more about how you could do it or how you can get help from someone else to do it.*

Stage C: Revise the Risk Reduction Step-POSITIVE

4-5 Minutes

1. Develop a new or more challenging step with the client

(If necessary remind client of issues and concerns from the pre-result session)

- *You did an excellent job with developing this first Risk Reduction step.*
- *What do you need to do differently to reduce your risk of transmitting HIV?*
- *I am concerned that the things we talked about earlier that put you and others at risk will happen again.*
- *Remember that risk reduction and behavior change are best done in small, achievable steps. What do you need to do next to reduce your risk?*

2. Identify actions to achieve the step

- *Let us look at the issues that need to be addressed to reduce your risk and complete your new plan. [List issues]*
- *What do you need to do first, second, third?*
- *Try to think about how to improve or modify the step so it works better for you.*
- *It sounds like disclosing your status is very scary for you. How could you protect your partners without disclosing your status? (just using a condom, only being a bottom)*

(continued)

Stage C: Revise the Risk Reduction Step-POSITIVE

3. Identify strengths and barriers to the Risk Reduction step

- *What do you think will allow you to make this step work for you?*
- *What might make it hard to do this step?*
- *How would it feel to tell your partner so they can share in the responsibility of protecting themselves from infection?*
- *What will you do if someone asks a specific question about testing or status?*
- *When you try this step, think about what feels good and works for you, and which parts are hard or uncomfortable.*

4. Document the revised Risk Reduction step

- *Just as before, we will write your step on a piece of paper, and we will include all the actions needed to complete it. **[Write out actions.]***
- *Sometimes just looking at the paper can help you remember the step and help you see yourself completing it.*
- *You may want to be careful about where you keep your plan to assure no one sees it unless you show them.*

Stage D: Identify Sources of Support-POSITIVE

1-2 Minutes

1. Does the client have a support system?

(Disclosure of status may be a significant issue now.)

- *As we discussed earlier it may be useful to share your step with someone who can support you in your efforts to reduce your risk. Who could you trust to tell about your visit here and talk with about this step?*
- *Now that you have a preliminary positive result, what other support will you need? Are there different people who you are thinking about now?*
- *It sounds like your (sibling, cousin, friend...) will be a good person to help you with this.*
- *Is there anyone else you would want to share this with and get support from? Someone who will help you stick to your plan?*

2. Discuss how client will go about discussing this with the people they have identified. Problem solve

- *How will you go about talking to [name]?*
- *What do you think might be difficult about talking to this person?*
- *If you have talked to them in the past about difficult things, what could you do next time to make sure you are able to talk to him or her about this?*
- *How do you feel about talking to [name] about your plan now?*

(continued)

Stage D: Identify Sources of Support-POSITIVE

- *What will you say to [name]?*
- *What questions do you think [name] might have?*

3. [If client doesn't identify someone] Help identify a person to whom the client could comfortably disclose the step/your status

- *Who in your life is supportive of you?*
- *Could you talk with him or her about the step/your status?*
- *Who do you usually talk with about challenges you are facing?*
- *Do you and your friends ever talk about concerns about HIV?*
- *Who knows you came for a test? Might they be someone to talk to?*

4. Establish a concrete, specific approach for the client to use in sharing the step/status with a friend or relative

Offer to role-play talking with support person and give feedback

- *So, you believe you could tell [name] about this step/status?*
- *It's important to tell [name] about your intentions concerning the step and then to report back to them about how it went.*
- *When and how will you tell [name]?*
- *What will you say? Would you like to practice?*
- *What words will you use to disclose your status to [name]?*

Stage E: Provide Referral-POSITIVE

1-2 Minutes

1. If a referral was provided in the pre-result session, follow-up on the client's opinion of the referral post-result

- **(If a referral was provided in the pre-result session)** *When we talked earlier, I gave you a referral to [name]. How do you feel about calling to make an appointment now?*
- *What might be more useful now?*
- *May I have a linkage counselor talk to you before you leave today?*
- *What would help you when you leave here today?*
- *Is there anything else I can do to help you before you leave here today?*

2. Address the long-standing or hard-to-manage issues that contribute to risk (optional)

- *Your step seems really good, yet some important issues contribute to your risk that may best be handled with the help or assistance of professionals.*
- *Would some professional help to deal with [drug use and/or alcohol, mental health] be useful to help keep you from putting yourself and others at risk?*

3. Assess the client's willingness to seek professional help and use a referral (optional; repeat from Pre-result Session)

- *Some of the issues we talked about today are beyond my expertise and what we can deal with in this short time. How do you feel about seeking some additional support with these?*

(continued)

Stage E: Provide Referral-POSITIVE

- *What about seeking assistance (e.g., counseling or a support group, methadone treatment, Narcotics Anonymous)? Have you (re)considered this?*
- *How interested would you be in getting a referral for services to deal with the issue?*
- *What would be the hardest thing about seeking support for [name the issue]?*

4. Evaluate the types of referral the client would be most receptive to (optional)

- *Would you be more comfortable talking to an individual provider or going to a support group?*
- *Is there a particular type of support or service you would be willing to consider using?*
- *What has been helpful in the past that might help with the issues you are dealing with now?*

5. Provide appropriate referral (optional)

- *Here is the name and phone number of the agency you can call to get assistance with the issue we discussed.*
- *How comfortable do you feel doing this?*
- *What questions do you have?*
- *Would you like to use my phone to call right now?*

Stage F: Close the Session-POSITIVE

1-2 Minutes

1. Review the follow-up schedule if appropriate

If no follow-up is being scheduled, skip to “Closing” in section 3 below.

- *Your confirmatory test result will be ready ____, it is important that you come back for that.*
- *If you want we can schedule a follow-up session to discuss how it went with your step/plan. You can also discuss your step with your case manager or other service providers.*

2. Help client to remember follow-up appointment

- *What would help you remember to keep this appointment?*
- *Where do you usually record appointments so that you can remember?*
- *Many people use their phones to keep track of appointments. How do you keep track?*

3. Write down appointment

(Follow clinic protocols regarding paperwork and complete any required forms as directed by your supervisor.)

- *Is [day, date, time] okay?*
- *I am going to write your appointment down on the back of the piece of paper you wrote your step on so you will have it for easy reference. (May ask client to write down appointment and step.)*

(continued)

Stage F: Close the Session-POSITIVE

- *Let me make sure that you know how to contact me should you need to change the appointment.*

Closing

- *Thank you for coming in to talk with me today. You have done a lot of hard work.*
- *What will you do when you leave here and how will you take care of yourself?*



RESPECT Behavior Change Logic Model

The **RESPECT Behavior Change Logic Model** provides a systematic and visual representation of the internal logic of the intervention. The model depicts the relationships between:

- The factors from behavioral theory that impact risk behavior (behavioral determinants).
- The activities of the intervention that are meant to act on those behavioral determinants, and
- The expected outcomes, or changes, as a result of the activities targeting the behavioral determinants.

The **problem statement** describes the target population and the risk factors that RESPECT is intended to address.

The **behavioral determinants** are those things that influence risky behaviors (e.g. perceptions about risk behavior) and is addressed by one or more activities of the RESPECT intervention.

The **activities** to address the behavioral determinants and are the specific components of RESPECT.

The **outcomes** are the expected changes in the behavioral determinants that result from the activities. Examples of the immediate outcomes for RESPECT are Increase in perception of personal susceptibility for HIV/STDs, increase awareness and identification of causes. The Intermediate outcomes are decreases in risk behaviors, or increases in protective behaviors including increased ability of the client to consistently follow their risk-reduction plan.

RESPECT Intervention Behavior Change Logic Model

Problem Statement: Persons who engage in unprotected sex with multiple partners are at increased risk for HIV/STD infection or transmission. RESPECT is an individual-level, client-focused prevention counseling intervention consisting of two brief interactive counseling sessions to: reduce HIV/STDs, increase condom use, learn HIV status in order to be supported in reducing HIV transmission, and, receive referrals for care and treatment.			
Behavioral Determinants <i>Factors from behavioral theory that impact behavior</i>	Activities to address Behavioral Determinants <i>To address behavioral determinants</i>	Outcomes Expected changes as a result of activities targeting behavioral risk determinants	
		Immediate Outcomes	Intermediate Outcomes
<ul style="list-style-type: none"> • Perception of personal susceptibility for HIV • Recognition of the context of personal triggers, circumstances, and/or behavioral patterns where sexual risk-taking occurs • Self-efficacy to adopt risk-reduction behaviors • Intentions to adhere to risk reduction plan. 	Implements RESPECT counseling sessions as follows: <ul style="list-style-type: none"> • Conduct interactive one-on-one counseling, using RESPECT protocol prompts as necessary • Create a “teachable moment” to motivate client to change risk-taking behaviors • Explore circumstances and context of a recent risk behavior to increase perception of personal susceptibility • Explore circumstances and context of a recent risk behavior to increase perception of personal susceptibility • Explore, identify, and illuminate points of dissonance on a variety of levels (between intentions and behaviors, two mutually exclusive goals/mutually exclusive courses of action, etc.) • Provide support for intention to change and/or behavior change steps already achieved by aligning with the part of the client invested in reducing HIV risk • Negotiate an achievable step that supports a larger risk reduction goal • Foster the development of needed skills for achieving behavior change step (e.g. through condom demonstration, role play scenarios) • Implement and maintain quality assurance procedures 	<ul style="list-style-type: none"> • Increase in perception of personal susceptibility for HIV/STDs • Increase of awareness/insight into how certain points of dissonance may have served as an impediment to reducing risk • Identification of at least one trigger or circumstance that contributes to risk-taking behavior (e.g. lack of condoms, inconsistent or improper condom use), the context (when/with whom), and/or environment (where) in which behavior occur • Increased safer sex skills (e.g., correct application) and other prevention skills • Identification of a challenging, yet achievable step toward a risk reduction (RR) goal • Increased intent to practice RR step 	<ul style="list-style-type: none"> • Increased self-efficacy for reducing high-risk personal behaviors and choosing lower risk partners • Increased self-efficacy for ability to negotiate safer sexual and other high-risk behaviors with partners • Increased ability to consistently follow risk-reduction plan • Decreased risk-taking behaviors with high-risk partners • Increase condom use with casual partners • Decrease in the number of concurrent partners

RESPECT STUDY and **Appendix A**
RESPECT 2 STUDY

Efficacy of Risk-Reduction Counseling to Prevent Human Immunodeficiency Virus and Sexually Transmitted Diseases

A Randomized Controlled Trial

Mary L. Kamb, MD, MPH; Martin Fishbein, PhD; John M. Douglas, Jr, MD; Fen Rhodes, PhD; Judy Rogers, MS; Gail Bolan, MD; Jonathan Zenilman, MD; Tamara Hoxworth, PhD; C. Kevin Malotte, DrPH; Michael Iatesta, MA; Charlotte Kent, MPH; Andrew Lentz, MPA; Sandra Graziano, PhD; Robert H. Byers, PhD; Thomas A. Peterman, MD, MSc; for the Project RESPECT Study Group

Context.—The efficacy of counseling to prevent infection with the human immunodeficiency virus (HIV) and other sexually transmitted diseases (STDs) has not been definitively shown.

Objective.—To compare the effects of 2 interactive HIV/STD counseling interventions with didactic prevention messages typical of current practice.

Design.—Multicenter randomized controlled trial (Project RESPECT), with participants assigned to 1 of 3 individual face-to-face interventions.

Setting.—Five public STD clinics (Baltimore, Md; Denver, Colo; Long Beach, Calif; Newark, NJ; and San Francisco, Calif) between July 1993 and September 1996.

Participants.—A total of 5758 heterosexual, HIV-negative patients aged 14 years or older who came for STD examinations.

Interventions.—Arm 1 received enhanced counseling, 4 interactive theory-based sessions. Arm 2 received brief counseling, 2 interactive risk-reduction sessions. Arms 3 and 4 each received 2 brief didactic messages typical of current care. Arms 1, 2, and 3 were actively followed up after enrollment with questionnaires at 3, 6, 9, and 12 months and STD tests at 6 and 12 months. An intent-to-treat analysis was used to compare interventions.

Main Outcome Measures.—Self-reported condom use and new diagnoses of STDs (gonorrhea, chlamydia, syphilis, HIV) defined by laboratory tests.

Results.—At the 3- and 6-month follow-up visits, self-reported 100% condom use was higher ($P < .05$) in both the enhanced counseling and brief counseling arms compared with participants in the didactic messages arm. Through the 6-month interval, 30% fewer participants had new STDs in both the enhanced counseling (7.2%; $P = .002$) and brief counseling (7.3%; $P = .005$) arms compared with those in the didactic messages arm (10.4%). Through the 12-month study, 20% fewer participants in each counseling intervention had new STDs compared with those in the didactic messages arm ($P = .008$). Consistently at each of the 5 study sites, STD incidence was lower in the counseling intervention arms than in the didactic messages intervention arm. Reduction of STD was similar for men and women and greater for adolescents and persons with an STD diagnosed at enrollment.

Conclusions.—Short counseling interventions using personalized risk reduction plans can increase condom use and prevent new STDs. Effective counseling can be conducted even in busy public clinics.

IN THE UNITED STATES, an estimated 580 000 people are infected with human immunodeficiency virus (HIV). New acquired immunodeficiency syndrome (AIDS) cases are declining among gay men and injection drug users but continue to rise among heterosexuals and women.¹ AIDS is now the leading cause of death for black women aged 25 through 44 years.² Among heterosexual patients attending publicly funded sexually transmitted disease (STD) clinics, HIV prevalence is 50% to 100% higher than in the general population.³

Recent therapeutic breakthroughs have led to marked improvement in morbidity and mortality for HIV-infected persons; however, treatment costs are high and there is still no cure.⁴ Sound policy recommendations for disease pre-

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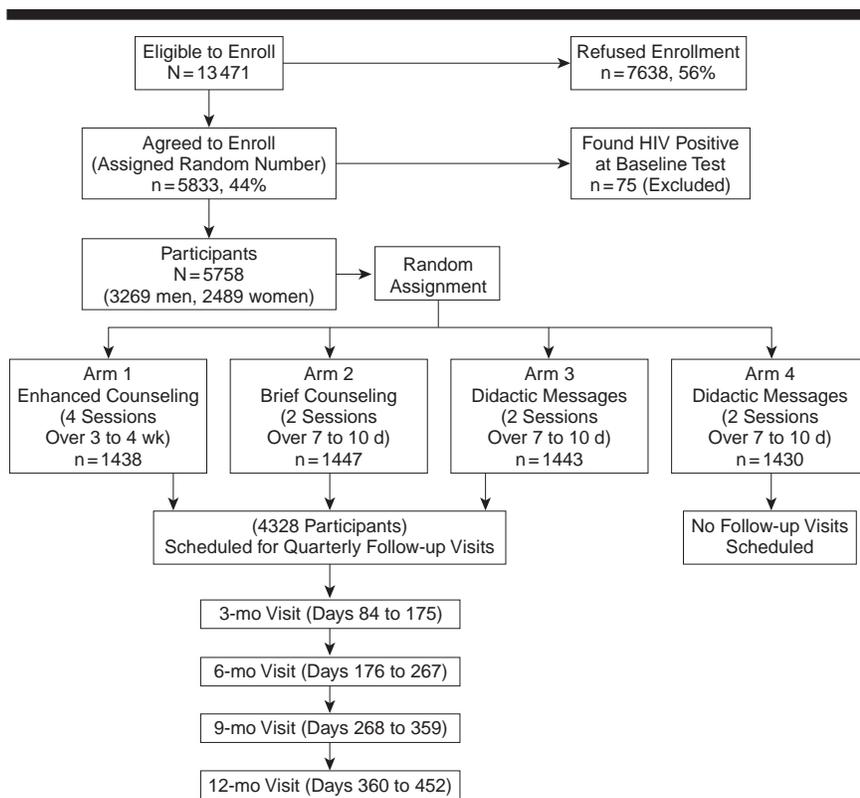


Figure 1.—Study visits were calculated from the enrollment date to occur at 3-month intervals. The first visit occurring during each calculated 3-month interval was considered as the follow-up visit. For the first follow-up visit (3-month visit), the interval began 7 days before the calculated date 3 months after enrollment and may have occurred up to 7 days before the calculated date 6 months after enrollment. HIV indicates human immunodeficiency virus.

vention depend on reliable efficacy data, preferably based on the results of well-conducted randomized controlled trials measuring disease outcomes.⁵⁻⁷ However, there are limited data supporting the impression that current HIV prevention strategies, including HIV/STD counseling, are effective in reducing new infections. In the case of HIV counseling, studies that have attempted to evaluate counseling efficacy have been limited by inadequate experimental designs, interventions, and outcomes.^{5,8,9}

Considerable debate has occurred on the content and duration of counseling necessary to achieve meaningful change in risk behaviors. Many HIV counseling programs focus on collecting risk data and providing general information about HIV/AIDS. However, a number of health professionals have argued that, for greatest benefit, counseling should be an interactive process aimed at personal risk reduction.¹⁰ Brief intervention strategies have been successfully applied in behavioral interventions for other health risks such as alcohol use,¹¹ but other experts maintain that changing sex behaviors requires multiple (ie, ≥ 10) intervention sessions.¹²

Project RESPECT was a randomized controlled trial specifically designed to as-

sess the efficacy of HIV prevention counseling in reducing high-risk sexual behaviors and preventing new sexually transmitted infections. We studied counseling approaches believed by experts to have the highest likelihood for success and, thus, evaluated risk reduction counseling models that used an interactive process between counselor and client. We were also concerned about feasibility and coverage of the interventions, and thus, we studied interventions that were acceptable to participants and able to be replicated in busy public clinic settings. This project evaluated one-on-one HIV/STD prevention counseling models—one with 4 sessions (200 minutes total) and the other with 2 sessions (40 minutes total). We compared the counseling models with each other and with brief, didactic messages that approximate the one-on-one prevention approach typically used in STD clinics and other HIV test sites.

METHODS

Study Design

The trial was conducted from July 1993 through September 1996 among patients from public, inner-city STD clinics in Baltimore, Md; Denver, Colo; Long Beach, Calif; Newark, NJ; and San Fran-

cisco, Calif, in collaboration with the Centers for Disease Control and Prevention (CDC), Atlanta, Ga. Eligible participants were HIV-negative men and women aged 14 years or older who came to one of the clinics for a full diagnostic STD examination and agreed to have an HIV test. Men who reported having a male sex partner in the past 12 months or who identified themselves as bisexual or homosexual were excluded from the study. All potential participants whose command of English would limit full participation in the interventions and those who had declined to participate in the study at earlier clinic visits were excluded also. All participants gave written, informed consent, and the institutional review boards at each site reviewed and approved the protocol.

Participants were assigned randomly to 1 of 4 intervention arms (Figure 1). Those assigned to arms 1, 2, or 3 were asked to return for follow-up appointments 3, 6, 9, and 12 months after enrollment. We included arm 4 to assess the possible intervention effects of repeated follow-up contacts, because it was speculated that these might be of sufficient magnitude to obscure differences between the interventions. Arm 4 participants had no follow-up visits scheduled after the intervention but results for syphilis and gonorrhea tests (routinely done at all 5 clinics) were obtained each time they voluntarily returned to the clinic during the 12-month study interval. To assess the effects of repeated contact, we excluded from the analysis STDs diagnosed for arm 3 participants at study-prompted follow-up visits, and we compared participants in arm 3 with arm 4 on the proportion for whom syphilis or gonorrhea was diagnosed at voluntary (unscheduled) visits. In addition, 12 months after enrollment, arm 4 participants were sought and, if located, interviewed. Their recent condom use was compared with arm 3 participants.

Randomization

Random assignment took place after enrollment and before the baseline interviews and examinations. Allocation concealment procedures were defined by protocol and complied with published recommendations.¹³ A data management company provided each site with opaque, sealed envelopes containing computer-generated random assignments. To ensure the numbers in arms were roughly equal, random assignments were made within blocks that varied in size from 4 to 20 and were done separately for men and women at each site. Once a number was assigned, it was not reassigned even if participants dropped out of the study.

