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**SEPA IMPLEMENTATION MANUAL**





## ACKNOWLEDGMENTS

The Centers for Disease Control and Prevention (CDC), through cooperative agreement # 5H62PS000781-02, provided 100 percent of the funding for this product, developed by Elias P. Vasquez, School of Nursing and Health Studies, University of Miami, with support from Jennifer Weil, Jenny Namur Karp, and other staff at Social Solutions International, Inc.

SEPA is one in a series of products sponsored by CDC's Division of HIV/AIDS Prevention's Prevention Research Branch and its project, Replicating Effective Programs (REP). Information on REP can be found at [http://www.cdc.gov/hiv/topics/prev\\_prog/rep/](http://www.cdc.gov/hiv/topics/prev_prog/rep/).

The original research to establish the efficacy of SEPA was conducted by Nilda Peragallo, with support from the National Institutes of Health Research Project Grant Program (R01 NR04746-04; Nilda Peragallo P.I.). Research outcomes were published in Peragallo, N., DeForge, B., O'Campo, P., Lee, S.M., Kim, Y.J., Cianelli, R., et al. (2005). A randomized clinical trial of an HIV-risk-reduction intervention among low-income Latina women. *Nursing Research*, 54(2), 108-118.

Special thanks for help with developing the SEPA package are extended to the CDC Project Officer, Marlene Glassman, and other CDC staff:

Jorge Alvarez, Ted Castellanos, Vyann Howell, Roberto Mejia, Susan Shewmaker, JoAna Stallworth, and Aisha Leftridge Wilkes.

We also thank Care Resource in Miami, FL and MUJER in Homestead, FL for testing the SEPA intervention package, the Ai Miami International University of Art & Design for the development of the SEPA logo, Norma Jaramillo for graphic design, and the Community Advisory Board members for their input.

SEPA Implementation Manual

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## INTRODUCTION

This document is the Implementation Manual for SEPA, an evidence-based intervention supported by the Centers for Disease Control and Prevention's (CDC) Replicating Effective Programs (REP) project. REP identifies HIV/AIDS prevention interventions with demonstrated evidence of efficacy and supports the original researchers in developing a user-friendly package of materials for prevention providers. The REP package for SEPA is the result of collaboration among researchers, community-based practitioners, and behavioral scientists. The package was field tested in two community-based organizations in southern Florida by non-research staff.

This Implementation Manual contains fundamental information on planning and implementation so you are prepared to properly conduct SEPA to meet the HIV prevention needs of your clients.

The manual contains four chapters and 10 appendices. The Facilitators Guide used to implement SEPA appears as a separate document.

- Chapter 1: Introduction to SEPA
- Chapter 2: Pre-Implementation Information and Activities
- Chapter 3: Implementing SEPA
- Chapter 4: Maintaining SEPA
- Appendices



## What Materials are in the SEPA Package?

In addition to this Implementation Manual, which is the crux of your SEPA package, the package includes the following items:

- A CD-ROM of all project materials, including PowerPoint slides used during implementation
- A notebook with copies of each of the PowerPoint slides
- A copy of the DVD “Mi Hermano\*” used during Session 1 of the intervention
- Suggested narrative for a brochure to help with client recruitment and a brochure with basic information on SEPA as needed for marketing or stakeholder support

### \*Video Disclaimer

*This video is to be used with guidance from trained facilitators, and is not intended for general audiences. The video was produced by the American Red Cross with funding from the Centers for Disease Control and Prevention.*



## CHAPTER 1 INTRODUCTION TO SEPA

### Latinas and HIV Risk

Many factors place women at risk of HIV infection, including limited recognition of partners' risky behaviors, inequality in relationships with men, biological vulnerability, substance misuse, and socioeconomic status. Additional risk factors among Latinas include social and cultural influences, such as traditional sex role socialization; domestic violence; limited exposure to sex and health education; and low awareness of risk.