Interventions

Participants were assigned to 1 of 3 individual face-to-face HIV prevention strategies that each involved an HIV test. All interventions encouraged consistent condom use for vaginal and anal sex with all partners; however, interventions were tailored to each individual's personal risks.¹⁰ For arm 1, the 4 sessions were completed within 4 weeks of enrollment. For arms 2, 3, and 4, both sessions were completed within 10 days. Whenever possible, the same counselor conducted all of a participant's sessions. The counselor conducting an intervention never collected outcome data for that participant. No interactive counseling was provided at follow-up visits; however, regardless of assigned intervention, whenever HIV tests were obtained counselors provided brief information about the test and answered any questions.

Patients assigned to arm 1 received enhanced counseling.¹⁰ This 4-session intervention, based on the theory of reasoned action and social cognitive theory,¹⁴⁻¹⁶ sought to change key theoretical elements (eg, self-efficacy, attitudes, and perceived norms) underlying condom use. Session 1 lasted 20 minutes and was conducted during the initial clinic visit; the remaining sessions were 60 minutes each. Test results for HIV were given during session 3. Each session built on lessons from the preceding session. The first 3 sessions concluded with a behavioral goal-setting exercise in which the participant arrived at a small behavioral risk-reduction step that could be achieved before the next session. At the final session, a longer-term, risk-reduction plan for each participant was agreed on.

Participants assigned to arm 2 received brief counseling, a 2-session intervention modeled after CDC's recommended HIV counseling for patients attending public clinics and HIV test sites.^{17,18} Session 1 (20 minutes) was conducted during the initial clinic visit and was identical to the first session of enhanced counseling. Session 2 (20 minutes) included a discussion of the HIV test result as well as additional counseling. The objectives of brief counseling were to assess actual and self-perceived HIV/STD risk, to help the participant recognize barriers to risk reduction, to negotiate an acceptable and achievable risk-reduction plan, and to support patient-initiated behavior change. The first session concluded with a behavioral goal-setting exercise in which the participant arrived at a small risk-reduction step that could be achieved before the second session. At the second session, progress in completing the behavioral step was reviewed, barriers and facilitators to completing the behavioral step were dis-

cussed, and a longer-term risk-reduction plan was developed.

Participants assigned to arms 3 and 4 received didactic messages. This 2-session informational intervention was designed to approximate what was being done in most STD clinics.¹⁰ Two brief messages about HIV and STD prevention were delivered, explicitly not engaging the participant in interactive counseling. Session 1 (5 minutes) was conducted by the clinician who had examined and treated the participant during the STD clinic visit. In session 2 (5 minutes), participants were informed about their HIV test results and limitations of the test and were given didactic prevention messages about HIV and STD pertinent to their reported risks. Participants were asked whether they had questions.

To ensure the quality and consistency of interventions, counselors and clinicians received a standard training course from a single trainer, used structured intervention protocols, and had routine observation and feedback by on-site supervisors and an outside observer who traveled to all sites (6% of the sessions were observed). In addition, process evaluations assessing intervention content and client satisfaction with the interventions were performed periodically by surveying participants, counselors, and clinicians.¹⁰

Study Outcomes

Principal outcomes were defined before the trial. Incident STDs were defined by laboratory tests, with gonorrhea defined as a positive culture for *Neisseria gonorrhoeae* or, for men, gram-negative intracellular diplococci on a Gram stain of a urethral swab; chlamydia as a positive *Chlamydia trachomatis* polymerase chain reaction from an endocervical (women) or a urine (men) specimen; syphilis as a suggestive history and physical examination with supportive treponemal and nontreponemal antibody test results; and HIV infection as a repeatedly reactive enzyme immune assay for HIV antibody with a positive confirmatory test result. Study clinicians collected specimens necessary for each of these tests from participants assigned to arms 1, 2, or 3, at the baseline, at 6- and 12-month visits, and at all voluntary (unscheduled) clinic visits. Specimens were also obtained at 3- and 9-month visits if participants or their sex partners had symptoms of an STD or if participants requested tests. Study clinicians used standard procedures to collect the study specimens and used an order specified by protocol. Specimen collection procedures were periodically monitored. Arm 4 participants returning to the clinic during a self-initiated visit underwent only tests routinely performed at the clin-

ics (ie, gonorrhea culture and syphilis serology). Participants found to have STDs at the baseline or subsequent visits were treated according to standard treatment guidelines and were advised (when applicable) about the importance of partner treatment.¹⁹ Participants found to have HIV were referred for early intervention services, available at all 5 clinics.

We planned to use self-reported 100% condom use during vaginal and anal sex as principal behavioral end points. However, anal sex was rarely reported. At enrollment, 10% of the participants reported having anal sex during the past 3 months and half of these reported only 1 episode. Thus, we used self-reported 100% condom use during vaginal sex with all sex partners as the principal behavioral outcome, measured as "no unprotected vaginal sex" (ie, either no sexual contact or condom use during every sex episode). Interviewers asked about behaviors during the preceding 3 months, including frequency of vaginal sex and condom use with primary and any other sex partners. We calculated condom use from the total number of times condoms were used and from the total number of sex episodes. Interviewers also asked participants about number of sex partners they had; about the risks of their sex partners; and about the participants' and partners' condom use beliefs, attitudes, self-efficacy, intentions, and perceived norms regarding consistent use of condoms. Participants in arms 1, 2, and 3 were interviewed at enrollment, immediately after the final intervention session, and at the 3-, 6-, 9-, and 12-month visits.

Incentives

For intervention sessions, participants were offered free condoms at every visit and \$15 for each session attended after the first session (ie, for enhanced counseling, a maximum of \$45, and for brief counseling and didactic messages, a maximum of \$15). For collection of outcome data, participants who returned for scheduled follow-up visits were offered \$15 for each questionnaire and \$25 for each STD examination. No incentives were given for voluntary (unscheduled) STD examinations, including those completed at the 3- and 9-month visits.

Data Analysis

Assuming 15% per year cumulative incidence of STD among didactic messages participants,²⁰ we calculated a recruitment goal of 6000 (1500 per arm) for 80% power to detect a 25% reduction in STDs between counseling and control arms. For preliminary analyses of principal outcomes, analysts were blinded to intervention arm. For all analyses, any patient as-

Table 1.—Baseline Characteristics of Participants According to Intervention Arm (N = 5758)*

Characteristics	Arm 1 Enhanced Counseling (n = 1438)	Arm 2 Brief Counseling (n = 1447)	Arm 3 Didactic Messages (n = 1443)	Arm 4 Didactic Messages (n = 1430)†
Sex, %				
Female	43	43	43	43
Male	57	57	57	57
Site, %				
Baltimore, Md	19	19	19	19
Denver, Colo	24	24	24	24
Long Beach, Calif	18	19	18	18
Newark, NJ	21	21	20	20
San Francisco, Calif	18	18	18	18
Report of previous HIV test, %	72	71	69	72
Report of previous STD, %	61	64	64	63
STD at enrollment, %	33	31	30	33
Injected drugs, %	2	2	1	2
Ever had a sex partner who had injected drugs, %	16	14	14	18
Ever had a known HIV-positive sex partner, %	2	1	1	2
Ever gave (men) or took (women) money for sex, %				
Men	8	7	6	8
Women	12	13	16	17
Sex partners last 3 mo, mean/median No.	2.1/1	2.3/1	2.5/1	2.4/1
At least 1 new sex partner in last 3 mo, %	49	46	48	48
Have a primary partner, %				
Men	76	75	77	76
Women	88	89	89	87
Have a nonprimary partner, %				
Men	61	60	59	61
Women	38	36	38	40
Vaginal sex episodes with a condom in last 3 mo, %				
None	38	38	38	38
1-49	24	23	25	26
50-99	23	25	24	24
100	16	13	13	12

*HIV indicates human immunodeficiency virus; STD, sexually transmitted disease.

†For arm 4, screening demographic data were collected on all participants, but full behavioral questionnaires were collected only on a sample (484 [34%]) of the 1430 participants.

signed a random number was included except for 75 persons whose baseline HIV test result was positive (Figure 1). Outcome analyses were performed using data on all participants, whether or not they completed their assigned intervention (intent to treat).^{20,21} For STD outcomes, we compared the cumulative percentage of participants with any STD from enrollment until the end of a specified visit interval. For behavioral outcomes, we compared the proportion of subjects reporting the behavior during the 3 months before each scheduled visit, first considering all participants who came to any follow-up visit and then only those who came to all 4 follow-up visits (51% of all enrolled). For comparisons between interventions, we used χ^2 tests, relative risks with 95% confidence intervals (CIs), and generalized estimating equations²² to account for correlations due to repeated observations on the same subject. In addition to the principal outcomes, we performed 5 subset analyses, stratifying on sex, site, age (≤ 20 vs ≥ 21 years), STD diagnosis at enrollment vs no STD, and report at enrollment of a prior HIV test vs no prior test.

RESULTS

Participants

From July 1993 through June 1995, 13 471 eligible patients were invited, and 5833 (43%) agreed to participate. After excluding 75 patients with positive baseline HIV test results, there were 3269 men and 2489 women (Figure 1). Study participants resembled the clinics' total populations in that they were young (median age, 25 years), minority (59% black, 19% Hispanic, 16% white, 6% other races), and low income (54% unemployed, 42% with annual income $<$ \$5000). Study participants and those who had refused were similar in age, racial and ethnic background, and education (median, 12 years). But compared with those who had refused, participants were more likely to be women (relative risk [RR], 1.49; 95% CI, 1.44-1.55), to have had an STD at enrollment (RR, 1.19; 95% CI, 1.14-1.24), and to have been previously tested for HIV (RR, 1.13; 95% CI, 1.08-1.18). The intervention arms were similar at baseline with respect to demographic characteristics, risk behaviors, condom use, and STD diagnoses at enrollment (Table 1).

Intervention Adherence

Of 5758 patients enrolled, 82% completed all assigned intervention sessions. Completion was lower ($P < .001$) for those in the 4-session enhanced counseling arm (72%) than for those in either of the 2-session interventions (brief counseling, 85%; didactic messages, 85%). For the enhanced counseling arm, 99% of participants completed the first session, 80% completed the second session, 72% completed the third session, and 72% completed all 4 sessions. Regardless of assignment, most participants ($>85%$) surveyed about the interventions reported that the sessions were "informative," "good," and "helpful."

Coverage at Follow-up Visits

Of the 4328 participants assigned to follow-up visits every 3 months, 71% returned for the 3-month, 70% for the 6-month, 64% for the 9-month, and 66% for the 12-month visits. Of all 4328 participants, 81% returned for at least 1 of the 4 follow-up visits; 73% for at least 2 visits; 63% for 3 visits; and 51% for all 4 scheduled visits. Return for follow-up visits did not differ significantly between intervention arms.

Intervention Efficacy Behaviors

At the follow-up visits, reported condom use and "no unprotected vaginal sex" increased substantially over baseline for all 3 interventions (Figure 2). At the 3- and 6-month visits the greatest increases were among those in the 2 counseling intervention arms, with enhanced counseling participants most frequently reporting any condom use (86%) and "no unprotected vaginal sex" (46%). At the 3-month visit, enhanced counseling participants reported "no unprotected vaginal sex" significantly more often than participants in the didactic messages control intervention arm (46% vs 38%; RR, 1.21; 95% CI, 1.09-1.35). This was also true for brief counseling participants vs didactic messages participants (44% vs 38%; RR, 1.15; 95% CI, 1.03-1.27). Differences in "no unprotected vaginal sex" between enhanced counseling and brief counseling were small (46% vs 44%; RR, 1.06; 95% CI, 0.96-1.17). Frequency of sex was similar among the interventions. At the 6-month visit, differences in "no unprotected vaginal sex" between interventions were less pronounced, although trends were similar (39% enhanced counseling vs 34% didactic messages; RR, 1.14; 95% CI, 1.01-1.28; and 39% brief counseling vs 34% didactic messages; RR, 1.12; 95% CI, 1.00-1.25). At the 9- and 12-month visits, any condom use and "no unprotected vaginal sex" were reported more

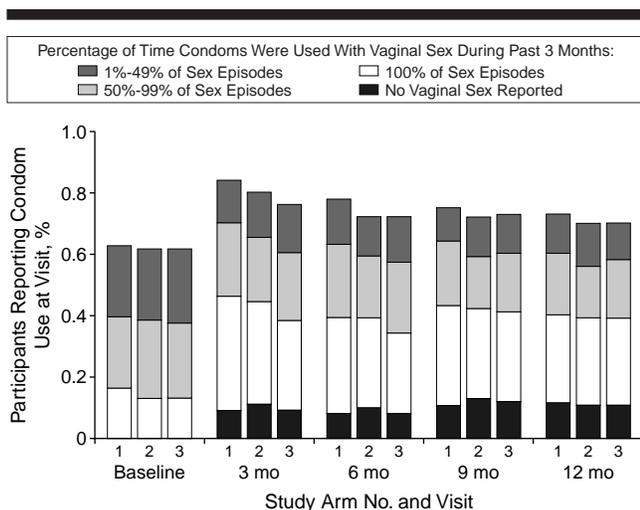


Figure 2.—Percentage of participants reporting condom use with vaginal sex during the preceding 3 months, baseline, and 3-, 6-, 9-, and 12-month visits.

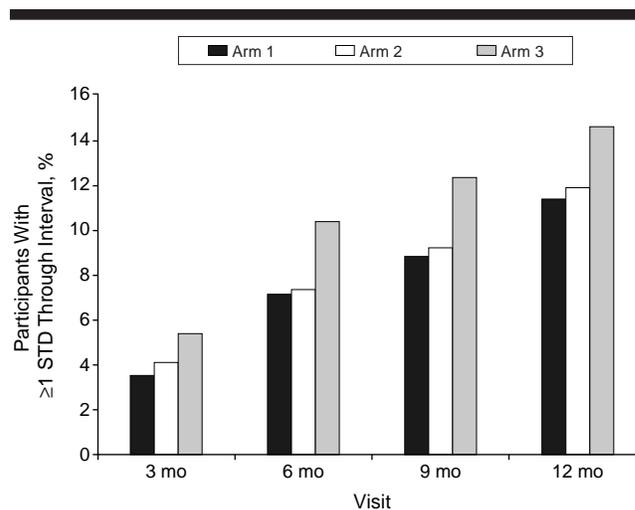


Figure 3.—Percentage of participants with a new sexually transmitted disease through the 3-, 6-, 9-, and 12-month visits.

frequently than at enrollment, but there were no significant differences among interventions. Considering only the 2732 participants who came to all 4 follow-up visits, we observed similar results. Using generalized estimating equations, we found enhanced counseling participants were more likely to report “no unprotected sex” than participants in the other interventions at 12 months ($P = .02$).

The interventions focused on consistent condom use, but we observed modest differences among them for some other “safe” behaviors (Table 2). At the 3- and 6-month visits, more participants in each counseling intervention reported safe behaviors compared with those in the didactic messages arm. For measures of condom use (eg, “any use” and “condoms with last sex”), enhanced counseling participants tended to report safe behaviors most often, followed by those who were assigned to the brief counseling arm and then those who were assigned to the didactic messages arm. But for safe behaviors unrelated to condoms (eg, “no casual partners” and “no new partners”), brief counseling participants tended to report safe behaviors most often, followed by those assigned to the enhanced counseling arm, and then by those assigned to the didactic messages arm. At the 9- and 12-month visits, there were no significant differences between the interventions.

Sexually Transmitted Diseases

Through the 12-month visit, a total of 549 participants (12.7%) were diagnosed as having a new STD, including 314 men (12.8%) and 235 women (12.6%). There were 271 participants (6.3%) diagnosed as having gonorrhea; 315 (7.3%) as having chlamydia; 25 (0.6%) as having syphilis; and 8 (0.2%) as having HIV. Some

participants had multiple diagnoses.

Fewer participants assigned to either of the interactive counseling intervention arms developed new STDs compared with participants assigned to the didactic messages control arm (Figure 3). Through the 6-month visit, 149 participants (10.4%) in the didactic messages arm had new STDs compared with 103 (7.2%) in the enhanced counseling arm (RR, 0.69; 95% CI, 0.54-0.88) and 107 (7.3%) in the brief counseling arm (RR, 0.71; 95% CI, 0.58-0.89). Through the 12-month visit, 211 participants (14.6%) in the didactic messages arm had developed new STDs, compared with 165 (11.5%) in the enhanced counseling arm (RR, 0.78; 95% CI, 0.64-0.94) and 173 (12.0%) in the brief counseling arm (RR, 0.81; 95% CI, 0.67-0.98). The 2 interactive counseling interventions had very similar cumulative incidence of STD through the 6- and 12-month visits. The number of participants counseled per STD averted during the 12-month study interval was 31 for the enhanced counseling arm and 38 for the brief counseling arm.

The STD reduction associated with the interactive counseling interventions was similar among men and women, that is, about 30% fewer participants had new STDs at the 6-month visit and 20% fewer participants had new STDs at the 12-month visit, respectively. Consistently at all 5 study sites fewer participants in the counseling intervention arms had new STDs compared with those in the didactic messages arm. Considering specific STDs as outcomes, counseling was equally effective for gonorrhea and chlamydia. For HIV, there were 4 new infections among those in the didactic messages arm, 4 in those assigned to the enhanced counseling arm, and none in those assigned to the brief counseling arm

($P = .06$) through the 12-month visit. In the subgroup analyses, efficacy was highest in the subgroups with highest risk (ie, highest STD incidence), although differences were not significant at $P < .05$. The relative effectiveness of counseling was greatest for patients aged 20 years or younger (vs those older), patients reporting no prior HIV test (vs those reporting a test), and patients who had an STD diagnosed at the enrollment visit (vs those with no STD).

Effect of Repeated Contact

Gonorrhea and syphilis were diagnosed at voluntary clinic visits less often among arm 3 participants (3.3%) than arm 4 participants (4.1%), although observed differences may have been due to chance (RR, 0.80; 95% CI, 0.55-1.17). At 12 months, only 462 arm 4 participants (32%) were found and interviewed. However, compared with these, arm 3 participants were more likely to report “no episodes of unprotected vaginal sex” during the previous 3 months (39% vs 34%; RR, 1.15; 95% CI, 0.99-1.33). Although some biases are possible, these analyses were consistent in suggesting that repeated contact with study personnel, instruments, or both may have themselves had a modest intervention effect.

COMMENT

Project RESPECT demonstrated that interactive, client-centered HIV/STD counseling resulted in an overall reduction in STD incidence of about 30% after 6 months and 20% after 12 months of follow-up. The STD reduction occurred among both men and women and was observed consistently at all 5 study sites. Since 1994, CDC has recommended client-centered HIV prevention counseling for persons determined to be at risk for HIV infec-

Table 2.—Proportion of Participants With Selected Safe Behaviors by Intervention Arm at the 3-Month and 6-Month Visits*

Safe Sex Behavior Last 3 Mo	Arm 1 Enhanced Counseling		Arm 2 Brief Counseling		Arm 3 Didactic Messages	
	3 mo, %	6 mo, %	3 mo, %	6 mo, %	3 mo, %	6 mo, %
	Any condom used	83†‡	78†‡	79	73	76
≤1 Sex partner	71†	70	72†	70	66	66
No casual partners	70	69	73†	70	66	66
Condoms last sex, primary partner§	63†	59	61	59	58	54
Condoms last sex, other partner	79†	78	80†	77	73	74
No new partners	72	71	75†	73	71	70
If new partner, asked if partner:						
Tested for HIV	58	56	61†	50	50	52
Tested for STDs	44	46	50†	41	41	38
Ever injected drugs	40	39	41	38	35	35

*HIV indicates human immunodeficiency virus; STD, sexually transmitted disease.

† $P < .05$ compared with arm 3 (didactic messages) at same study visit.

‡ $P < .05$ compared with arm 2 (brief counseling) at same study visit.

§For those reporting a primary sex partner.

||For those reporting a nonprimary ("other") sex partner.

tion.^{17,18} Several observational studies and a few randomized trials using behavioral outcomes support that direct, personalized ("client-centered") counseling is likely to initiate the behavior changes that might lead to reduction in new HIV infections.^{8,9,23,24} However, the efficacy of such counseling in reducing HIV or other STDs had not been shown. This large randomized controlled trial evaluating interactive risk reduction counseling among STD clinic patients is the first to report that counseling leads to reduction in sexually transmitted infections. In addition to concerns about efficacy, concerns that interactive counseling is not feasible for busy, publicly funded clinics, or cannot be conducted by the personnel currently employed by health departments, should now be put to rest.

The follow-up results indicate that interactive counseling had greatest disease reduction benefit during the first 6 months after intervention completion but suggest that some counseling benefits continued over time. Even if the counseling benefits wane, a 20% STD reduction over 12 months is important for several reasons. A 20% STD reduction in these clinic patients will diminish disease prevalence in the community. In addition, reducing or eliminating STDs such as syphilis, gonorrhea, chlamydia, and herpes may directly reduce new HIV infections, as the presence of these STDs has been found to enhance HIV acquisition and transmission.^{7,25} Furthermore, even transient reduction in risk for an individual may have large effects on lifetime risk if the behavior changes occur when the likelihood of infection is high (eg, during adolescence). As for whether the STD reduction found with counseling would hold true for HIV as well, we cannot say this with certainty. To the extent that sexual trans-

mission of the condom-preventable STDs we studied here and HIV are similar, client-centered counseling is likely to have the same disease prevention benefits. Human immunodeficiency virus seroconversion is relatively rare in the United States, even among this high-risk population. To find a 20% reduction in HIV transmission in this population with incidence of 0.3% per year would require a study size of 241 000 in order to have an 80% likelihood of detecting a difference. The cost of such a study would be prohibitive. But the cost of counseling programs for 241 000 people (which we estimate at \$8 per patient over current costs) would be easily recovered in savings from preventing an expected 145 new AIDS cases, which cost an estimated \$100 000 to \$200 000 per case.⁴

The finding that the 4-session enhanced counseling and the much shorter 2-session brief counseling had equivalent STD reduction was surprising and is good news for public health programs. Conventional wisdom has suggested that multiple-session interventions are needed for effective change of sexual behavior,¹² but our results challenge this viewpoint. Timing may be an important element for intervention success; it is possible that individuals who seek STD testing and treatment are particularly amenable to behavior change. However, this is not the first study indicating that brief interventions may be as effective as longer therapies. Recently published results of a large alcohol treatment study indicate that a brief motivational intervention was as effective in achieving alcohol cessation as a longer, more intensive counseling intervention.¹¹ A brief intervention in active drug users has also been reported as being effective as a longer intervention in changing risk behaviors.²⁶ We studied 4-session coun-

seling because we were not convinced that CDC's recommended 2-session counseling would have such a powerful disease reduction impact. Although long recommended and supported by counselors, client-centered HIV prevention counseling is seldom done in STD clinics, probably because program managers also have not believed that a 2-session intervention could have a significant impact. However, this brief counseling model was designed for implementation, at low cost and with existing personnel, in the context of routine health care services. The intervention adherence we found suggests that 2-session counseling would have at least the same retention as the didactic approach that is currently used and would have greater retention than longer therapies.

This study has several strengths. The randomized controlled design, if well conducted, permits the most unbiased comparison of effects. In conducting this trial, we sought to comply with recommended procedures that have since been published as guidelines for conducting and reporting randomized controlled trials.²⁷ The use of disease as an outcome measure can help validate self-reported data. More important, measuring disease outcomes allowed us to measure directly the interventions' disease reduction effects, and thus permit counseling to be directly compared with other HIV/STD prevention strategies. Losses to follow-up could be an important source of bias if those not returning differed in risk from those who returned for follow-up. Our 66% follow-up after 12 months (81% with at least 1 follow-up visit) is within an acceptable range for prospective studies. Follow-up was similar for all intervention arms, and our study population rarely sought STD care at other locations,²⁸ so the differences between interventions are unlikely to be caused by loss to follow-up. We also attempted to minimize biases in the analysis by identifying principal outcomes before the trial and by masking investigators to intervention strategies during preliminary analyses. An additional strength of this study was the use of several quality-control procedures, helping ensure that the counseling interventions were conducted by counselors at all sites consistently and as conceived.¹⁰ Also, the long follow-up period allowed us to measure the interventions' effects over time.

We were unable to avoid some potential biases. One limitation mentioned earlier was the use of STDs as a surrogate for HIV infection. Although STDs inform about unprotected sex and partner risk, they may not be an accurate measure of heterosexual HIV risk.²⁹ Generalizability of results is also of concern. We studied 5 widely located STD clinics that we believe

to be fairly representative of the range of public clinics in the United States. However, the 43% enrollment rate was low (although not unexpected, given the length and intensity of the follow-up that participants were asked to complete). Intervention enrollment may be higher in practice because participants would not need to return for the study-related follow-up. However, participation may be lower without the \$15 incentive used in this study. Perhaps more important, results may not pertain to other populations or settings. Since we studied only heterosexual STD clinic patients, we cannot know whether similar counseling sessions would be effective in other settings where HIV tests are performed, such as alternative test sites (where many gay men go for testing), among injection drug users, or at managed care plans (where many adolescents and young women receiving Medicare obtain health care). However, the individually tailored approach used in the counseling models studied here could be easily adapted to different settings.

We conclude that brief, interactive HIV/STD prevention counseling prevents new STDs and, by inference, HIV infections. This quality of counseling can be successfully conducted in busy public clinic settings. These results have several implications for existing programs, particularly those serving populations with a high HIV/STD prevalence. First, most clinics already employ HIV counselors who collect risk data, discuss the HIV test, and provide didactic prevention messages.³⁰ These counselors could prevent new infections if they adopted interactive HIV/STD prevention counseling aimed at risk reduction. The Project RESPECT counselors were health department staff members who were motivated and enthusiastic but typically did not have advanced degrees or long experience in interactive counseling. Second, quality-control measures are critical to intervention success and are feasible for most programs.¹⁰ Quality assurance should be approached as an integral part of the process and as a means of providing a better product. Third, some programs might consider targeting counseling to higher-risk clients, such as adolescents and individuals with previous STDs, to reduce costs while retaining large effects on disease reduction. Finally, given our finding that counseling benefits may wane over time, we wonder if an additional interactive counseling session done some months after brief 2-session counseling might be beneficial and might sustain or even enhance the risk-reduction benefits observed in this trial.

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Relative Efficacy of Prevention Counseling With Rapid and Standard HIV Testing: A Randomized, Controlled Trial (RESPECT-2)

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Background: Two risk-reduction counseling sessions can prevent sexually transmitted diseases (STDs); however, return rates for test results are low.

Study: A randomized, controlled trial compared rapid HIV testing and counseling in 1 visit with standard HIV testing and counseling in 2 visits. Main outcomes were STDs (gonorrhea, chlamydia, trichomoniasis, syphilis, HIV) within 12 months. Participants were 15- to 39-year-old STD clinic patients in Denver, Long Beach, and Newark. STD screening and questionnaires were administered every 3 months.

Results: Counseling was completed by 1632 of 1648 (99.0%) of the rapid-test group and 1144 of 1649 (69.4%) of the standard-test group. By 12 months, STD was acquired by 19.1% of the rapid group and 17.1% of the standard group (relative risk [RR], 1.11; confidence interval [CI], 0.96–1.29). STD incidence was higher in the rapid-test group than in the standard-test group among men (RR, 1.34; CI, 1.06–1.70), men who had sex with men (RR, 1.86; 95% CI, 0.92–3.76), and persons with no STDs at enrollment (RR, 1.21; 95% CI, 0.99–1.48). Behavior was similar in both groups.

Conclusions: Counseling with either test had similar effects on STD incidence. For some persons, counseling with standard testing may be more effective than counseling with rapid testing.

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IN THE UNITED STATES, in 1998, there were 621,150 human immunodeficiency (HIV) tests done in sexually transmitted disease (STD) clinics and 7731 were positive.¹ HIV-negative persons visiting STD clinics are at a relatively high risk of becoming infected with HIV² and of having subsequent STDs.³ It is thus important that STD clinics provide effective interventions to prevent HIV and other STDs. Project RESPECT showed that for STD clinic clients, 2 20-minute sessions of prevention counseling with HIV testing, given a week apart, decreased the risk of acquiring an STD during the following year 20% more than HIV testing with 2 sessions of information alone.³ In practice, however, it is often not

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possible to deliver 2 prevention counseling sessions in STD clinic settings because many clients do not return for their HIV test result.^{1,4,5} In U.S. STD clinics, the overall rate of return for HIV test results was 44.9% in 1998.¹ Contacting HIV-positive clients who do not return for their HIV test result consumes time and resources.

Rapid HIV tests make it possible to provide HIV testing, counseling, and the test result, in 1 clinic visit, overcoming the problem of clients not returning for test results.^{6,7} Although other studies have shown that rapid HIV testing increases the proportion of persons who learn their HIV test result,^{6,8} immediate knowledge of HIV test results could be an important modifier of subsequent behavior change. We are not aware of any studies that compare the efficacy of counseling with rapid testing to counseling with standard testing. We therefore compared the efficacy of counseling and testing with a rapid HIV test in 1 visit with counseling and testing with a standard HIV test in 2 visits.

Materials and Methods

Study Design

We conducted a multicenter, randomized, controlled trial. At enrollment, participants were randomly assigned to receive prevention counseling with either a rapid HIV test or a standard HIV test. Half the participants in each HIV test group were also randomly assigned to receive an additional (booster) counseling session 6 months later. The effects of booster counseling are reported elsewhere.⁹

Setting and Study Population

Participants were recruited from 3 public STD clinics in Denver, Long Beach, and Newark. All 3 clinics had participated in Project RESPECT.³ Eligible clients were those who came to the clinics for a full diagnostic STD examination, were HIV-negative at enrollment, had had vaginal or anal sex in the preceding 3 months, and were aged 15 to 39 years. Participants at the Newark site were aged 18 years or older because of a local Institutional Review Board requirement for parental consent for enrolling minors, which was not feasible for our study. Participants were also required to be fluent in English (as judged by the screener), to be willing to return for follow-up visits, and to provide written informed consent. Persons enrolled in HIV vaccine trials were ineligible, and participants were not permitted to enroll more than once. During the recruitment phase, study staff nonselectively screened as many clients as possible for eligibility. Participants with a confirmed positive HIV test result at enrollment were referred for care and were ineligible to continue in the study. This exclusion was planned in advance and was specified in the study protocol and the consent form.

HIV Testing

At enrollment, all participants received their first counseling session and were tested for HIV antibodies. The Single Use Diagnostic System for HIV-1 (SUDS) test (Abbott-Murex Diagnostics, Norcross, GA) was used for rapid HIV testing. After blood collection, this test takes approximately 20 to 30 minutes. Standard testing was done using the HIV enzyme immunoassay (EIA) in use at each clinic; the Denver and Long Beach clinics used serum specimens, and the Newark clinic used oral fluid specimens (Orasure; OraSure Technologies Inc., Bethlehem, PA). All positive (repeatedly reactive) HIV test results were confirmed using Western blot, regardless of the type of HIV test used for the initial screening.

Participants in the rapid-test group were also given their HIV test result and a second counseling session during the initial visit. They were also given a clinical examination for STDs. Most participants in the rapid-test group did not have to spend additional time waiting for their HIV test result because the test was performed while they were being examined. Participants with a preliminary positive test result were asked to return to the clinic a few days later for their confirmatory test result. Persons with confirmed positive results were referred for care and excluded from the study.

Participants in the standard-test group were given a clinical examination for STDs during the initial visit and were scheduled to return 1 week later for their HIV test result and second counseling session. A reminder letter to return for their HIV test result and second counseling session was mailed the day after enrollment, and a reminder telephone call was made the day before the scheduled second visit. Those who did not return for their second counseling session as scheduled were phoned 1 or 2 more times and were sent another reminder letter. Outreach efforts were discontinued after 28 days unless the participant had a positive HIV test result. Those in the standard-test group who did not complete their second session within 28 days from the initial visit were considered not to have completed the intervention, but on request, they were given their HIV test result and counseling according to usual clinic practice at subsequent clinic visits. All participants were given \$10 for completing the enrollment visit. Those assigned to the standard-test group were not compensated for returning for their HIV test result and second counseling session.

Counseling Interventions

Counseling interventions were based on the 2-session "brief" counseling intervention used in Project RESPECT.³ This intervention complied with the approach to counseling recommended by the Centers for Disease Control and Prevention (CDC)¹⁰ at the time of the Project RESPECT study and with the revised CDC guidelines,¹¹ published in 2001 while the current study (RESPECT-2) was in progress. This intervention integrates theoretical principles from several models of behavior change interventions but is not based on a single theoretical model. The counseling techniques are similar to motivational interviewing¹² and include both cognitive and action-oriented strategies.

In our study, the standard-test group received the original 2-session intervention used in Project RESPECT. The counseling protocol was modified for use with a rapid HIV test, but the modifications were kept to a minimum to make the rapid-test intervention as similar as possible to the original intervention. The intervention was designed to take approximately 40 minutes for both counseling sessions with the standard test and approximately 30 minutes with the rapid test. The main differences between the 2 interventions were in the number of visits required to complete the intervention (1 or 2 visits), the waiting time for the HIV test result, and whether the participants had an opportunity to try an initial risk-reduction plan and discuss their effort at the second counseling session.

Quality Assurance of the Interventions

Written quality assurance procedures were followed to ensure quality and consistency of the counseling interventions. These procedures required that at least 10% of counseling sessions be reviewed using a structured quality assurance tool. Trained supervisors at each site were required to observe at least 5% of sessions in person and to review audiotapes of an additional 5% of sessions. Sessions were chosen for in-person observation on a convenience basis, but the counselor supervisor at each site was expected to

observe a minimum of 2 counseling sessions per counselor per month. At enrollment, 5% of participants were randomly assigned to have all their counseling sessions audiotaped. Supervisors held regular staff meetings with counselors to discuss counseling issues and to provide additional one-on-one coaching as needed. Two monitors from the CDC observed counseling sessions during semi-annual site visits and reviewed a random sample of audiotaped counseling sessions from each site.

Outcomes

Outcomes were measured at 13-week intervals, scheduled 3, 6, 9, and 12 months from the date of enrollment. Before each follow-up visit, study staff mailed a reminder letter to each participant and made a reminder phone call. When participants did not keep appointments, staff mailed additional reminder letters and made phone calls to reschedule the visit, as needed. Participants who were due for a study follow-up visit were screened for STDs and interviewed if they visited the clinic any time from 1 week before the due date up to 12 weeks after the due date. Participants were given \$25 for completing each follow-up visit. This was later increased to \$50 in an attempt to improve retention rates.

The primary outcome was STD incidence over the 12 months after the intervention. STD incidence was measured using the combined results of tests for gonorrhea, chlamydia, trichomoniasis, syphilis, and HIV infection. Participants were tested for all 5 infections at the enrollment visit and were screened for gonorrhea, chlamydia, and trichomoniasis at each quarterly follow-up visit. Participants were routinely retested for HIV and syphilis at the 12-month visit and at other visits on request. STD test results and treatment details were abstracted from clinic charts for all clinic visits during the follow-up period, including visits not related to the study.

An incident STD was defined as a positive laboratory result either preceded by a negative result for the same STD or detected more than 14 days after documented treatment with antibiotics effective against that STD. STD testing was done in the local laboratories used by each clinic. Tests for gonorrhea and chlamydia were done on urine specimens by means of nucleic acid amplification tests (NAATs). The Long Beach and Newark clinics used ligase chain reaction (LCR; LCx Uriprobe; Abbott Diagnostics Division, Abbott Park, IL). The Denver clinic used polymerase chain reaction (PCR; Cobas Amplicor CT PCR and Cobas Amplicor GC PCR; Roche Diagnostic Systems, Inc., Branchburg, NJ) initially but 18 months later changed to strand displacement amplification (SDA; BDProbeTec ET CT/GC; BD Diagnostic Systems, Sparks, MD). *Trichomonas vaginalis* was cultured using the InPouch TV test (BioMed Diagnostics Inc., San Jose, CA) or modified Diamond's medium as the culture medium. Cultures were done using vaginal swab specimens from women and urine sediment specimens from men. At follow-up visits, vaginal swabs were collected by the participant (Denver and Long Beach) or a clinician (Newark), depending on local clinic policy.

Secondary outcomes were sexual risk behaviors. Behavioral data were collected using audio computer-assisted self-interview (ACASI) technology. Participants completed an ACASI questionnaire at enrollment and at each study follow-up visit. The ACASI questionnaires were developed for this study and pilot-tested in advance. The questionnaires included closed-ended questions on STD history, sexual behavior history, and other risk behavior and risk markers. The ACASI questionnaires were programmed to check responses for internal consistency, and if inconsistent responses were detected, to ask questions again. For most questions, a uniform 3-month recall period was used, irrespective of the time since the most recent study visit.

Sample Size Determination

The sample size goal was 4100 participants. We projected that 11.5% of the standard-test group would have an STD detected by the 12-month visit if 70% of participants were tested for STDs at each follow-up visit. The sample size was calculated to provide 80% power to detect a statistically significant difference ($P \leq 0.05$) if the relative risk of having an incident STD after 1 year of follow up was 1.25 or more. For sample size calculations, we assumed that there would be no important interaction between the enrollment interventions and the booster counseling intervention.

Randomization Procedures

Computer-generated randomization sequences were prepared in advance by an independent data management company. Randomization was stratified by site and gender. Within each site-gender stratum, randomization was done in blocks of variable size, ranging from 1 to 5. A separate series of sequentially numbered, sealed, opaque envelopes was prepared for each site-gender stratum. After the client signed consent to participate, the recruiter opened the next envelope in the series while the participant watched. Participants were told their HIV test assignment and whether they had been assigned to have booster counseling at the 6-month visit. Any lapses in adherence to the randomization protocol were reported to the data management company and the principal investigator at the CDC.

Allocation Concealment (Blinding)

Although participants and study staff were aware of intervention assignments, the laboratory staff who performed the STD tests were not. Preliminary analyses of STD outcomes by intervention group used coded group identifiers so that the data analysts also did not know the intervention assignment. The code was broken only after the preliminary analyses had been completed.

Data Analysis

We did an intention-to-treat analysis. Participants were grouped according to the intervention assigned by randomization, regardless of whether they received or completed the assigned intervention (intention-to-treat analysis). Relative risks were used as the primary method of comparing intervention groups. In addition, crude and adjusted odds ratios were calculated and compared to check for evidence of confounding. The odds ratios were adjusted for the baseline presence of an STD or the risk behavior being considered as well as gender and clinic site. The Breslow-Day test for homogeneity of odds ratios¹³ was used to test for interaction between the testing and counseling interventions given at enrollment and the booster counseling intervention given at the 6-month visit using cumulative STD incidence from enrollment to the 12-month visit as the outcome. This test was also used to test for interaction between the testing and counseling interventions at enrollment and the characteristics considered in subgroup analyses.

Cumulative STD incidence was determined for the interval from enrollment to each quarterly study visit. Participants were classified as having either no incident STD or at least 1 incident STD by the end of the interval. The STD incidence in the 2 intervention groups was also compared using generalized estimating equations (GEE)¹⁴ to take all incident STD episodes into account among those with more than 1 incident STD during the follow-up period. All participants were included in the analysis of STD outcomes, including those who did not return for STD screening. Many STD are symptomatic and lead patients to seek care. Thus, subjects who

return to the clinic may be more likely to have an STD than subjects who did not return. Therefore, those who were not screened were assumed not to have had an incident STD. Analyses of behavioral outcomes included only those participants with behavioral outcome data, because we did not know how various behaviors might be associated with missing visits. Behavioral outcomes were calculated for each 3-month interval and were noncumulative. We also did exploratory subgroup analyses by gender, gender of partners (among males), age group, site, and by STD infection status at enrollment. For subgroup analyses by age, participants were stratified into 3 age groups: younger than 20 years, 20 to 29 years, and 30 years or older.

The study was funded by the CDC. The protocol was approved by Institutional Review Boards at each site and at CDC.

Results

From February 1999 through December 2000, 9457 clients were assessed for eligibility. Of the 7587 found to be eligible on screening, 3342 (44.0%) consented to participate and were randomly assigned to a group (Fig. 1). Refusal rates were higher in men (60.8%) than women (48.3%), increased with age (<20 [46.3%], 20–29 [57.2%], >29 [58.6]), and varied by site, being highest at the Denver site (67.6%) and lowest at the Newark site (39.0%). We did not gather additional data from persons who refused to be in the study and therefore cannot assess their baseline risk status.