Effective HIV prevention interventions for at-risk women are critically important. Research shows that HIV-infected women suffer worse psychosocial outcomes than men living with HIV, including poorer perceived self-concept; more external locus of control; and higher rates of anxiety, depression, and suicidal ideation after diagnosis. <sup>1</sup>

To increase awareness and reduce behaviors that put Latinas at risk of contracting HIV, SEPA — Salud, Educación, Prevención, Autocuidado or Health, Education, Prevention, Self-care — was developed and evaluated by Dr. Nilda Peragallo, dean of the School of Nursing and Health Studies at the University of Miami. <sup>2</sup>

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<sup>1</sup> Gielen AC, McDonnell KA, O'Campo PJ, Burke JG. Suicide risk and mental health indicators: do they differ by abuse and HIV status? *Women's Health Issues*. 2005;15(2):89-95.

<sup>2</sup> Peragallo, N, DeForge, B, O'Campo, P, Lee, S, Kim, Y, Cianelli, R, & Ferrer, L. A randomized clinical trial of an HIV-risk reduction intervention among low-income Latina women. *Nursing Research*. 2005; 54(2): 108-118.



## Overview of SEPA

SEPA is small-group level, evidence-based HIV/AIDS behavior change intervention for heterosexually active Hispanic women/Latinas<sup>3</sup> between the ages of 18 and 44 at risk for HIV and STD infection due to unprotected sex with male partners.

SEPA consists of six two-hour sessions that include presentations; group discussions; and practice exercises on male and female condom use, condom negotiation, and assertive communication. Session content covers HIV and STD transmission and prevention, male and female reproductive anatomy, human sexuality, interpersonal communications, and domestic and intimate partner violence. The six sessions of SEPA are:

- Session 1: The Impact of HIV and AIDS on Our Community
- Session 2: HIV and AIDS, Other Sexually Transmitted Diseases, Human Anatomy, and Human Sexuality
- Session 3: How to Prevent HIV and Other Sexually Transmitted Diseases
- Session 4: Ways to Improve Communication with Our Partners
- Session 5: Relationship Violence, HIV Risk, and Safety Measures
- Session 6: Commencement and Welcome to a Brighter Future

## Who Should Participate in SEPA?

Women are eligible to participate in SEPA if, during the six months prior to enrollment, they had unprotected sex with a man of unknown serostatus or a man living with HIV, and/or if they were treated for an STD during the previous six months. The intervention does not address the specific prevention needs of commercial sex workers, injection drug users, or women with substance misuse problems. Participants should understand and be able to speak English.

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<sup>3</sup> For brevity, we refer to SEPA clients as “Latinas.”



As previously noted, SEPA was developed for Latinas between the ages of 18 and 44 who are at risk of HIV and STD infection due to unprotected sex. Although the intervention's efficacy trial included Mexican and Puerto Rican women, researchers believe that SEPA can be of benefit to at-risk women of diverse races and ethnicity if their prevention needs can be addressed by SEPA's activities. This means that SEPA can be adapted for women who are not Hispanic or Latino if they are in need of information on HIV and STD prevention and domestic violence, and if they need to strengthen their skills in communication with male partners, condom use, and condom negotiation. An in-depth discussion of adaptation appears in Chapter 2.

## **What Are The Benefits Of SEPA?**

Agencies, clients, and the Latino community can all benefit from SEPA. By implementing SEPA, agencies know they provide HIV prevention that works to reduce risky sexual behavior. CDC considers SEPA an evidence-based intervention. This means research has demonstrated that the intervention was efficacious – that is, it produced significant reductions in sexual behaviors that put Latinas at risk for infection with the virus that causes AIDS. Women who participate in SEPA benefit because they learn how to protect their health and improve relationships with partners through skill-building activities on condom use and condom negotiation with male partners. When women in the community are healthy and there are reduced rates of HIV and STDs, the entire Latino community benefits.