Of those enrolled, 22 participants in the rapid-test group and 23 participants in the standard-test group were later determined to be ineligible and were excluded from the study and the analyses. HIV-positive test results at enrollment caused 16 participants in the rapid-test group and 18 participants in the standard-test group

to be excluded. The remaining 11 (for both groups combined) were excluded because they failed to meet other eligibility criteria; 7 reported no vaginal or anal sex in the 3 months before enrollment, 2 for coming to the clinic for reasons other than an STD examination, 1 for being over 39 years, and 1 for enrolling in the study a second time. After excluding ineligible participants, 1648 participants remained in the rapid-test group and 1649 participants remained in the standard-test group. We terminated enrollment earlier than planned because the SUDS test was unavailable for several months and no alternative licensed rapid HIV test was available. As a result, the final sample size of 3297 was approximately 20% less than our goal of 4100.

No significant interaction was evident between the initial interventions and the 6-month intervention ($P = 0.62$), so we combined the booster and no-booster groups for comparisons of the rapid-test and standard-test interventions. Baseline demographics and risk characteristics were similar in both intervention groups (Table 1). Almost 10% of men reported having engaged in sex with another man in the 3 months before enrollment. Reports of having ever participated in commercial sex or having ever injected drugs were infrequent.

Of those in the rapid-test group, 1632 of 1648 (99.0%) completed both counseling sessions and received their HIV test result (nearly always during the initial visit), compared with 1144 of 1649 (69.4%) of those in the standard-test group. Of the 16 (1.0%) in the rapid-test group who did not complete the intervention as assigned, 4 did not receive HIV testing or counseling, 10 had only the first session and did not receive their HIV result, and 2 were given the standard-test intervention in error. Of the 505 (30.6%) in the standard-test group who did not complete the intervention as assigned, 5 did not receive HIV testing or counseling, 456 had only 1 session, 43 were given a second counseling session more than 28

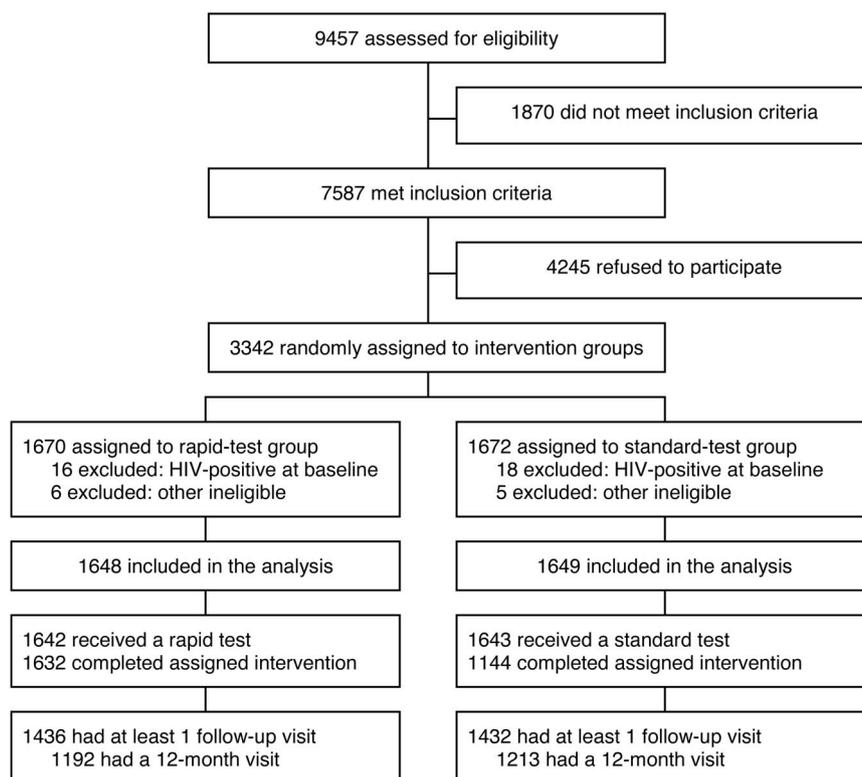


Fig. 1. Participant recruitment, group assignment, and study participation.

TABLE 1. Baseline Demographics and Risk Characteristics, by Intervention Group

Characteristic	Intervention Group	
	Rapid* (n = 1648)	Standard† (n = 1649)
Assigned to booster counseling (%)	50.0	50.3
Female (%)	45.9	45.5
Race/ethnicity (%)		
Black	49.3	51.9
Hispanic	19.0	17.3
White	22.7	21.2
Other	9.0	9.6
Age, median/mean (yrs)	24/25.4	25/25.8
Men	25/25.8	26/26.4
Women	23/24.9	24/25.0
≥High school diploma (%)	74.6	76.3
Unemployed (%)	25.9	26.4
Ever injected drugs (%)	2.3	2.2
Ever exchanged sex for money or drugs (%)	6.2	7.5
Previous HIV test (self-report) (%)	77.6	77.1
Previous STD (self-report), %	38.1	37.5
Laboratory-confirmed STD at enrollment (%)	26.5	24.4
Men	25.0	23.5
Women	28.2	25.4
Behaviors in the past 3 mo		
Male-male sex, % of men	9.8	9.5
≥2 sex partners (%)	55.7	53.8
Any unprotected sex (%)	87.3	86.2
Any unprotected sex with nonprimary partner (%)	40.5	40.0
Any unprotected sex while drunk or high (%)	39.3	38.7
Sex with new partner on day first met (%)	14.9	15.3
One-time sex partner (%)	38.7	36.6

*Rapid-test intervention.

†Standard-test intervention.

HIV = human immunodeficiency virus; STD = sexually transmitted disease.

days after the first session, and 1 was given the rapid-test intervention in error. The median time taken for the first session was 18 minutes in the rapid-test group and 25 minutes in the standard-test group. The median time taken for the second session was 14 minutes in the rapid-test group and 15 minutes in the standard-test group.

Return rates for follow-up visits were similar in both intervention groups and showed little attrition over the follow-up period (Table 2). The mean return rate for follow-up visits, averaged across all 4 follow-up visits, was 73.5% in the rapid-test group and 73.8% in the standard-test group. The proportion of participants with at least 1 follow-up visit and the proportion of participants with a 12-month visit was also similar in both groups but varied by gender (women, 77.4%; men, 69.2%) and by site (Denver, 79.9%; Long Beach, 73.1%; Newark, 64.8%). No adverse events occurred as a result of study participation.

The cumulative incidence of STDs by the 12-month visit was higher in the rapid-test group than in the standard-test group (Table 3), but this difference was not statistically significant ($P = 0.15$). Differences in cumulative STD incidence between groups were more evident at the 6-month visit and the 9-month visit than at the

TABLE 2. Rates of Follow-Up by Intervention Group

	Intervention Group	
	Rapid* (%) (n = 1648)	Standard† (%) (n = 1649)
≥1 follow-up visit	87.1	86.8
3-mo visit	76.4	75.0
6-mo visit	72.7	73.0
9-mo visit	72.5	73.4
12-mo visit	72.3	73.6

*Rapid-test intervention.

†Standard-test intervention.

12-month visit. Comparisons of incident STDs by intervention group using GEE produced similar findings (not shown).

The cumulative incidence of STDs was higher in women (23.5%) than in men (13.5%), mainly because of trichomoniasis being detected more frequently in women than in men. Among the 1507 female participants, there were 163 cases of chlamydia (10.8%), 78 cases of gonorrhea (5.2%), 169 cases of trichomoniasis (11.2%), 13 cases of syphilis (0.9%), and no cases of HIV infection. Among the 1790 male participants, there were 127 cases of chlamydia (7.1%), 114 cases of gonorrhea (6.4%), 20 cases of trichomoniasis (1.1%), 10 cases of syphilis (0.6%), and 4 cases of HIV infection (0.2%). Of the 4 cases of HIV infection, 3 were in the rapid-test group and 1 was in the standard-test group.

Subgroup analyses showed that the relative effect of the 2 interventions on STD incidence by 12 months varied significantly by gender ($P = 0.05$), but not by site ($P = 0.52$) or by age ($P = 0.58$). Among men, the relative effect of the 2 interventions was not significantly different among men who had sex with men (MSM) compared with men with no male partners ($P = 0.30$). Among men, those in the rapid-test group had a significantly higher incidence of STDs than those in the standard-test group (Table 3), both within the first 6 months ($P = 0.01$) and over 12 months ($P = 0.02$). Among MSM, the incidence of STDs in the rapid-test group was almost double that in the standard-test group at 12 months, but this difference was not statistically significant ($P = 0.08$). Among men with no male partners, those in the rapid-test group had a higher incidence of STDs than those in the standard-test group, a finding that was statistically significant for STDs acquired within the first 6 months ($P = 0.03$), but not at 12 months ($P = 0.06$). Among women, the incidence of STDs was similar in both intervention groups.

The relative effect of the 2 interventions on STD incidence differed by STD infection status at enrollment. Enrollment STD status modified the intervention effects significantly at 6 months ($P = 0.02$), but not at 12 months ($P = 0.11$). Regardless of intervention group, participants with an STD at enrollment had a greater risk of acquiring an STD during follow up than those with no STD at enrollment (Table 3). However, among those with no STD at enrollment, those in the rapid-test group had a significantly higher incidence of STDs than those in the standard-test group within the first 6 months ($P = 0.01$), but not at 12 months ($P = 0.06$). Among those with an STD at enrollment, the incidence of STDs over the next 12 months was similar in both intervention groups.

Sexual risk behaviors during the preceding 3 months were similar in both intervention groups at the 3-month visit (Table 4). Sexual risk behaviors during the preceding 3 months were also similar in both intervention groups within subgroups of women, MSM, and men with no male partners. Sexual risk behaviors in

TABLE 3. Cumulative Incidence of Sexually Transmitted Disease Since Baseline by Intervention Group and Select Participant Characteristics

STD by Visit	Intervention Group		Relative Risk (95% CI)
	Rapid* (%)	Standard† (%)	
All participants (rapid, n = 1648; standard, n = 1649)			
3 mo	6.4	5.9	1.09 (0.84–1.43)
6 mo	12.3	10.3	1.20 (0.99–1.46)
9 mo	16.1	13.6	1.18 (1.00–1.40)
12 mo	19.1	17.1	1.11 (0.96–1.29)
Gender			
Women (rapid, n = 757; standard, n = 750)			
6 mo	15.1	14.4	1.05 (0.82–1.33)
12 mo	23.3	23.7	0.98 (0.82–1.18)
Men (rapid, n = 891; standard, n = 892)			
6 mo	10.0	6.8	1.47 (1.08–2.01)
12 mo	15.5	11.6	1.34 (1.06–1.70)
MSM (rapid, n = 87; standard, n = 85)			
6 mo	12.6	8.2	1.54 (0.62–3.77)
12 mo	21.8	11.8	1.86 (0.92–3.76)
Men, no male partners (rapid, n = 800; standard, n = 809)			
6 mo	9.5	6.6	1.45 (1.04–2.03)
12 mo	14.6	11.5	1.27 (0.99–1.64)
STD status at enrollment visit			
No STD (rapid, n = 1,210; standard, n = 1,235)			
6 mo	10.0	7.0	1.44 (1.10–1.87)
12 mo	15.0	12.4	1.21 (0.99–1.48)
STD (rapid, n = 436; standard, n = 398)			
6 mo	18.8	20.9	0.90 (0.69–1.19)
12 mo	30.3	31.9	0.95 (0.78–1.16)

*Rapid-test intervention.

†Standard-test intervention.

CI = confidence interval; STD = sexually transmitted disease (baseline STDs include gonorrhea, chlamydia, trichomoniasis, and syphilis; STDs at follow up include gonorrhea, chlamydia, trichomoniasis, syphilis, and HIV); MSM = men who had sex with men.

both intervention groups were also similar at subsequent visits (data not shown).

Discussion

Overall, after 1 year of follow up, we found little difference in the incidence of STDs after rapid HIV testing with counseling compared with standard HIV testing and 2 counseling sessions; the relative risk was 1.11, a difference that was not statistically significant. Our study was designed to detect statistically significant results if the true relative risk of incident STDs in the rapid-test group compared with the standard-test group was 1.25 or larger. We thought that the other benefits of rapid testing (such as less loss-to-follow up of HIV-infected persons) would make the rapid-test intervention preferable to the standard-test intervention, even if counseling were found to be slightly less effective in the rapid-test group. Thus, the difference in STD incidence that we found at 1 year is also smaller than what we consider to be a clinically important difference.

Our results suggest that in the short term and in some subgroups, the rapid-test intervention may be somewhat less effective at preventing STDs than the standard-test intervention. Subgroup analyses, although planned in advance, were exploratory because we did not have hypotheses about differential effects. Conclusions drawn from the results of subgroup analyses are thus tentative¹⁵ and need to be addressed by additional studies. The results suggest that the rapid-test intervention may be somewhat less effective at preventing STDs than the standard-test intervention in men but not in women. Among MSM, the STD incidence at 12 months was

almost twice as high in the rapid-test group as that in the standard-test group, but there were relatively few MSM in the study and this difference is not statistically significant. Some other randomized, controlled trials have also found differences in the effectiveness of behavioral interventions by gender with more marked intervention effects in men than in women.^{16–20} Interventions that promote safer sexual practices may have greater effect in men than in women because men tend to have greater control over protective measures such as the use of condoms.^{19,21}

It has been suggested that receiving a negative HIV test result may disinhibit risk behavior.²² The potential for disinhibition may be less after the standard-test intervention than after the rapid-test intervention. Clients given a standard test have counseling on 2 separate occasions, spend slightly more time with a counselor, and have 1 to 2 weeks to reflect on their risk before learning their HIV test result. Our finding of an excess risk of STDs after rapid testing among men, including MSM, may not be generalizable, and we did not ask questions about disinhibition in this study. However, we think that the potential for disinhibition after receiving a negative test result is important to consider in future research, especially as the use of rapid tests expands in outreach settings.

We found no consistent differences in the effects of the 2 interventions on sexual risk behavior overall or within gender subgroups, despite finding some differences in STD incidence by intervention group. Participants in both intervention groups developed an individualized risk-reduction plan as part of the intervention. Because the interventions did not promote the same risk-reduction plan among all participants, we are not surprised that we did not detect differences in sexual risk behavior by group. Fur-

TABLE 4. Sexual Behavior Reported at the 3-Month Visit by Intervention Group and Gender

Behavior During Past 3 Months	Intervention Group		Relative Risk (95% CI)
	Rapid* (%)	Standard† (%)	
All participants (rapid, n = 1259; standard, n = 1236)			
≥2 sex partners	33.7	30.3	1.11 (0.99–1.25)
Any unprotected sex	64.2	62.5	1.03 (0.97–1.09)
Any unprotected sex with nonprimary partner	18.7	15.8	1.18 (0.99–1.41)
Any unprotected sex while drunk or high	23.7	22.2	1.07 (0.92–1.23)
Sex with new partner on day first met	6.7	7.4	0.90 (0.67–1.20)
One-time sex partner	20.1	18.7	1.07 (0.91–1.26)
Women (rapid, n = 600; standard, n = 583)			
≥2 sex partners	28.5	23.2	1.23 (1.01–1.49)
Any unprotected sex	68.4	64.1	1.07 (0.98–1.16)
Any unprotected sex with nonprimary partner	16.1	13.6	1.18 (0.89–1.56)
Any unprotected sex while drunk or high	24.6	21.0	1.17 (0.94–1.45)
Sex with new partner on day first met	2.7	4.0	0.68 (0.36–1.27)
One-time sex partner	13.0	11.9	1.09 (0.80–1.48)
MSM (rapid, n = 72; standard, n = 71)			
≥2 sex partners	54.9	55.1	1.00 (0.74–1.35)
Any unprotected sex	49.3	37.7	1.31 (0.89–1.92)
Any unprotected sex with nonprimary partner	16.9	19.1	0.88 (0.43–1.80)
Any unprotected sex while drunk or high	22.5	13.0	1.73 (0.82–3.64)
Sex with new partner on day first met	36.6	39.1	0.94 (0.61–1.43)
One-time sex partner	43.7	43.5	1.00 (0.69–1.46)
Men, no male partners (rapid, n = 583; standard, n = 579)			
≥2 sex partners	36.6	34.3	1.07 (0.91–1.25)
Any unprotected sex	61.7	64.0	0.96 (0.88–1.06)
Any unprotected sex with nonprimary partner	21.4	17.5	1.22 (0.96–1.56)
Any unprotected sex while drunk or high	22.8	24.6	0.93 (0.75–1.15)
Sex with new partner on day first met	6.9	6.9	1.00 (0.65–1.54)
One-time sex partner	24.4	22.4	1.09 (0.88–1.35)

*Rapid-test intervention.

†Standard-test intervention.

CI = confidence interval; STD = sexually transmitted disease; MSM = men who had sex with men.

thermore, as STD risk is determined by the interrelationship of risk behaviors as well as the STD prevalence among partners, single risk behaviors may not correlate well with STD or HIV risk.^{23–30}

Our study considered only 1 method of providing prevention counseling at the time of rapid HIV testing. Some clients may benefit from additional counseling after they receive their HIV test result. Because it may be difficult to persuade clients to return for an additional counseling session once they know their HIV test result, additional counseling could be given by phone. Clients and staff may find that 1 counseling session after the test, instead of counseling before and after the test (like done in this study), is more convenient and efficient. The efficacy of these other methods of prevention counseling has not been evaluated. Before implementation of new methods, we recommend that they be evaluated by comparing them with methods that have been shown to be effective.

Our study has several strengths. It was a large randomized, controlled trial that measured both STD incidence and behavior and included men and women. Almost 70% of participants were black or Hispanic, the racial and ethnic groups with the highest incidence of HIV infection, and was done in STD clinic attendees, a population that has a relatively high risk of acquiring HIV and STDs. The measurement of STD incidence was more rigorous than in some other studies^{27,31} because all participants were screened for STDs at enrollment (enabling us to exclude prevalent STDs that were not acquired during the follow-up period) and participants were routinely screened for STDs at follow-up visits (enabling us to detect asymptomatic STDs).³² In addition, the fol-

low-up period was longer than that of several other intervention trials,^{33,34} enabling us to measure the longer-term effects of the interventions. Finally, behavioral outcomes were collected using ACASI, a method of data collection that reduces interviewer bias and has been shown to be associated with greater disclosure of socially undesirable risk behavior than in-person interviews.^{35–43}

Our study also has some limitations. First, we enrolled 20% fewer participants than we had planned to enroll. The STD incidence in the standard-test group was higher than that used in our sample size calculations, so the reduction in sample size did not result in less power than we had expected. Second, the research process may have altered the effectiveness of the interventions. At the enrollment visit, participant fatigue resulting from the ACASI questionnaire may have limited the effectiveness of counseling. This may have had greatest effect on the rapid-test group because they received all their counseling during the enrollment visit. Also, responding to an ACASI questionnaire at each visit may have had an intervention effect that obscured differences in the effects of the study interventions. Third, STD incidence may not accurately reflect the risk for HIV infection.^{44–46} Fourth, we are likely to have failed to detect some STDs because over 20% of participants did not return at each follow-up visit. However, because return rates were similar for both groups, the number of STDs missed should be similar for both groups. Fifth, some incident STDs may have been false-positive results because when prevalence is low, the predictive value of a positive test result is low even when highly specific tests are used.⁴⁷ STD measurement errors are likely to have occurred with a similar frequency in both intervention groups

and so may have made the effects of the interventions appear more similar than they truly are.

The generalizability of our findings to other settings and to nonresearch situations may be limited. Our study focused on testing and counseling in STD clinics, a setting where prevention counseling has been shown to be of benefit.^{3,48} However, the generalizability of our findings to STD clinic clients in nonresearch situations may be limited because those who declined to participate may have differed in important respects from those who enrolled (eg, concern about their risk of acquiring HIV and STDs, willingness to be tested for HIV, and receptiveness to prevention counseling interventions). Also, return rates for the second session in the standard-test group were higher than they would have been under nonresearch conditions. This may have increased the overall effectiveness of the standard-test intervention, making the rapid-test intervention appear relatively less effective by comparison than it would be under nonresearch conditions. Because all participants in our study were given counseling with HIV testing, the results do not provide information on the relative efficacy of rapid and standard HIV testing in settings where testing is done without counseling such as some outreach settings. This study also does not provide information on the effects of testing and counseling with a rapid test compared with no intervention, or the effects of rapid HIV testing and counseling compared with rapid HIV testing alone.

Using rapid HIV testing instead of standard HIV testing has some definite programmatic advantages. With the recent licensure of a simpler and more accurate rapid HIV test,^{49,50} the use of rapid HIV tests is likely to increase. The greater convenience of completing testing in 1 visit is likely to increase testing among those at high risk who have not sought testing in the past and increase the proportion of those tested that receive their test result. These factors are likely to increase the proportion of persons with HIV infection who know that they are infected. Early diagnosis enables early treatment and may reduce transmission because persons who are aware of their infection change their behavior.⁵¹ The overall similarity in STD incidence and behavior after rapid testing compared with standard testing favors the use of rapid HIV testing in settings with a high prevalence of HIV infection and a low rate of return for test results. In other settings, the most effective counseling and testing strategy is less straightforward, particularly for men. Further research is needed on the potential for disinhibition of risk-taking behavior after rapid testing with a negative result.

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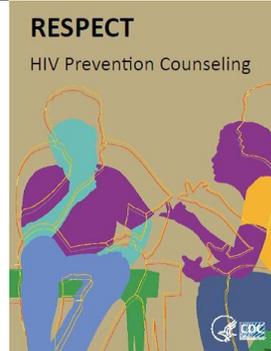
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Appendix B

CDC PROCEDURAL GUIDANCE and FACT SHEET

RESPECT PROCEDURAL GUIDANCE



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).

The RESPECT model is recommended by the CDC for providing HIV counseling, testing, and referral. The model is also consistent with the CDC recommendations for advancing HIV prevention (AHP) and the National HIV/AIDS Strategy, which emphasize that people learn their HIV status and are provided with support for reducing HIV transmission and for referral to care, treatment, and prevention services. In response to the needs of CDC's grantees in, RESPECT was adapted in 2012 to a Single-session RESPECT that includes the HIV Rapid Test, all conducted in one client visit. The overall results of RESPECT 2, prevention counseling with rapid and standard HIV testing in a randomized, controlled trial showed the single session model to be as effective over a 12-month period as the 2-session model. Over a 30-day period, the results were less clear. For more information see Metcalf CA, Douglas et. al.²

This RESPECT training curriculum is part of an integrated, multimedia training package developed by the California STD/HIV Prevention Training Center (CA PTC) for the Centers for Disease Control and Prevention (CDC) to support providers in implementing the 2-Session RESPECT HIV Prevention Counseling (2-Session RESPECT) model and the Single-Session RESPECT with Rapid Testing model. This Training of Trainers (TOT) combination guide includes slides and information for those training on either model. However, it is anticipated that most trainings will accommodate the single-session model. It is important to ask about the model participants will be implementing before beginning the training. The TOT curriculum is intended to train experienced HIV prevention providers and supervisors to deliver the RESPECT model. Information on training can be found 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. If conducting the Single-Session RESPECT with Rapid Testing, the test is performed at the beginning of the session to allow time for processing the test. In the second session, the counselor delivers the HIV test result (if a test was given, such as in a CTR setting), and 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).

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.

The overall results of RESPECT 2 showed the single session model to be as effective over a 12-month period as the 2-session model. Over a 30-day period, the results were less clear. It was less effective in certain sub-groups such as men who have sex with men, and more effective in women and youth. However, the interpretation of these results is difficult. The RESPECT 2 study cohort was significantly smaller. In addition, men who have sex with men were excluded from the original RESPECT study.

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.
The Rapid Test can be introduced at this time if conducting testing
- 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.

If conducting the single session RESPECT then:

- Provide RAPID test result if conducting testing*
- Review Risk Reduction Step*
- Revise Risk Reduction Step*
- Identify sources of support*
- Provide Additional Referrals if Necessary*

Stage 8: Close the session

Session 2 Stages (if conducting 2-session RESPECT the client returns on another scheduled day)

- 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. Also, the main difference in the single-session RESPECT is providing test results after stage 7 in session 1 and revisiting the risk-reduction steps and sources of support depending on the results.

If in a Rapid Test Setting:

As indicated in the description, the RESPECT intervention can be conducted in 1-session with Rapid Testing. The California Prevention training Center has worked with CDC to adapt the RESPECT protocol to include rapid testing which will be disseminated during training (www.effectiveintervention.org).

When conducting rapid testing it is important to let the client know how long the test will take and the potential results: negative, preliminary positive and invalid. Let them know that there is a Post-Result counseling session, so you'll have time to process the results with them and offer any referrals that might be needed. The second session will vary depending on the setting such as standard 2-session HIV testing vs. RAPID single-session testing. The difference will be that: the rapid test will be introduced after the introduction and the additional wait time will be used to continue with the protocol stages of the RESPECT Intervention. After identifying referrals and sources of support, the counselor will continue to the next stage to provide the client with the results of the test. The RESPECT provider cards provide the steps and examples of language that can be used to deliver negative and preliminary positive test results.

Agencies providing other interventions such as comprehensive risk counseling and services (CRCS), prevention with positives (PWP), or partner counseling and referral services (PCRS) can use these interventions as referral sources, depending on the client's need and risk reduction plan. Implementers will need to check with their agencies about how the RESPECT model is being applied in their setting; and, to ensure they are following the protocol for conducting the Rapid Testing.

When providing test results:

When conducting single session RESPECT with Rapid testing, the counselor should ask how or if the result will impact plans for risk-reduction step. The usual standardized procedures for giving positive or negative test results should be followed.

A main difference is that the clients will not have had the opportunity to implement the risk-reduction step. Therefore, the counselor should validate the client's feelings by reflecting back on what was previously discussed and the question should be raised about whether the test result, negative or positive, changes the way the client thinks about the agreed upon step and their motivation to follow-through.

Also, those planning to adopt the RESPECT intervention should examine different settings: C & T, CRCs, PCRS, PWP; or different types of testing: Standard 2-Session, Single RAPID; or different populations: Youth, MSM, Trans. Protocols should be developed by the adopting agencies about how they will proceed to recruit and address the needs of the various populations. Technical assistance is available through the CDC's Capacity Building Request Information System (CRIS) at www.cdc.gov/CRIS2009/.

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; (see added steps to consider on page 6) although researchers found that the latter might be slightly less effective with men.²

RESOURCE REQUIREMENTS

Staff

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. Providers should have referral sources for clients who need additional assistance in decreasing risk behaviors. These can be related to 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

Specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators 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. Specific data reporting requirements will be provided to agencies after notification of award. CDC through the Program Evaluation Branch in DHAP will also provide training and guidance on data collection and reporting requirements. CDC funded agencies should check with their assigned project officers for more information.

RESPECT-2 – SINGLE SESSION COUNSELING PROTOCOL - RAPID TEST

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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Appendix C

PWP INFORMATION

Topics Related to Prevention with Positives

Serosorting: limiting sex, protected or not, to people of your own HIV status. By choosing partners of the same HIV status, individuals are able to engage in a wider range of sexual or needle using behaviors without risk of HIV transmission or acquisition.

Seropositioning: deciding on sexual roles (i.e. top or bottom) according to HIV status as a way to minimize likelihood of HIV transmission.

Viral Load: Deciding on an acceptable level of risk based on a positive person's level of viral load i.e. someone with a higher viral load is likely to be more infectious than someone with a lower or undetectable level of viral load. A lower viral load equals a different level of acceptable risk.

Reinfection: The possibility that someone who is infected with HIV can become infected again with the same or a different strain of HIV if he or she has unprotected sex with another person living with HIV. While there has been some evidence that this can happen, most research has shown that the original virus will predominate and there is no health risk to the person becoming re-infected.

STDs: The concern that certain sexual activities, even those with a low risk for HIV transmission, could put an HIV infected person at risk for acquiring STDs. There is evidence that STDs may have more of an adverse effect on the health of someone living with HIV than someone who is HIV negative. The biological impact of STD infection in a person living with HIV may also result in increased infectivity.

Areas of Competency in Doing Prevention Work with People Living with HIV

➤ *Responding to HIV Related Stigma*

- The ability to define, recognize and validate HIV related stigma.
- The ability to recognize the impact of HIV related stigma on the choices people make about risk behavior.
- The ability to recognize the impact of HIV related stigma on the client/provider relationship.
- The ability to recognize the layers of stigma co-existing in the client's life.

- *Acknowledgement of Individual and Community Experience with HIV*
 - The ability to explore the ways in which a client's thoughts or feelings about prevention issues may be impacted by her personal or community experience with HIV.
 - The ability to recognize and explore the ways in which a client's developmental stage of living with HIV may impact his thoughts and feelings about prevention issues.
 - The ability to recognize and explore the degree to which a client is or is not identified with a community impacted by HIV and the ways in which her level of identification may affect her thoughts and behaviors about prevention issues.

- *Understanding of Risk Redefinition*
 - Knowledge of the hierarchy of sexual risk behaviors involved in transmitting HIV and the ways in which it differs from those that result in acquisition of HIV.
 - The ability to recognize that prevention concerns and strategies for people living with HIV are different than those for people concerned about becoming infected with HIV.

- *Recognition of Experience with Treatment and Care Services*
 - The ability to identify the impact that HIV related treatment and/or side effects may have on a person's sense of self.
 - The ability to recognize medical complications, small or large, as a result of HIV infection that may impact a person's overall sense of well-being as well as his or her relationship to risk behaviors.
 - The ability to identify the ways in which accessing care systems may increase a client's sense of being stigmatized. This may happen in a variety of ways from accessing HIV-specific services to being asked to talk about behaviors that have historically been stigmatized, such as sex or drug use.

- *Recognition of Disclosure Challenges*
 - The ability to explore the ways in which a client's decisions about disclosure have impacted him or her.
 - The ability to explore and support how disclosure decisions relate to decisions about risk behavior.

- Knowledge of the basic legal and ethical implications of disclosure.
 - The ability to recognize and validate that decisions about disclosure have a direct impact on a client's relationship development. For example, disclosing one's status can create premature intimacy or rejection.
- *Validation and Appreciation of Sources of Resiliencies and Strengths*
- The ability to explore, validate and support a client's concerns about HIV transmission as well as his or her desire to achieve health and wellness.
 - The ability to explore a client's level of peer support and knowledge of appropriate peer-based referral sources.
 - The ability to explore and validate the internal and external resources that clients have used in managing sources of oppression and stigma in their lives including living with HIV.

Appendix D

COGNITIVE DISSONANCE THEORY

(From the Third Edition of *A First Look at Communication Theory* by Em Griffin, © 1997, McGraw-Hill, Inc. This text-only version of the article appears on the World Wide Web site www.afirstlook.com. The text version does not contain any figures. A facsimile of the original article, which includes all figures, is also available in PDF format.)

Chapter 16

Cognitive Dissonance Theory

of Leon Festinger

Aesop tells a story about a fox that tried in vain to reach a cluster of grapes that dangled from a vine above his head. The fox leapt high to grasp the grapes, but the delicious-looking fruit remained just out of reach of his snapping jaws. After a few attempts the fox gave up and said to himself, "These grapes are sour, and if I had some I would not eat them."¹

Dissonance: Discord Between Behavior and Belief

Aesop's fable is the source of the phrase "sour grapes." The story illustrates what former Stanford University social psychologist Leon Festinger called *cognitive dissonance*. It is the distressing mental state in which people feel they "find themselves doing things that don't fit with what they know, or having opinions that do not fit with other opinions they hold."²

The fox's retreat from the grape arbor clashed with his knowledge that the grapes were tasty. By changing his attitude toward the grapes, he provided an acceptable explanation for his behavior.

Festinger considered the human need to avoid dissonance as basic as the need for safety or the need to satisfy hunger. It is an aversive drive that goads us to be consistent. The tension of dissonance motivates us to change either our behavior or our belief in an effort to avoid a distressing feeling. The more important the issue and the greater the discrepancy between behavior and belief, the higher the magnitude of dissonance that we will feel. In extreme cases cognitive dissonance is like our cringing response to fingernails being scraped on a blackboard – we'll do anything to get away from the awful sound.

Three Hypotheses: Ways to Reduce Dissonance Between Attitudes and Actions

The focus of cognitive dissonance theory is attitude change. Festinger hypothesized three mental mechanisms people use to ensure that their actions and attitudes are in harmony. Because teaching is about influence as well as instruction, I've found that the principles of cognitive dissonance theory apply to students' interactions with me and among themselves. I'll illustrate different aspects of the theory from events in a class students referred to as "The Island Course."

For twenty years I taught a two-week off-campus seminar on the topic of group dynamics. Limited to eight students, this summer school class was held on a remote island in northern Lake Michigan. Travel to and from the island was by a single-engine airplane I piloted.³ All of us lived together in a cabin that is the only structure on the island. Except when a few of us flew off the island to buy groceries, group members had only each other to talk with.

Although the format of the seminar included regular reading assignments and four hours of class a day, the island course was primarily a venture in experiential education. We learned about group dynamics by studying our own interaction. Students were asked to adopt the role of participant-observer. Whatever happened among us became a legitimate topic for group discussion.

My goals for the course went beyond academic knowledge. I openly embraced the humanistic values that Carl Rogers advanced – congruence, empathic understanding, and unconditional positive regard. (See the introduction to the Relational Development section.) I encouraged students to enact these values through appropriate self-disclosure, sensitive listening, and positive feedback that would enhance self-esteem. I also tried to facilitate an honest discussion of the conflict that inevitably comes up when living in close quarters.

Advocates of experiential learning are often lavish in their claims of life-changing impact, yet notoriously short on evidence of long-term positive results. Did the island course achieve my ambitious agenda? In an effort to find out I surveyed the 150 former students whose collective experience spanned two decades. The open-ended responses of the 115 alumni who replied not only provide evidence of lasting impact, they also attest to the power of cognitive dissonance.⁴ I've changed their names, but I'll cite their actual words to show how the potential discomfort of conflicting thoughts can induce people to alter their beliefs and actions.

Hypothesis 1: Selective Exposure Prevents Dissonance

Festinger claimed that people avoid information that is likely to increase dissonance. Not only do we tend to select reading material and television programs that are consistent with our existing beliefs, we usually choose to be with people who are like us. By taking care to “stick with our own kind,” we can maintain the relative comfort of the status quo. Like-minded people buffer us from ideas that could cause discomfort. In that sense, the process of making friends is an example of selecting our own propaganda.

Students self-selected themselves for the island seminar; no academic program required the class. Each applicant came for a thirty-minute interview with me before signing up for the course. On one level the meetings gave me a chance to make sure I was putting together a diverse group. Their main function, however, was to give students a chance to consider whether or not they would be comfortable sharing openly with others and, in turn, receiving feedback from the group. I'm not an advocate of forced intimacy, nor did I desire to create dissonance.

Selective exposure worked well in most cases. The majority of students signed up because they were primed for personal change, so like Rodney, they were open to comments from others.

Rodney: The island trip came at a major turning point in my life. I was beginning to tire of being the class clown. It was difficult to bullshit Em and the other students. They saw through the mask to an intelligent, introspective guy. I welcomed the opportunity to be quiet.

Over half the respondents recorded a major relational stress occurring shortly before we came together – marriage, falling in love, broken engagement, divorce, date rape, death of a friend. They, like Rodney, welcomed the open atmosphere they found on the island, and experienced little or no dissonance.

The process of selective exposure failed to protect everyone from dissonance. Kari was one who felt disconnected and lonely, wary of an island-induced togetherness with people she barely knew.

Kari: I don't put myself in situations where I don't know the people I'm with. Even a hand-picked, carefully selected group is more than I would do without being friends with at least one beforehand.

German psychologist Dieter Frey surveyed all the pertinent research on selective exposure and concluded that the avoidance mechanism doesn't kick in if we don't regard the dissonant information as a threat.⁵ Warm personal relationships are probably the best guarantee that we'll consider discrepant views:

Jake: At first I thought the people on the island were a bunch of dorks. They viewed me as never serious, insincere, and aloof. I saw myself as very caring and fun to be around. As the barriers broke down, I realized that they were the caring ones. They cared enough to be honest. I learned to be more real with my classmates and friends. The dork conspiracy showed me that there was no substitute for honesty in relationships. If you can't be who you are, who are you?

Hypothesis 2: Postdecision Dissonance Creates A Need for Reassurance

According to Festinger, close-call decisions can generate huge amounts of internal tension after the decision has been made. Three conditions heighten postdecision dissonance: (1) the more important the issue, (2) the longer an individual delays in choosing between two equally attractive options, and (3) the greater the difficulty involved in reversing the decision once it's been made, then the more the person will agonize over whether he or she has made the right choice. Sometimes referred to as "morning-after" doubts, the misgivings or second thoughts that plague us after a tough choice motivate us to seek reassuring information and social support for our decision.

A classic example of postdecision dissonance is the mental turmoil a person experiences after signing a contract to buy a new car. The cost is high, there are many attractive models from which to choose, and the down payment commits the customer to go through with the purchase. It's not unusual to find a customer in the library poring over the pages of the *Consumer Reports* auto issue *after* placing an order. The buyer is seeking information that will quiet nagging doubts.

Daily living on the island required students to make lots of group decisions. What kind of food did they want to buy with limited funds? When would they turn off the generator at night? On what basis were they willing to be graded? By far the hardest decision for most students turned out to be whether or not to voice the conflict they felt with another person.

Karen: A guy in the course had a habit of hugging people—it bothered me. He crossed over my personal boundaries for someone I didn't know very well. I finally told him in the kindest way I knew, but he didn't take it well. I still remember how torn up I felt inside. Did I do the right thing?

That night Karen sought support from the other women in the group. Their reassurance put her qualms to rest. She now looks back on the experience as positive, a first step at learning not to be afraid of honesty with others and asserting her rights.

Hypothesis 3: Minimal Justification for Action Induces a Shift in Attitude

Persuasion researchers have long distinguished between public compliance and private acceptance. But before cognitive dissonance theory came along, it seemed natural to think of inner attitude and outward behavior as the beginning and end of a cause-and-effect sequence. For example, suppose I want students at the island to study more and water-ski less. Conventional wisdom suggests that I must convince them that the reading assignments are filled with valuable insights that apply to their lives. Then they'll study and value the material.

Festinger's minimal justification hypothesis reverses the sequence. The hypothesis suggests that the best way for me to stimulate long-term student interest in group dynamics literature is to get them to read it.

Festinger attached one important condition, however. Instead of giving students massive rewards for studying the material – granting automatic As, doubling the food budget, bestowing lavish praise – I should offer only the minimum incentive required to draw them away from the beach to the books.

Thus if one wanted to obtain private change in addition to mere public compliance, the best way to do this would be to offer just enough reward or punishment to elicit overt compliance.⁶

Festinger's advice squares with what I observed on the island. In the early years of the course, test scores made up the bulk of the final grade. Students dutifully read the assigned material, yet once the test was over, they showed little interest in the ideas presented. In later years, quizzes counted for only 10 to 20 percent of the total grade, yet students still did the reading. Perhaps a feeling of group accountability or conformity pressure spurred them on. Whatever the reason, it was these students who brought an interest in the theoretical concepts of group dynamics back to campus. From my perspective, minimal justification brought about the best results.

Joan: I have thought from time to time over the years that of all the course work I've done through the doctoral level that I've retained more from the Island Course than any other.

Tracking Down the Cause and Effect of Dissonance

The noncommonsensical nature of Festinger's minimal justification hypothesis generated a great deal of hostility in social science circles. Theorists who interpreted all behavior as the result of incentives seemed affronted at the notion that rewards might hurt a cause rather than help it. The controversy stimulated a mass of studies from advocates and detractors of the surprising prediction. It all began with the famous \$1/\$20 experiment.

Would I Lie to You?

In the late 1950s, Festinger and James Carlsmith recruited Stanford University men to participate in a psychological study of unknown purpose. As each man arrived at the lab, he was assigned the boring and repetitive task of sorting a batch of spools into lots of twelve and turning square pegs a quarter turn to the right. The procedure was designed to be both monotonous and tiring. At the end of an hour the experimenter approached the subject and made a request. A student assistant had supposedly failed to show up, and the researcher needed someone to fill in by telling a potential female subject in the waiting room how much fun the experiment was. Dissonance researchers call this "counter-attitudinal advocacy." We'd call it lying.

Some of the men were promised \$1 to express enthusiasm about the task; others were offered \$20. It is comforting to know that six of the men refused to take part in the deception, but most students tried to recruit the young woman. The typical conversation was similar for both payment conditions:

she: "I heard it was boring."

he: "Oh no, it's really quite interesting."