## **Intervention Efficacy and Theoretical Basis**

### **The Original Research**

SEPA was developed and refined using a variety of research methods to ensure that the program is empirically based. The first study tested the appropriateness of an HIV risk assessment interview for use with a multi-ethnic community in Chicago. The interview was originally developed by Dr. Nilda Peragallo and used with Puerto Ricans living on the east coast. The Chicago study identified the importance of partner communication and



intimacy for understanding the context for AIDS risk reduction among Latinas in Chicago. A second study provided in-depth information about partner communication and related issues essential for the development of the intervention. Finally, a three-phase pilot study developed a culturally appropriate intervention, tested pre- and post-test tools that captured culturally relevant HIV risk behaviors and associated factors, and conducted a process evaluation to establish the feasibility and acceptability of the intervention.

Once pilot research was completed, a randomized clinical trial (RO1 NR04746-04; Nilda Peragallo P.I) funded by the National Institutes of Health was conducted in Chicago between 1999 and 2001. The trial used a pre-test and post-tests immediately after completion of the intervention and at three- and six-month intervals after completion to measure client outcomes.

Mexican and Puerto Rican women aged 18 to 44 (N=657) who reported sexual activity during the previous three months were recruited and randomly assigned to the intervention and control groups.

Latinas who were bilingual, bicultural, and certified by the American Red Cross as HIV counselors and instructors in English and Spanish facilitated the intervention. Acculturation and HIV-risk-related outcomes were examined. Findings indicated that SEPA was effective in reducing high-risk sexual behaviors among low-income Mexican and Puerto Rican women living in Chicago.

Compared to members of the control group 4.5 months after the intervention, SEPA participants showed significant increases in:

- HIV knowledge
- Communication with partners about HIV issues
- Risk-reduction behavioral intentions
- Condom use

In addition, SEPA participants had significant decreases in perceived barriers to condom use.



## **The Theory Basis of SEPA**

Designed to help Latinas build the skills necessary for behavioral changes that lead to more healthy relationships and safer sex, SEPA is based on Social Cognitive Theory.<sup>4</sup> The theory suggests that behavior change requires more than just increasing knowledge of HIV transmission and the benefits of condom use. Rather, the adoption of healthy and safer sex behaviors is developed through interaction between person, behavior, and others in the environment. According to Social Cognitive Theory, performance of a behavior is a function of outcome expectancies (expectations of more positive than negative outcomes) and self-efficacy (confidence in the ability to perform a behavior). SEPA enables participants to build self-efficacy through practice and role-playing exercises. Participants learn the importance of condom use and negotiation and are taught the skills needed to enhance their confidence in their ability to successfully perform the behaviors.

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<sup>4</sup> Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*, Englewood Cliffs, NJ: Prentice-Hall.

## Core Elements and Key Characteristics

### Core Elements



*Core elements* are intervention components that must be maintained without alteration to help ensure program success. The seven core elements of SEPA are described below.



#### **Core Element #1**

Provide culturally and linguistically appropriate information to sexually active women at risk of acquiring HIV from unprotected sex with male partners in interactive, small-group sessions that focus on:

- HIV and STD transmission and prevention;
- human sexuality and male and female anatomy;
- interpersonal communications; and
- relationship violence.

This core element demonstrates the need for

- factual information presented in understandable ways that are consistent with participants' cultural values and beliefs; and
- shared learning through group discussion and activities.



## Core Element #2

Incorporate skill-building activities into sessions to enhance women's self-efficacy for safer sex behaviors, including demonstrations and practice exercises on male and female condom use and role-plays on assertive communication with sex partners, including condom negotiation.

Core element #2 illustrates the use of Social Cognitive Theory because skill-building exercises are used to enhance self-efficacy, a fundamental determinant of behavior change.



## Core Element #3

Build self-efficacy and knowledge for safer sex behaviors, improved communication with partners, and violence management through homework exercises and the sharing of personal experiences.