What did differ were privately expressed attitudes after the study was over. Students who lied for \$20 confessed that they thought the task of sorting spools was dull. Those who lied for \$1 maintained that it was much more enjoyable. (Festinger and Carlsmith practiced their own form of deception in the study—subjects never received the promised money.)

By now you should have a pretty good idea of how dissonance theorists analyze the results. They note that \$20 was a huge sum of money (worth more than \$50 in today's economy). If a student felt qualms about telling a "white lie," the cash was a ready justification. Thus he felt little or no tension between his action and attitude. But the men who lied for a dollar had lots of cognitive work to do. The logical inconsistency of saying a boring task was interesting had to be explained away through an internal dialogue:

I'm a Stanford man. Am I the kind of guy who would lie for a dollar? No way. Actually what I told the girl was true. The experiment was a lot of fun.

Festinger says that \$1 was just barely enough to induce compliance to the experimenter's request, so students had to create another justification. They changed their attitudes toward the task to bring it into line with their behavior.

You can probably think of alternative ways to account for Festinger and Carlsmith's findings. The study has been replicated and modified many times in an effort to close off loopholes that would admit other explanations. The results have made it necessary to qualify Festinger's minimal justification hypothesis. Today most persuasion researchers accept a revised version of cognitive dissonance theory.

Saving Face: The Rationalizing Animal

University of California social psychologist Elliot Aronson was attracted to cognitive dissonance theory because of Leon Festinger's startling minimal justification prediction. He quickly determined that the theory in its original form had some "conceptual fuzziness." It failed to state the conditions under which a person would definitely experience dissonance. When early disciples of Festinger weren't sure what the theory predicted, their advice was, "If you want to be sure, ask Leon."

Aronson concluded that the issue isn't *logical* inconsistency, but *psychological* inconsistency. We aren't rational animals; we are rationalizing animals who want to appear reasonable to ourselves. He interprets the \$1/\$20 experiment as a study of self-esteem maintenance. "If dissonance exists, it is because the individual's behavior is inconsistent with his self-concept."⁷ The Stanford men were in a bind because they regarded themselves as decent, truthful human beings. If they had seen themselves as liars, cheats, or jerks, they would have felt no tension.

According to Aronson, the amount of dissonance a person can experience is directly proportional to the effort he or she has invested in the behavior. Since Marine boot camp is tougher than basic training in the regular Army, Aronson would expect a recruit to feel greater tension if he violated the norms of the Marine Corps. The harder it is to get into a group, the more an initiate values membership. Rarely does a football player brag that his coach schedules light workouts.

Even the reactions of Aesop's fox make sense in light of the animal's low investment of energy. Aronson points out that the fox wouldn't think the grapes were sour if he had spent the whole afternoon jumping to get them. Attitudes follow behavior because of the effort we've committed.

For many who enrolled in the island seminar, the feature of the course that took the most effort was a self-disclosure exercise labeled "This Is Me."⁸ Each night after dinner one person would have an

uninterrupted thirty minutes to tell the story of his or her life. The open-ended format allowed students to select a level of transparency within their comfort zone. For a few painfully shy students like Jason, however, the anticipatory dissonance was acute. As cognitive dissonance theory predicts, so was the transformation.

Jason: Before the autobiographical "This Is Me" time, I was extremely nervous. I couldn't imagine talking for that long. Then I burst. Words, times, details, events, places, gushed out in what one of the groupies later called "this weird energy." He was right. It was my first major self-disclosure before a group. I don't remember what I said, as much as that it came easily, with urgency, and afterwards so many questions. I felt loved, accepted, and chiefly, an interesting person. It was the genesis of the social me.

Personal Responsibility for Bad Outcomes

As a predictor of dissonance, Aronson's fear of looking foolish proved better than Festinger's logical inconsistency. But it remained for University of Texas researcher Robert Wicklund and his colleague from the University of Kansas, Jack Brehm, to establish the definitive conditions under which counterattitudinal advocacy leads to change in conviction. They determined that personal responsibility for undesirable consequences is the ultimate cause of dissonance. Wicklund and Brehm also showed that this sense of accountability comes only when we *foresee* problems looming on the horizon yet *choose* to keep going in the same direction. Two examples from the island course illustrate the link between dissonance and choice.

I asked island course alumni to write about the single incident that held the most significance for them. One fellow wrote about the group's unanimous resistance to his demand for a gallon of milk per day:

Larry: I argued for buying plenty of milk to last the remainder of our time together. When the group vetoed me I insisted on going on the next plane ride to shop for groceries. That way I got my milk, but still not as much as I wanted. I felt angry at being cast as the group deviant and argued with some "jerk-know-it-all." I knew I'd clash with him and there was nothing I could do about it.

Larry took no personal responsibility for the conflict that swirled around him. Because he felt he had no choice, he experienced no cognitive dissonance and his attitude never changed. Contrast Larry's response with the dissonance Natalie describes.

Natalie: I made a life-changing discovery during an influence exercise. My partner and I "won" the exercise, but I felt terrible afterward about manipulating others. The experience has stuck with me ever since because I saw graphically how I can violate another person's dignity when I get power-hungry or competitive. This applies to my relationship with my husband and trying to "get my way." It was a watershed experience.

Consistent with Wicklund and Brehm's prediction, a sense of hurting others was dissonant with Natalie's ideal self, so she changed her competitive attitude. Cognitive dissonance can have a powerful effect.

Critique: Dissonance over Dissonance

Despite extensive revisions, cognitive dissonance theory still has weaknesses. In Chapter 3, I illustrated the problem of testability with my boyhood pal's "never-miss shot" on his driveway basketball court. In the same way, cognitive dissonance is the never-miss prediction of communication theory. When it works, the results are spectacular. When it doesn't, the true believer treats the negative result as tacit evidence that the person in question didn't feel enough dissonance. In other words, the theory could never be proved wrong.

The criteria for a good scientific theory discussed in Chapter 3 also recommends simplicity. Many critics think that Festinger's appeal to cognitive dissonance as an explanation for opinion change is unnecessarily complicated. For example, Cornell University psychologist Daryl Bem agrees that attitudes change when a person acts with minimal justification, but he claims that *self-perception* is a much simpler

explanation than cognitive dissonance. He believes we judge our internal dispositions the same way others do—by observing our behavior.

Bem ran his own \$1/\$20 study to test his alternative explanation. People heard a recording of a Stanford man's enthusiastic account of the spool-sorting, peg-turning task. Some listeners were told he received \$1 for recruiting the female subject. Since he had little obvious reason to lie, they assumed that he really liked the task. Other listeners were told that the man received \$20 to recruit the woman. These folks assumed that the man was bored with the task and was lying to get the money. Bem's subjects didn't speculate about what was going on inside the Stanford man's head. They simply judged his attitude by looking at what he did under the circumstances. If people don't need an understanding of cognitive dissonance to forecast how the men would react, Bem asks, why should social scientists? Bem is convinced that cognitive dissonance theory is like the mousetrap pictured on page 36, much too convoluted.

Despite detractors, dissonance theory in its present form has made a significant contribution to the field of attitude change. Its implications for the persuader are clear. High-pressure tactics may get immediate compliance, but they won't gain long-term commitment. The hard sell is out; the soft sell is in.

People who want to stimulate a permanent change in attitude might consider developing an ongoing, warm relationship with the folks they want to influence. That way they can bypass selective exposure screens and be there to offer reassurance when post-decision dissonance kicks in. The agent of change who understands cognitive dissonance will offer incentives to induce others to act in new ways, but not so many or so great that others regard the offer as one they can't refuse. The wise advocate will take pains to insure that people who respond favorably have a good understanding of the future implications of their decision. Then, if things turn sour, the new convert won't.

Questions to Sharpen Your Focus

1. Cognitive dissonance is a *distressing mental state*. When did you last experience this *aversive drive*? Why might you have trouble answering that question?
2. The results of Festinger's famous \$1/\$20 *experiment* can be explained in a number of different ways. Which explanation satisfies you?
3. Suppose you want your friends to change their sexist attitudes. What advice does the *minimal justification hypothesis* offer?
4. I see cognitive dissonance theory as a "never-miss shot." What would it take to make the theory *testable*?

A Second Look

Recommended resource: Elliot Aronson, "The Rationalizing Animal," *Psychology Today*, May 1973, pp. 46–51.

Original statement: Leon Festinger, *A Theory of Cognitive Dissonance*, Stanford University, Stanford, Calif., 1957.

Secondary resource: Daniel J. O'Keefe, "Cognitive Dissonance," in *Persuasion: Theory and Research*, Sage, Newbury Park, Calif., 1990, pp. 61–78.

Selective exposure: Dolf Zillman and Jennings Bryant (eds.), *Selective Exposure to Communication*, Lawrence Erlbaum Associates, Hillsdale, N.J., 1985.

\$1/\$20 experiment: Leon Festinger and James Carlsmith, "Cognitive Consequences of Forced Compliance," *Journal of Abnormal and Social Psychology*, Vol. 58, 1959, pp. 203–210.

Saving face: Elliot Aronson, "The Theory of Cognitive Dissonance: A Current Perspective," in *Advances in Experimental Social Psychology*, Vol. 4, Leonard Berkowitz (ed.), Academic Press, New York, 1969, pp. 2-34.

Personal responsibility: Robert Wicklund and Jack Brehm, *Perspectives on Cognitive Dissonance*, Lawrence Erlbaum Associates, Hillsdale, N.J., 1976.

Development of the theory: Elliot Aronson, "The Return of the Repressed: Dissonance Theory Makes a Comeback," *Psychological Inquiry*, Vol. 3, 1992, pp. 303-311.

State of the art: Joel Cooper and Russell Fazio, "A New Look at Dissonance Theory," in *Advances in Experimental Social Psychology*, Vol. 17, Leonard Berkowitz (ed.), Academic Press, Orlando, Fla., 1984, pp. 229-266.

Self-perception: Daryl Bem, "Self-Perception: An Alternative Interpretation of Cognitive Dissonance Phenomena," *Psychological Review*, Vol. 74, 1967, pp. 183-200.

Critique: Charles Lord, "Was Cognitive Dissonance Theory a Mistake?" *Psychological Inquiry*, Vol. 3, 1992, pp. 339-342.

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Appendix E

Quality Assurance Forms

RESPECT Quality Assurance Observation Protocol

Session Observation Quality Assurance

To ensure quality counseling, adherence to the protocol, and consistency of delivery of the intervention within and across sites, supervisors should annually observe counselors who are conducting RESPECT. New counselors should be observed at least twice during the first month of work, then monthly for the next 3 months or as needed.. Experienced counselors should be observed twice annually.

Observation Procedures

Prior to the session, the counselor should ensure that the participant agrees to the session being observed. The counselor should explain to the participant that the observer/supervisor is directing his or her attention toward the counselor's work during the session and not to the issues presented by the participant. The observer should attempt to sit so that he or she is able to observe the counselor without interfering with the counselor-client interaction, (i.e. he or she is not facing the participant). The observer should not speak during the session except to thank the participant for his or her consent for the observation.

Completion of Counselor Observation Forms

A *Counselor QA Observation Form*, corresponding to the type of session being conducted, should be completed by each observer. The *Counselor QA Observation Form* should be completed in a manner that does not interfere or distract from the counseling session (see attached Counselor Observation Form).

Observation Feedback

Supervisors should provide feedback to the counselor as soon as possible following the observed session, but no later than three (3) days following the observation. If a peer is observing the counseling session, he/she should also complete the *Counselor QA Observation Form*. These forms should be submitted to the site supervisor. Peer feedback should be directed at mutual enhancement of skills and review of the protocol elements. These are not to be construed as evaluation or performance appraisal.



Establishing Guidelines for Counselor Observation Quality Assurance Things to Consider

1. INITIAL EXPECTATIONS

Develop an observation tool (please see the RESPECT package which contains an observation tool which can be used or adapted as needed) that includes the areas that will be observed in the counseling observation session. Share the observation guidelines and information with the counselors prior to beginning the observation. Answer any questions that counselors may have about the observation session.

A. Scheduling the observation with the counselor

- a) Discuss the frequency (make the observation realistic to the setting and experience of the counselor).
- b) Suggest twice a month for the first month work of a new counselor, then monthly for the next 3 months as needed.
- c) There should be at least two yearly observations for counselors with more than a year experience.
- d) Observations should be conducted at least twice a year and on an as needed basis.

B. Setting the time

- a) The schedule should take into account the need for prompt feedback, preferably within the week.
- b) Counselors should be given as much control over the experience as possible.

C. Purpose of the observation

- a) Clarify the purpose of the observation especially regarding skill development and performance evaluation.
- b) Make clear to the counselor that the goal is to improve prevention counseling.
- c) Note what, if any, role the process has in the counselor's formal work performance assessment that may impact status and compensation.

- d) Encourage counselor to express any anxiety or expectations regarding the observation process.
- e) Most counselors will have some apprehension about being observed which should be addressed prior to the beginning of the process.
- f) Encourage the counselor to focus on skills or steps where support or guidance is desired.
- g) Some counselors will be aware of problems or challenges in their prevention counseling and seek supervisor guidance prior to the observation.

D. Standards

- a) Ensure that counselor is aware of RESPECT counseling standards and tools to be used.
- b) Provide the counselor with a copy of the tool that the supervisor will use prior to the observation.

2. OBSERVATION LOGISTICS

Develop a protocol on how the observation will be introduced to the client; how the client's permission will be obtained; and, what physical/space arrangement will be made.

- A. Obtain client's permission
 - a) Who, where, when, how
- B. Plan how introductions will be made
 - a) How will supervisor be introduced?
 - As a trainer
 - Co-counselor
- C. Discuss means to address the client's anxiety about being observed
- D. Consider how space will be arranged
 - Counselor and client facing each other and supervisor fully out of sight of the client, but able to see the counselor
- E. Determine arrangement for feedback and strategizing after the observation

3. SUPERVISOR BEHAVIOR DURING OBSERVATION

What will the supervisor do and not do during the process?

- A. Plan means to minimize impact of supervisor's presence on counseling process
 - Clarify note taking and the value of minimizing but do not eliminate it. You must be able to provide specific feedback
 - Possibly use a short check-off list

- Focus on both work needing adjustment
- B. Should a supervisor intervene?
- The supervisor should not intervene unless it is a dire emergency
- C. What happens if misinformation is being given or major pieces are being missed?
- The supervisor should document the issue
 - The supervisor should not interrupt to correct an issue when it happens – that could cause discomfort to both the client and the counselor.
 - Some issues can be addressed at the end of session (Single-visit RESPECT) or when the client returns (Two-session RESPECT)?
 - a) The counselor may correct his/own “errors” or “forgotten” items and observing this would be lost if supervisor intervenes in the midst of the session
 - b) Note taking should be kept to a minimum, but be sure to provide specific feedback to counselor
 - c) Intervene or correct only when an error is clearly detrimental to the client, to the success of the process or a threat to either
- D. The client should not engage the supervisor in the session.
- E. The counselor should not defer to the supervisor for assistance during the session.
- F. The supervisor should remain as in obtrusive as possible during the session

4. TAPING SESSIONS

What would be your considerations and plans if you were to audio tape the session?

How will this be included in the introduction and permission with the client?

How would the tape be used?

- A. Include information about taping the session in the introduction and obtain client permission
- a) Explain how tape will be used and how long it will be kept
 - b) Address security and confidentiality concerns regarding the use of the tape including how and when it will be destroyed
 - c) When will tape be turned on and off and new tapes added?
 - d) Make prior decisions, if necessary, regarding which aspects of the sessions are necessary for taping (i.e. if all or some components of

the sessions will be taped), and share that information with both the counselor and the client.

B. Legal considerations

- a) a) Prior to taping, you may need to obtain consent (written or verbal) from the client. Specific releases may be required in order to replay the tapes. When in doubt, consult with your agency's policies regarding this issue.

C. Establish a protocol for the observation.

Quality Assurance Direct Observation RESPECT with Rapid Testing

Quality Assurance Session Observation

Ensuring quality counseling, adherence to protocol and consistency of delivery of the intervention within sites and across sites are important. Supervisors from each site shall observe at least one session based on the agency's plan (See the Quality Assurance Observation Protocol). Each counselor should observe one peer session where possible, again based on the agency's QA Observation Protocol. CDC staff (Project Officer and/or DT member) and CBA provider, depending on availability of funds, and need, should arrange to observe at least 2 sessions per year.

Observation Procedures

The counselor should ensure that the client agrees to the session observation. The supervisor/observer will explain to the client that he/she is directing his or her attention toward the counselor's work during the session and not to the issues presented by the client. The supervisor/observer should attempt to sit where he or she is able to observe the counselor without interfering with the counselor-client interaction, and not looking directly at the client. The supervisor/observer should not speak during the session except to thank the participant for his or her cooperation in the observation.

Completion of Counselor Observation Forms

The Quality Assurance Direct Observation with Rapid Testing Form corresponds to the type of session being conducted and reflects the protocol steps in the RESPECT Provider Cards. It is designed to assist counselors and supervisors by summarizing the observations of the sessions and documenting the counselor's completion, or lack of completion of each stage (Yes/No); and documenting the counselor's communication and counseling skills. The observer should be subtle about taking notes to minimize any potential to distract the counselor and participant from engaging in the intervention.

Observation Feedback

Supervisors should provide feedback to the counselor as soon as possible following the observed session. This feedback session should occur within 3 days following the observation. For the CDC/CBA Observation, the observation feedback should be completed and the Observation Form should be reviewed with the supervisor. In the case of the CDC/CBA observation, a copy of the Observation Form should be sent to the DT Lead and the Project Officer at the CDC if and when this occurs. CDC site reviewers observing sessions will provide feedback, as directed, by the local site supervisor.

Peer supervision should also include completion of the Quality Assurance Direct Observation Guide with Rapid Testing Form. These forms should be submitted to the site supervisor. Should there be questions or concerns, a copy should be sent to the CDC DT Lead and Project Officer. Peer feedback should focus on mutual enhancement of skills and review of the protocol elements which may not necessarily follow the numbering for each step identified. This feedback should not to be construed as an evaluation or a staff performance appraisal.

Quality Assurance Direct Observation
RESPECT with Rapid Testing
FORM

1. **Session date:** ____/____/____
2. **Single Session RESPECT: YES** _____ **NO:** _____
3. **2- Session RESPECT: Session number:** _____
4. **Site name (session location):** _____
5. **RESPECT Facilitator/Counselor :** _____
6. **RESPECT Observer:** _____
7. **Duration of session (minutes):** _____

The RESPECT session follows a structured protocol that guides the provider to conduct a personalized risk assessment, facilitate a discussion about client’s risk situations, and encourage and assist clients to develop a realistic risk reduction step.

The supervisor/observer should familiarize himself/herself with the basic structure of the provider cards that should be followed to ensure the same degree of success that was demonstrated in the research. This tool is intended as a guide for the supervisor/observer so they can provide feedback to the counselor about how well they followed the stages and steps of the intervention, and make recommendations for improvement.

The purpose of the section below is to evaluate the counselor’s adherence to the intervention protocol. Please check ‘yes’ or ‘no’ to note whether the counselor has or has not met the expectations of each stage. Comments can be noted for each stage if appropriate.

Coloring coding on this: **Salmon** = RESPECT
Gold = RAPID test and Negative Result
Green = Preliminary Positive result.

PRE-RESULT SESSION

PROTOCOL STAGES

Did the counselor...	Yes	No	Comments
1. Introduce and orient client to the session?			
Explain the rapid test process to the client; and, get the client's consent.			
2. Enhance the client's sense of self-risk?			
3. Explore the specifics of the most recent risk?			
4. Review previous risk reduction experiences?			
5. Summarize the risk incident and risk patterns?			
6. Negotiate a risk-reduction step?			
7. Identify sources of support and provide referrals?			

POST-RESULT SESSION-NEGATIVE

PROTOCOL STAGES

Did the counselor....	Yes	No	Comments
A. Deliver test result?			
B. Review the risk reduction step?			
C. Revise risk-reduction step?			
D. Identify sources of support for risk reduction step?			
E. Provide referrals as necessary?			
F. Close the session			

POST-TEST RESULT SESSION-POSITIVE			
Did the counselor...	Yes	No	Comments
A. Deliver Test results?			
B. Review the risk-reduction step?			
C. Revise the risk reduction step?			
D. Identify sources of support for risk reduction step?			
E. Provide referrals as necessary?			
F. Close the session			

Additional Observations/ Comments:

Counselor Strengths:

Areas to be improved and Recommendations:

Quality Assurance Form for 2-Session RESPECT Session I

Provider Name _____ Type of QA: Tape Observation

Reviewer Name _____

Date of Observation _____ Session Start Time _____

Client ID _____ Session End Time _____

Session 1 Protocol Activities	Not Achieved	Achieved	N/A
Introduce and orient client to the session			
Introduce yourself to client			
Explain role of provider			
Indicate the duration of session			
Outline content of session			
Provide referrals			
Discuss activities (lab work in test setting) with client			
Address immediate questions and concerns			
Enhance the client's sense of self-risk			
Find out why client has come in for HIV testing			
Listen for and identify behaviors that put client at risk			
Assess client's level of concern for getting/having HIV			
Discuss client's HIV test history			
Assess whether client is engaging in risky behavior because of previous HIV test result			
Discuss examples of conflicts between beliefs and behavior			
Explore the specifics of most recent risk incident			
Explore the who, what, when, where, of recent risk incident			
Assess level of risk acceptable to client			
Assess communication about HIV with partners			
Identify circumstances or situations that contribute to risk incident			
Identify risk vulnerabilities and triggers to the risk behavior incident			
Discuss examples of conflicts between beliefs and behavior			
Review previous risk-reduction experience			
Assess the client's pattern of risk behavior			
Identify successful attempts at practicing safer sex			
Identify obstacles to risk reduction			
Explore triggers and situations that increase the likelihood of high-risk behavior			
Assess client's communications with friends and partners about risk			
Discuss the client's level of acceptable risk			
Discuss examples of conflicts between beliefs and behavior			

Quality Assurance Form for 2-Session RESPECT Session I ...continued

Session 1 Protocol Activities	Not Achieved	Achieved	N/A
Summarize risk incident and risk patterns			
Provide feedback about client's risk for HIV			
Summarize the information the client has provided			
Note the pattern of risk behavior			
Identify triggers and things that make the client vulnerable			
Discuss examples of conflicts between beliefs and behavior			
Convey concern and urgency about the client's risks			
Support and encourage client in addressing risk issues			
Negotiate risk-reduction step			
Prioritize risk-reduction behavior			
Explore behavior(s) that client will be most motivated about or capable of achieving			
Identify a reasonable, yet challenging, step toward changing the behavior			
Break down the risk step into specific, concrete actions			
Problem solved obstacles to step			
Role-play the step (if applicable)			
Identify support for risk-reduction step			
Confirmed with the client that the step is reasonable and acceptable			
Acknowledge that the step is a challenge and opportunity to review it at next session			
Ask client to be aware of strengths and weaknesses in the step			
Document the risk-reduction step, keeping a copy for yourself			
Identify sources of support and provide referrals			
Assess the client's support system			
Addressed the long-standing or tough-to-manage issues that contribute to risk			
Assessed client's willingness to seek professional help or use a referral			
Evaluate the types of referral the client would be most receptive to			
Provide appropriate referrals			
Close the session			
Review follow-up schedule			
Identify ways for the client to remember follow-up appointment			
Review contact information for the client and the provider			
Proceed with organization's guidelines to obtain specimen for HIV test			

Main risk: _____

Other long-standing issues: _____

Risk-reduction step: _____

Referral: _____

Other notes: _____

Quality Assurance Form for 2-Session RESPECT Session II

Provider Name _____ Type of QA: Tape Observation

Observer Name _____

Date of Observation _____ Session Start Time _____

Client Number _____ Session End Time _____

Session 2 Protocol Activities	Not Achieved	Achieved	N/A
Welcome and Orient Client			
Welcome the client back			
Explain what to expect in the session			
Check in about feelings			
Review the risk-reduction step			
Assess client's efforts to try out the risk-reduction step			
Provide encouragement and support for client's risk-reduction efforts			
Explored supports for and barriers to risk-reduction step			
Problem solve issues with step			
Revise the risk-reduction step			
Revise or develop a new risk-reduction step			
Discuss a more challenging step or revise previous step			
Identify or clarify actions to achieve the step			
Confirm with the client that the step is reasonable and achievable			
Document the revised risk-reduction step and give copy to client			
Identify sources of support for the risk-reduction step			
Emphasize importance of client discussing with a trusted friend/relative the intention and content of step			
Identify a person to whom the client could comfortably disclose the step			
Establish a concrete, specific approach for client to use in sharing the step with friend/relative			
Ask client be aware of strengths/weaknesses when trying it out			
Let client know you have confidence in his or her ability to complete the step			
Provide referral and end session			
If a referral was provided in previous session, follow-up on the client's completion.			
Address long-standing or hard-to-manage issues that contribute to risk			
Assess the client's willingness to seek professional help and use a referral			
Evaluate types of referral			
Provide appropriate referral			
Provide closure			

Risk-reduction step: _____

Referral: _____

Other notes: _____

Appendix F

Resources

Revised Guidelines for HIV Counseling, Testing and Referral MMWR
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>

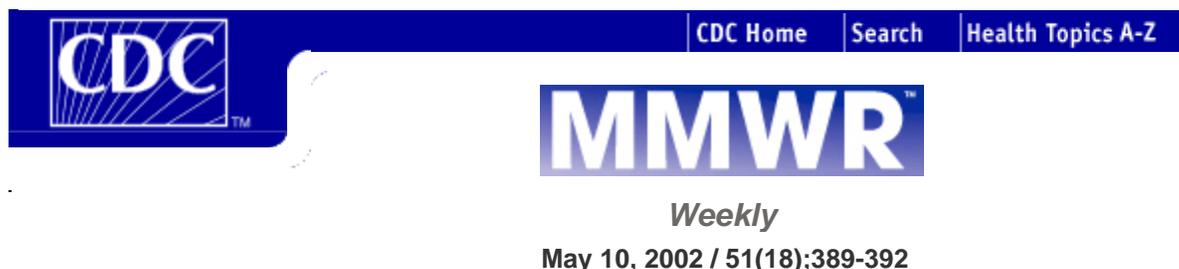
Quality Assurance for HIV Prevention Counseling in a Multi-Center Randomized Controlled Trial
<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1382050>

Partner Counseling and Referral Services Guidelines (under revision)
<http://www.cdc.gov/hiv/resources/guidelines/pcrs/index.htm>

Revised Guidelines for HIV Counseling, Testing and Referral and Revised Recommendations for HIV Screening of Pregnant Women
<http://www.cdc.gov/mmwr/pdf/rr/rr5019.pdf>

Appendix G

DEBI Required Materials



Nonoxynol-9 Spermicide Contraception Use --- United States, 1999

Most women in the United States with human immunodeficiency virus (HIV) become infected through sexual transmission, and a woman's choice of contraception can affect her risk for HIV transmission during sexual contact with an infected partner. Most contraceptives do not protect against transmission of HIV and other sexually transmitted diseases (STDs) (1), and the use of some contraceptives containing nonoxynol-9 (N-9) might increase the risk for HIV sexual transmission. Three randomized, controlled trials of the use of N-9 contraceptives by commercial sex workers (CSWs) in Africa failed to demonstrate any protection against HIV infection (2--4); one trial showed an increased risk (3). N-9 contraceptives also failed to protect against infection with *Neisseria gonorrhoeae* and *Chlamydia trachomatis* in two randomized trials (5,6), one among African CSWs and one among U.S. women recruited from an STD clinic. Because most women in the African studies had frequent sexual activity, had high-level exposure to N-9, and probably were exposed to a population of men with a high prevalence of HIV/STDs, the implications of these studies for U.S. women are uncertain. To determine the extent of N-9 contraceptive use among U.S. women, CDC assessed data provided by U.S. family planning clinics for 1999. This report summarizes the results of that assessment, which indicate that some U.S. women are using N-9 contraceptives. Sexually active women should consider their individual HIV/STD infection risk when choosing a method of contraception. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections.

CDC collected information on types of N-9 contraceptives purchased and family planning program (FPP) guidelines for N-9 contraceptive use. The national FPP, authorized by Title X of the Public Health Service Act, serves approximately 4.5 million predominantly low-income women each year. Program data for 1999 were obtained from all 10 U.S. Department of Health and Human Services (HHS) regions on the number of female clients and the number of female clients who reported use of N-9 contraceptives or condoms as their primary method of contraception. CDC obtained limited purchase data for 1999 for specific N-9 contraceptives and program guidelines from eight state/territorial FPPs within six HHS regions. State health departments, family planning grantees, and family planning councils were contacted to request assistance in collecting data on purchasing patterns of the 91 Title X grantees; of the 12 FPPs that responded, eight provided sufficient data for analysis.

In 1999, a total of 7%--18% of women attending Title X clinics reported using condoms as their primary method of contraception. Data on the percentage of condoms lubricated with N-9 were not available. A total of 1%--5% of all women attending Title X clinics reported using N-9 contraceptives (other than condoms) as their primary method of contraception (Table 1). Among the eight FPPs that provided purchase data, most (87%) condoms were N-9--lubricated (Table 2). All eight FPPs purchased N-9 contraceptives (i.e., vaginal films and suppositories, jellies, creams, and foams) to be used either alone or in combination with diaphragms or other contraceptive products. Four of the eight clinics had protocols or

program guidance stating that N-9--containing foam should be dispensed routinely with condoms; two additional programs reported that despite the absence of a clinic protocol, the practice was common. Data for the other two programs were not available.

Reported by: *The Alan Guttmacher Institute, New York, New York. Office of Population Affairs, U.S. Dept of Health and Human Services, Bethesda, Maryland. A Duerr, MD, C Beck-Sague, MD, Div Reproductive Health, National Center Chronic Disease and Public Health Promotion; Div of HIV and AIDS Prevention, National Center HIV/AIDS, STDs, and TB Prevention; B Carlton-Tohill, EIS Officer, CDC.*

Editorial Note:

The findings in this report indicate that in 1999, before the release of recent publications on N-9 and HIV/STDs (4,6,7), Title X family planning clinics in the U.S. purchased and distributed N-9 contraceptives. Among at least eight family planning clinics, most of the condoms purchased were N-9--lubricated; this is consistent with trends in condom purchases among the general public (8). The 2002 STD treatment guidelines state that condoms lubricated with spermicides are no more effective than other lubricated condoms in protecting against the transmission of HIV infection and other STDs (7). CDC recommends that previously purchased condoms lubricated with N-9 spermicide continue to be distributed provided the condoms have not passed their expiration date. The amount of N-9 on a spermicide-lubricated condom is small relative to the doses tested in the studies in Africa and the use of N-9--lubricated condoms is preferable to using no condom at all. In the future, purchase of condoms lubricated with N-9 is not recommended because of their increased cost, shorter shelf life, association with urinary tract infections in young women, and lack of apparent benefit compared with other lubricated condoms (7).

Spermicidal gel is used in conjunction with diaphragms (1); only diaphragms combined with the use of spermicide are approved as contraceptives. The respective contributions of the physical barrier (diaphragm) and chemical barrier (spermicide) are unknown, but the combined use prevents approximately 460,000 pregnancies in the United States each year (1).

The findings in this report are subject to at least two limitations. First, data on specific products and patterns of contraceptive use were limited; CDC used a nonrepresentative sample of regions and states that voluntarily provided data, and specific use patterns of the contraceptives could not be extrapolated from these data. Second, data correlating use of N-9 contraceptives with individual HIV risk were not available.

Prevention of both unintended pregnancy and HIV/STD infection among U.S. women is needed. In 1994, a total of 49% of all pregnancies were unintended (9). Furthermore, 26% of women experience an unintended pregnancy during the first year of typical use of spermicide products (1). In 1999, a total of 10,780 AIDS cases, 537,003 chlamydia cases, and 179,534 gonorrhea cases were reported among U.S. women. Contraceptive options should provide both effective fertility control and protection from HIV/STDs; however, the optimal choice is probably not the same for every woman.

N-9 alone is not an effective means to prevent infection with HIV or cervical gonorrhea and chlamydia (2,7). Sexually active women and their health-care providers should consider risk for infection with HIV and other STDs and risk for unintended pregnancy when considering contraceptive options. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections. In addition, women seeking a family planning method should be informed that latex condoms, when used consistently and correctly, are effective in preventing transmission of HIV and can reduce the risk for other STDs.

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Table 1

TABLE 1. Number of women using male condoms or noxynol-9 (N-9) products as their primary method of contraception, by Title X Family Planning Region — United States, 1999

Region*	No. of women served	Male condoms		N-9 products†	
		No.	(%)	No.	(%)
I	179,705	27,726	(15)	1,251	(1)
II	404,325	73,069	(18)	21,515	(5)
III	487,502	73,088	(15)	4,807	(1)
IV	1,011,126	93,011	(9)	29,630	(3)
V	522,312	61,756	(12)	2,489	(1)
VI	478,533	40,520	(8)	11,212	(2)
VII	238,971	15,949	(7)	1,386	(1)
VIII	133,735	15,131	(11)	4,885	(4)
IX	672,362	109,678	(17)	14,547	(2)
X	186,469	17,320	(9)	1,275	(2)
Total	4,315,040	527,248	(12)	92,997	(2)

* Region I=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont; Region II=New Jersey, New York, Puerto Rico, Virgin Islands; Region III=Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia; Region IV=Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee; Region V=Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin; Region VI=Arkansas, Louisiana, New Mexico, Oklahoma, Texas; Region VII=Iowa, Kansas, Missouri, Nebraska; Region VIII=Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming; Region IX=Arizona, California, Hawaii, Nevada, American Samoa, Guam, Mariana Islands, Marshall Islands, Micronesia, Palau; Region X=Alaska, Idaho, Oregon, Washington.

† Primary method of contraception reported by these women was one of the following: spermicidal foam, cream, jelly (with and without diaphragm), film, or suppositories.

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Table 2

TABLE 2. Number of noxynol-9 (N-9) contraceptives purchased by Title X Family Planning Programs in selected states/territories, 1999

State/territory	No. of clients served	Physical barrier method		N-9 chemical barrier methods				
		Condoms with N-9	Condoms without N-9	Gel	Vaginal		Jelly	Foam
					Film	Insert		
Puerto Rico	15,103	148,072	5,000	12,900	0	NA*	12,841	2,400
New York†	283,200	1,936,084	NA	0	73,788	NA	3,112	23,830
West Virginia	60,899	1,300,000	9,360	0	0	NA	1,200	9,900
Florida	193,784	3,920,000	560,000	0	468,720	NA	5,760	25,920
Tennessee	111,223	2,865,160‡	717,088	0	94,500	12,528	756	2,758
Michigan	166,893	631,000	254,000	0	0	NA	1,000	1,200
Oklahoma	58,392	708,480	0	0	394,560	NA	1,200	0
Oregon	57,099	151,900	276,000	345	25,764	2,074	272	3,007

* Not available.

† 41 of 61 grantees responded.

‡ Purchasing by family planning and sexually transmitted disease programs are combined and cannot be separated.

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CDC National STD/HIV Hotline
(800) 227-8922 or (800) 342-2437
En Espanol (800) 344-7432
www.cdc.gov/std

Fact Sheet for Public Health Personnel:

Male Latex Condoms and Sexually Transmitted Diseases

In June 2000, the National Institutes of Health (NIH), in collaboration with the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and the United States Agency for International Development (USAID), convened a workshop to evaluate the published evidence establishing the effectiveness of latex male condoms in preventing STDs, including HIV. A summary report from that workshop was completed in July 2001 (<http://www.niaid.nih.gov/dmid/stds/condomreport.pdf>). This fact sheet is based on the NIH workshop report and additional studies that were not reviewed in that report or were published subsequent to the workshop (see "[Condom Effectiveness](#)" for additional references). Most epidemiologic studies comparing rates of STD transmission between condom users and non-users focus on penile-vaginal intercourse.

Recommendations concerning the male latex condom and the prevention of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), are based on information about how different STDs are transmitted, the physical properties of condoms, the anatomic coverage or protection that condoms provide, and epidemiologic studies of condom use and STD risk.

The surest way to avoid transmission of sexually transmitted diseases is to abstain from sexual intercourse, or to be in a long-term mutually monogamous relationship with a partner who has been tested and you know is uninfected.

For persons whose sexual behaviors place them at risk for STDs, correct and consistent use of the male latex condom can reduce the risk of STD transmission. However, no protective method is 100 percent effective, and condom use cannot guarantee absolute protection against any STD. Furthermore, condoms lubricated with spermicides are no more effective than other lubricated condoms in protecting against the transmission of HIV and other STDs. In order to achieve the protective effect of condoms, they must be used correctly and consistently. Incorrect use can lead to condom slippage or breakage, thus diminishing their protective effect. Inconsistent use, e.g., failure to use condoms with every act of

intercourse, can lead to STD transmission because transmission can occur with a single act of intercourse.

While condom use has been associated with a lower risk of cervical cancer, the use of condoms should not be a substitute for routine screening with Pap smears to detect and prevent cervical cancer.

Sexually Transmitted Diseases, Including HIV

Sexually transmitted diseases, including HIV

Latex condoms, when used consistently and correctly, are highly effective in preventing transmission of HIV, the virus that causes AIDS. In addition, correct and consistent use of latex condoms can reduce the risk of other sexually transmitted diseases (STDs), including discharge and genital ulcer diseases. While the effect of condoms in preventing human papillomavirus (HPV) infection is unknown, condom use has been associated with a lower rate of cervical cancer, an HPV-associated disease.

There are two primary ways that STDs can be transmitted. Human immunodeficiency virus (HIV), as well as gonorrhea, chlamydia, and trichomoniasis – the discharge diseases – are transmitted when infected semen or vaginal fluids contact mucosal surfaces (e.g., the male urethra, the vagina or cervix). In contrast, genital ulcer diseases – genital herpes, syphilis, and chancroid – and human papillomavirus are primarily transmitted through contact with infected skin or mucosal surfaces.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Condoms can be expected to provide different levels of protection for various sexually transmitted diseases, depending on differences in how the diseases are transmitted. Because condoms block the discharge of semen or protect the male urethra against exposure to vaginal secretions, a greater level of protection is provided for the discharge diseases. A lesser degree of protection is provided for the genital ulcer diseases or HPV because these infections may be transmitted by exposure to areas, e.g., infected skin or mucosal surfaces, that are not covered or protected by the condom.

Epidemiologic studies seek to measure the protective effect of condoms by comparing rates of STDs between condom users and nonusers in real-life settings. Developing such measures of condom effectiveness is challenging. Because these studies involve private behaviors that investigators cannot observe directly, it is difficult to determine

accurately whether an individual is a condom user or whether condoms are used consistently and correctly. Likewise, it can be difficult to determine the level of exposure to STDs among study participants. These problems are often compounded in studies that employ a “retrospective” design, e.g., studies that measure behaviors and risks in the past.

As a result, observed measures of condom effectiveness may be inaccurate. Most epidemiologic studies of STDs, other than HIV, are characterized by these methodological limitations, and thus, the results across them vary widely--ranging from demonstrating no protection to demonstrating substantial protection associated with condom use. This inconclusiveness of epidemiologic data about condom effectiveness indicates that more research is needed--not that latex condoms do not work. For HIV infection, unlike other STDs, a number of carefully conducted studies, employing more rigorous methods and measures, have demonstrated that consistent condom use is a highly effective means of preventing HIV transmission.

Another type of epidemiologic study involves examination of STD rates in populations rather than individuals. Such studies have demonstrated that when condom use increases within population groups, rates of STDs decline in these groups. Other studies have examined the relationship between condom use and the complications of sexually transmitted infections. For example, condom use has been associated with a decreased risk of cervical cancer – an HPV associated disease.

The following includes specific information for HIV, discharge diseases, genital ulcer diseases and human papillomavirus, including information on laboratory studies, the theoretical basis for protection and epidemiologic studies.

HIV / AIDS

HIV, the virus that causes AIDS

Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS.

AIDS is, by far, the most deadly sexually transmitted disease, and considerably more scientific evidence exists regarding condom effectiveness for prevention of HIV infection than for other STDs. The body of research on the effectiveness of latex condoms in preventing sexual transmission of HIV is both comprehensive and conclusive. In fact, the ability of latex condoms to prevent transmission of HIV has been scientifically established in “real-life” studies of sexually active couples as well as in laboratory studies.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Latex condoms cover the penis and provide an effective barrier to exposure to secretions such as semen and vaginal fluids, blocking the pathway of sexual transmission of HIV infection.