This core element reinforces the need for skill-building activities and learning by sharing personal experiences with members of the group and new information with members of the community. This core element draws from Social Cognitive Theory by emphasizing skill building and modeling.

Participants serve as models when they carry out homework assignments and share knowledge gained with friends and family in the community. It also reinforces the importance of sharing, belonging, and accomplishment as supports for self-efficacy and behavior change.



## Core Element #4

Show a culturally appropriate video during the first session that portrays the effects of HIV and AIDS on members of the target population and discuss what is communicated about the impact of HIV and AIDS on the community, including impacts on families and women.

Core element #4 underscores the importance of using culturally congruent materials and the importance of discussing HIV and AIDS in a culturally relevant context.



## Core Element #5

Use a female facilitator who speaks and understands the language of participants. The facilitator should not be a peer of participants but someone who is an experienced professional in health education, disease prevention, and risk reduction.

This core element emphasizes the need for trained and culturally competent staff. It recognizes the importance of matching facilitators who are content or subject matter experts in HIV and STD prevention with the target population. Core element #5 illustrates the concept of modeling in Social Cognitive Theory. There is the expectation that participants will learn by modeling the skills displayed by the facilitator.



## Core Element #6

Ask participants to write thank-you notes to fellow participants and pledge their commitment to community health during the final session. Present a certificate to each participant who attends at least half of the sessions.

This core element reflects the tenets of Social Cognitive Theory by enhancing participants' self-efficacy through a sense of accomplishment and by fostering the positive outcome expectancy of helping to improve community health.



## Core Element #7

Conduct no more than two sessions each week.

Core element #7 also relates to Social Cognitive Theory because we want SEPA participants to practice what they learn and to share information with others. If sessions are held without time between them for participants to do homework, core element #3 will be violated.

## Key Characteristics



Key characteristics are intervention activities, delivery methods, or other aspects of the intervention that are not required and can be changed, or adapted, to meet agency or target population needs. Even if an agency does not adapt an evidence-based intervention, it is sound practice to adhere to as many key characteristics as possible because they contribute to the success of evidence-based interventions. SEPA's key characteristics are:

-  Foster assertiveness and self-esteem among participants through education, skill-building exercises, and discussion, and by addressing cultural norms within the Hispanic/Latino community.
-  Explore the dynamics of sexual relationships in the context of Hispanic/Latino culture.
-  Address perceived personal risk and susceptibility to infection with HIV and other sexually transmitted diseases as well as perceived barriers to remaining HIV negative.
-  Use the video “Mi Hermano” to stimulate discussion about the impact of HIV and AIDS on Hispanic/Latino families, women’s HIV risk, and the need to practice safer sex behaviors.
-  Provide transportation assistance and childcare services to participants. Provide light refreshments at each session.
-  Employ facilitators who are certified by the American Red Cross as HIV instructors or who have attended HIV prevention training sponsored by a health department or prevention training center. Employ facilitators who have received training in domestic violence and sexual violence.



-  Invite a former SEPA participant who completed all sessions to assist with such activities as room setup and the distribution of handout materials.
-  After Session 1, groups should not meet with fewer than two or more than 12 participants.
-  Ask participants to complete an evaluation after each session.

## Behavior Change Logic Model

A behavior change logic model connects the theoretical components of an intervention with intervention activities to explain the intervention's effect on immediate and intermediate outcomes, including changes in behavior. Logic models help intervention developers and implementation staff understand the relationships among the target population's risk factors and behaviors, the theory that provides the behavior change logic of the intervention, intervention activities, and intended outcomes.

A behavior change logic model is a conceptual framework that visually delineates the:

- intent of the intervention (what is the target population, what behavioral problem is to be changed, and what change is intended?);
- determinants of behavior change for the target population;
- intervention activities expected to lead to behavior change; and
- anticipated outcomes.