Epidemiologic studies that are conducted in real-life settings, where one partner is infected with HIV and the other partner is not, demonstrate conclusively that the consistent use of latex condoms provides a high degree of protection.

Discharge Diseases, Including Gonorrhea, Chlamydia, and Trichomoniasis

Discharge diseases, other than HIV

Latex condoms, when used consistently and correctly, can reduce the risk of transmission of gonorrhea, chlamydia, and trichomoniasis.

Gonorrhea, chlamydia, and trichomoniasis are termed discharge diseases because they are sexually transmitted by genital secretions, such as semen or vaginal fluids. HIV is also transmitted by genital secretions.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. The physical properties of latex condoms protect against discharge diseases such as gonorrhea, chlamydia, and trichomoniasis, by providing a barrier to the genital secretions that transmit STD-causing organisms.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms can protect against the transmission of chlamydia, gonorrhea and trichomoniasis. However, some other epidemiologic studies show little or no protection against these infections. Many of the available epidemiologic studies were not designed or conducted in ways that allow for accurate measurement of condom effectiveness against the discharge diseases. More research is needed to assess the degree of protection latex condoms provide for discharge diseases, other than HIV.

Genital Ulcer Diseases and Human Papillomavirus

Genital ulcer diseases and HPV infections

Genital ulcer diseases and HPV infections can occur in both male or female genital areas that are covered or protected by a latex condom, as well as in areas that are not covered. Correct and consistent use of latex condoms can reduce the risk of genital herpes, syphilis, and chancroid only when the infected area or site of potential exposure is protected. While the effect of condoms in preventing human papillomavirus infection is unknown, condom use has been associated with a lower rate of cervical cancer, an HPV-associated disease.

Genital ulcer diseases include genital herpes, syphilis, and chancroid. These diseases are transmitted primarily through “skin-to-skin” contact from sores/ulcers or infected skin that looks normal. HPV infections are transmitted through contact with infected genital skin or mucosal surfaces/fluids. Genital ulcer diseases and HPV infection can occur in male or female genital areas that are, or are not, covered (protected by the condom).

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Protection against genital ulcer diseases and HPV depends on the site of the sore/ulcer or infection. Latex condoms can only protect against transmission when the ulcers or infections are in genital areas that are covered or protected by the condom. Thus, consistent and correct use of latex condoms would be expected to protect against transmission of genital ulcer diseases and HPV in some, but not all, instances.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms can protect against the transmission of syphilis and genital herpes. However, some other epidemiologic studies show little or no protection. Many of the available epidemiologic studies were not designed or conducted in ways that allow for accurate measurement of condom effectiveness against the genital ulcer diseases. No conclusive studies have specifically addressed the transmission of chancroid and condom use, although several studies have documented a reduced risk of genital ulcers in settings where chancroid is a leading cause of genital ulcers. More research is needed to assess the degree of protection latex condoms provide for the genital ulcer diseases.

While some epidemiologic studies have demonstrated lower rates of HPV infection among condom users, most have not. It is particularly difficult to study the relationship between condom use and HPV infection because HPV infection is often intermittently detectable and because it is difficult to assess the frequency of either existing or new

infections. Many of the available epidemiologic studies were not designed or conducted in ways that allow for accurate measurement of condom effectiveness against HPV infection.

A number of studies, however, do show an association between condom use and a reduced risk of HPV-associated diseases, including genital warts, cervical dysplasia and cervical cancer. The reason for lower rates of cervical cancer among condom users observed in some studies is unknown. HPV infection is believed to be required, but not by itself sufficient, for cervical cancer to occur. Co-infections with other STDs may be a factor in increasing the likelihood that HPV infection will lead to cervical cancer. More research is needed to assess the degree of protection latex condoms provide for both HPV infection and HPV-associated disease, such as cervical cancer.

Department of Health and Human Services

For additional information on condom effectiveness, contact
CDC's National Prevention Information Network
(800) 458-5231 or www.cdcnpin.org



**CONTENT OF AIDS-RELATED WRITTEN MATERIALS,
PICTORIALS, AUDIOVISUALS, QUESTIONNAIRES, SURVEY**



**INSTRUMENTS, AND EDUCATIONAL SESSIONS IN CENTERS FOR
DISEASE CONTROL AND PREVENTION (CDC) ASSISTANCE PROGRAMS**

Interim Revisions June 1992

1. Basic Principles

Controlling the spread of HIV infection and AIDS requires the promotion of individual behaviors that eliminate or reduce the risk of acquiring and spreading the virus. Messages must be provided to the public that emphasize the ways by which individuals can fully protect themselves from acquiring the virus. These methods include abstinence from the illegal use of IV drugs and from sexual intercourse except in a mutually monogamous relationship with an uninfected partner. For those individuals who do not or cannot cease risky behavior, methods of reducing their risk of acquiring or spreading the virus must also be communicated. Such messages can be controversial. These principles are intended to provide guidance for the development and use of educational materials, and to require the establishment of Program Review Panels to consider the appropriateness of messages designed to communicate with various groups.

- a. Written materials (e.g., pamphlets, brochures, fliers), audio visual materials (e.g., motion pictures and video tapes), and pictorials (e.g., posters and similar educational materials using photographs, slides, drawings, or paintings) should use terms, descriptors, or displays necessary for the intended audience to understand dangerous behaviors and explain less risky practices concerning HIV transmission.
2. Written materials, audiovisual materials, and pictorials should be reviewed by Program Review Panels consistent with the provisions of Section 2500 (b), (c), and (d) of the Public Health Service Act, 42 U.S.C. Section 300ee(b), (c), and (d), as follows:

"SEC. 2500. USE OF FUNDS.

(b) CONTENTS OF PROGRAMS. - All programs of education and information receiving funds under this title shall include information about the harmful effects of promiscuous sexual activity and intravenous substance abuse, and the benefits of abstaining from such activities.

(c) LIMITATION. - None of the funds appropriated to carry out this title may be used to provide education or information designed to promote or encourage, directly, homosexual or heterosexual sexual activity or intravenous substance abuse.

(d) CONSTRUCTION. - Subsection (c) may not be construed to restrict the ability of an education program that includes the information required in subsection (b) to provide accurate information about various means to reduce an individual's risk of exposure to, or to transmission of, the etiologic agent for acquired immune deficiency syndrome, provided that any informational materials used are not obscene."

c. Educational sessions should not include activities in which attendees participate in sexually suggestive physical contact or actual sexual practices.

d. Messages provided to young people in schools and in other settings should be guided by the principles contained in "Guidelines for Effective School Health Education to Prevent the Spread of AIDS" (MMWR 1988;37 [suppl. no. S-2]).

2. Program Review Panel

- a. Each recipient will be required to establish or identify a Program Review Panel to review and approve all written materials, pictorials, audiovisuals, questionnaires or survey instruments, and proposed educational group session activities to be used under the project plan. This requirement applies regardless of whether the applicant plans to conduct the total program activities or plans to have part of them conducted through other organization (s) and whether program activities involve creating unique materials or using/distributing modified or intact materials already developed by others. Whenever feasible, CDC funded community-based organizations are encouraged to use a Program Review Panel established by a health department or another CDC-funded organization rather than establish their own panel. The Surgeon General's Report on Acquired Immune Deficiency Syndrome (October 1986) and CDC-developed materials do not need to be reviewed by the panel unless such review is deemed appropriate by the recipient. Members of a Program Review Panel should:

- (1) Understand how HIV is and is not transmitted; and

- (2) Understand the epidemiology and extent of the HIV/AIDS problem in the local population and the specific audiences for which materials are intended.

2. The Program Review Panel will be guided by the CDC Basic Principles (in the previous section) in conducting such reviews. The panel is authorized to review materials only and is not empowered either to evaluate the proposal as a whole or to replace any other internal review panel or procedure of the recipient organization or local governmental jurisdiction.

3. Applicants for CDC assistance will be required to include in their applications the following:

- (1) Identification of a panel of no less than five persons which represent a reasonable cross-section of the general population. Since Program Review Panels review materials for many intended audiences, no single intended audience shall predominate the composition of the Program Review panel, except as provided in

subsection (d) below. In addition:

(a) Panels which review materials intended for a specific audience should draw upon the expertise of individuals who can represent cultural sensitivities and language of the intended audience either through representation on the panels or as consultants to the panels.

(b) The composition of Program Review Panels, except for panels reviewing materials for school-based populations, must include an employee of a State or local health department with appropriate expertise in the area under consideration who is designated by the health department to represent the department on the panel. If such an employee is not available, an individual with appropriate expertise, designated by the health department to represent the agency in this matter, must serve as a member of the panel.

(c) Panels which review materials for use with school-based populations should include representatives of groups such as teachers, school administrators, parents, and students.

(d) Panels reviewing materials intended for racial and ethnic minority populations must comply with the terms of (a), (b), and (c), above. However, membership of the Program Review Panel may be drawn predominately from such racial and ethnic populations.

(2) A letter or memorandum from the proposed project director, countersigned by a responsible business official, which includes:

(a) Concurrence with this guidance and assurance that its provisions will be observed;

(b) The identity of proposed members of the Program Review Panel, including their names, occupations, and any organizational affiliations that were considered in their selection for the panel.

4. CDC-funded organizations that undertake program plans in other than school-based populations which are national, regional (multi state), or statewide in scope, or that plan to distribute materials as described above to other organizations on a national, regional, or statewide basis, must establish a single Program Review Panel to fulfill this requirement. Such national/regional/State panels must include as a member an employee of a State or local health department, or an appropriate designated representative of such department, consistent with the provisions of Section 2.c.(1). Materials reviewed by such a single (national, regional, or state) Program Review Panel do not need to be reviewed locally unless such review is deemed appropriate by the local organization planning to use or distribute the materials. Such national/regional/State organization must adopt a national/regional/statewide standard when applying Basic Principles 1.a. and 1.b.
5. When a cooperative agreement/grant is awarded, the recipient will:
 - (1) Convene the Program Review Panel and present for its assessment copies of written materials, pictorials, and audiovisuals proposed to be used;

- (2) Provide for assessment by the Program Review Panel text, scripts, or detailed descriptions for written materials, pictorials, or audiovisuals which are under development;
- (3) Prior to expenditure of funds related to the ultimate program use of these materials, assure that its project files contain a statement(s) signed by the Program Review Panel specifying the vote for approval or disapproval for each proposed item submitted to the panel; and
- (4) Provide to CDC in regular progress reports signed statement(s) of the chairperson of the Program Review Panel specifying the vote for approval or disapproval for each proposed item that is subject to this guidance.

The ABCs of Smart Behavior

To avoid or reduce the risk for HIV

- **A** stands for abstinence.
- **B** stands for being faithful to a single sexual partner.
- **C** stands for using condoms consistently and correctly.

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August 11, 2000 / 49(31);717-8

Notice to Readers: CDC Statement on Study Results of Product Containing Nonoxynol-9

During the XIII International AIDS Conference held in Durban, South Africa, July 9--14, 2000, researchers from the Joint United Nations Program on AIDS (UNAIDS) presented results of a study of a product, COL-1492,* which contains nonoxynol-9 (N-9) (*I*). N-9 products are licensed for use in the United States as spermicides and are effective in preventing pregnancy, particularly when used with a diaphragm. The study examined the use of COL-1492 as a potential candidate microbicide, or topical compound to prevent the transmission of human immunodeficiency virus (HIV) and sexually transmitted diseases (STDs). The study found that N-9 did not protect against HIV infection and may have caused more transmission. The women who used N-9 gel became infected with HIV at approximately a 50% higher rate than women who used the placebo gel.

CDC has released a "Dear Colleague" letter that summarizes the findings and implications of the UNAIDS study. The letter is available on the World-Wide Web, <http://www.cdc.gov/hiv>; a hard copy is available from the National Prevention Information Network, telephone (800) 458-5231. Future consultations will be held to re-evaluate guidelines for HIV, STDs, and pregnancy prevention in populations at high risk for HIV infection. A detailed scientific report will be released on the Web when additional findings are available.

Reference

1. van Damme L. Advances in topical microbicides. Presented at the XIII International AIDS Conference, July 9--14, 2000, Durban, South Africa.

* Use of trade names and commercial sources is for identification only and does not constitute endorsement by CDC or the U.S. Department of Health and Human Services.

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Centers for Disease Control and Prevention
1600 Clifton Rd, MailStop E-90, Atlanta, GA
30333, U.S.A



Department of Health
and Human Services

This page last reviewed 5/2/01

Appendix H

Cost to Implement RESPECT HIV Prevention Counseling

Sample Budget for RESPECT With Testing

The budget to implement RESPECT will vary based on delivery costs in different regions of the country, the number of staff required for larger sites, and the use of optional components of the intervention (e.g., incentives). The sample budget provided here will assist implementers in determining the potential costs of their RESPECT intervention. The sample budget is an estimate for **one year** with minimum required staff, and based on 1,000 clients.

Basic Assumptions: (1) The agency is compliant with HIPAA and CLIA (if necessary) regulations regarding the handling of patient information and the management of laboratory services and tests; (2) Larger sites with more than 15 RESPECT providers will require more supervision, HIV testing, and support staff. (3) The number of individuals served will vary by agency and location; (4) The agency has access to the RESPECT intervention participants through an internal agency referral; (5) The Agency has an appropriate space that *does not require additional funds* (i.e., rent) to hold RESPECT sessions and HIV testing space and facilities; and, (6) The Agency has a computer, printer, and copy machine.

Space for RESPECT sessions: Because RESPECT is an individual level intervention, spaces allocated should be reasonable private and insulated from outside noise. If individual rooms are not available, larger ones can be subdivided using floor-to-ceiling noise resistant dividers. Each space will have to be equipped with at least two chairs, and preferably a table.

Provider Office Space: Individual providers are likely to require space to prepare and organize patient records and evaluation materials. To minimize costs, providers may not require individual desks, but should be equipped with filing cabinets and in-boxes or cubbyholes within a larger space with shared desks and tables.

HIV Testing Space and Facilities: HIV testing may take place in the counseling session rooms or in a separate space. HIV testing (including the storage of blood samples and testing equipment), maintaining data confidentiality and the reporting of results to state and local health departments, should conform to the CDC guidelines.

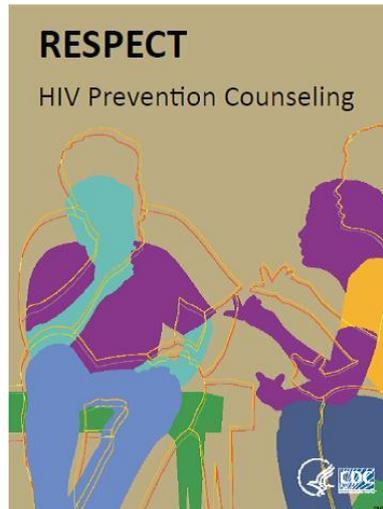
Sample 1-Year Budget for RESPECT

RESOURCE			TOTAL COST
Staff	Salary/Person	Persons	
Program Manager (30%)	\$60,000	1	\$18,000
RESPECT Provider (100%)	\$40,000	1	\$40,000
HIV C&T Staff (25%)	\$30,000	1	\$22,500
Support Staff (15%)	\$28,000	1	\$ 4,200
Fringe benefits @ 31%			\$26,947
		Total	\$91,647
Contracted Services	Salary/Person	Persons	
Program Evaluator (10%)	\$65,000		\$6,500
		Total	\$6,500
Intervention Supplies	Cost/Unit	Units	
Male and Female Condom Models (optional)			
Condoms—female (one/participant)	\$2.50	1000	\$2,500
Condoms—male (1,000/case)	\$70	10	\$ 700
Dental dams (one per participants—25/box) (optional)	\$30	3	\$ 90
Lubricants (100/box)	\$25	1	\$ 25
HIV Test Kits	\$20	1000	\$4,000
HIV Test Kit Storage (optional)	\$100	1	100
		Total	\$8,330

RESOURCES			TOTAL COST
Office Supplies	Cost/Unit	Units	
Office materials (Paper, pens, push pins, envelopes (#10 and 6x9), stamps, certificates, folders etc.	\$45	10	\$450
Photocopy or reproducing costs (e.g., handouts)	\$700	1	\$900
Paper, pens, push pins, etc.			\$1,350
		Total	
Facilities/Equipment	Cost/Unit	Units	
Telephone/Fax	\$275	1	\$275
Computer/Ink cartridges/Maintenance	\$700	1	\$700
Internet Service Provider	\$180	1	\$180
Transportation (staff vehicles - gas, mileage)	\$400	1	\$400
		Total	\$1,655
Incentives (optional)	Cost/Unit	Units	
Coupons (phone cards, bus tokens)	\$5	100	\$500
Gift cards (1/participant)	\$10	1000	\$1,000
Others (meals and snacks)	\$150	100	\$1,500
Bus tokens for participants)	\$150	100	\$1,500
		Total	\$4, 500
Grand Total			\$113, 982

Appendix =

Agency Readiness Tool



RESPECT Agency Readiness Guide

1. Does the agency have relevant experience in providing HIV prevention counseling; counseling, testing, and referral (CTR), comprehensive risk counseling and services (CRCS; former PCM), or partner counseling and referral services (PCRS) in the past.
2. Does the agency have staff skilled in conducting client-focused counseling?
3. Does the agency have a plan for staffing the RESPECT INTERVENTION?
 - a. 100% FTE counselor at least one 100% FTE counselor on staff that is trained in the fundamentals of HIV counseling. (E.g. this counselor will conduct one-on-one counseling, explain the HIV testing process, communicate HIV test results, collect client information in a neat and orderly manner, and complete legally required paperwork.)
 - b. Has at least one .25 FTE program manager on staff that will ensure that program integrity is maintained.
4. Does the agency have plans to prepare staff to deliver RESPECT?
 - a. (e.g., All RESPECT counselors and supervisors will complete the state/CDC approved “Fundamentals of HIV Prevention Counseling” training or other client-centered counseling training;
 - b. All RESPECT counselors and supervisors will complete the 2-day RESPECT training.
 - c. All RESPECT counselors and supervisors will complete training on the state’s HIV reporting laws and other state and local regulations.
 - d. All RESPECT counselors will have a minimum number of continuing education hours annually.
 - e. All RESPECT counselors will be trained on making and tracking referrals.
 - f. All RESPECT counselors will receive regular supervision.

5. Does the agency have the physical space where they will be conducting RESPECT?
 - a. Agency has designated a private room where auditory and visual privacy can be assured (e.g., use of white noise machines, room dividers, etc.).
 - b. Space can accommodate two people comfortably and has a desk.
 - c. Space can accommodate HIV testing and waste disposal (if testing will be conducted on-site).

6. Does the agency have a plan for providing HIV testing?
 - a. Agency provides testing (either standard or rapid) on-site.
 - b. Agency does not provide testing on-site, but has MOUs with local testing sites.
 - c. Agency has written information about testing locations, schedule of testing hours, and type of testing provided (i.e., traditional, rapid).
 - d. Agency has a strategy to increase the likelihood that clients return for their results.

7. Does the agency have plans for ensuring client confidentiality?
 - a. Agency has a written confidentiality protocol.
 - b. Staff receives regular HIV confidentiality training (minimum annually).
 - c. Client files are kept in a locked, secure file cabinet and electronic files are password-protected.

8. Does the agency have plans for providing referrals to clients?
 - a. Has a written referral protocol/policy.
 - b. Has an updated referral directory that includes prevention, support, mental health, and medical services providers.
 - c. Has current MOUs with referral agencies.
 - d. Has a plan for tracking referrals.

9. Does the agency have plans to ensure that clients return for Session 2 of the RESPECT model?
 - a. Describes a plan to use appointment cards, telephone reminders, or some other system for encouraging clients to return for the second session.

10. Does the agency have a plan to ensure quality assurance (QA) that supports consistent delivery of the intervention?
 - a. Has written QA protocol and/or monitoring plan for counseling and testing.
 - b. Staff receives training and continuing education.
 - c. Supervisor/Program manager conducts regular observation of HIV counselors counseling sessions and provides feedback.
 - d. Agency holds regular case conferences.
 - e. Supervisor/Program manager regularly reviews case records.
 - f. Agency administers client satisfaction surveys.