The intent of the intervention is presented in the logic model's problem statement. The problem statement depicts the target population, the behavior that places this population at risk for HIV, and factors that contribute to risk. For SEPA, the target population is Latinas between the ages of 18 and 44 who have unprotected sex with male partners. Factors that contribute to this



behavior include social and cultural issues, such as gender inequality, and gender role socialization.

The determinants of behavior change relate to SEPA's theoretical basis in Social Cognitive Theory. For intervention design, determinants help identify activities that can contribute to behavior change. As noted above, skill-building exercises that can enhance self-efficacy and belief in one's capacity to take action increase the likelihood that behavior change will occur.

The behavioral determinants for SEPA are knowledge, self-efficacy, attitudes, and intentions; the behavior change logic model shows which activities in each of SEPA's six sessions correspond to these determinants of behavior change.

Immediate outcomes correspond to activities and determinants of behavior change and are believed to contribute to the behavior changes noted under intermediate outcomes. The intent is for SEPA participants to successfully negotiate condom use with their partners and to correctly use condoms with partners whose HIV and STD status is not known.

SEPA's behavior change logic model appears below. A general information flyer for SEPA appears in Appendix 1.



## Behavior Change Logic Model for SEPA

Problem Statement			
Behavior Change Logic <sup>5</sup>			
Behavioral Determinants <i>Correspond to risk or contextual factors</i>	Activities <i>To address behavioral determinants</i>	Outcomes <i>Expected changes as a result of activities targeting behavioral determinants</i>	
		Immediate Outcomes: Expected to occur immediately following SEPA	Intermediate Outcomes: Expected to occur between one and six months after completing SEPA
1. Knowledge (knowledge of HIV transmission, prevention, and treatment)	<b>Session 1: The Impact of HIV and AIDS on Our Community</b> <u>Topics:</u> HIV transmission, perinatal prevention, testing for HIV infection <u>Activities:</u> Watch DVD, presentations, discussion; activities correspond to behavioral determinants 1, 2, and 4	Increases in: <ul style="list-style-type: none"> <li>• HIV knowledge</li> <li>• Favorable attitudes toward condom use</li> <li>• Self-efficacy in partner communication</li> </ul>	Increases in: <ul style="list-style-type: none"> <li>• Correct and consistent condom use with sex partners of unknown HIV serostatus during vaginal and anal sex</li> </ul>

<sup>5</sup> SEPA is grounded in Social Cognitive Theory.



<p>2. Attitudes (attitudes toward condom use)</p> <p>3. Self-efficacy (sense of competence in condom negotiation, condom use, and assertive communication skills)</p> <p>4. Intentions (intentions to reduce risks and practice safer sex)</p>	<p><b>Session 2: HIV and AIDS, Other Sexually Transmitted Diseases (STDs), Human Anatomy, and Human Sexuality</b>  <u>Topics:</u> Rumors and truths about HIV and AIDS; human reproductive anatomy; human sexuality; STD transmission, testing, and treatment  <u>Activities:</u> Presentations and discussion; activities correspond to behavioral determinants 1, 2, and 4</p> <p><b>Session 3: How To Prevent HIV and Other Sexually Transmitted Diseases</b>  <u>Topics:</u> ABCs of HIV prevention, the truth about condoms, the male condom, the female condom  <u>Activities:</u> Presentations, discussion, demonstrations, and skill-building exercises on male and female condom use; activities correspond to behavioral determinants 1, 2, 3, and 4</p> <p><b>Session 4: Ways to Improve Communication With Our Partners</b>  <u>Topics:</u> Self-esteem and how it affects relationships, types of communication, assertive communication, condom negotiation  <u>Activities:</u> Presentations, discussion, role-playing on assertive communication and condom negotiation; activities correspond to behavioral determinants 1, 2, 3, and 4</p>	<p>skills, condom use skills, and condom negotiation skills</p> <ul style="list-style-type: none"> <li>• Risk-reduction behavioral intentions</li> </ul>	
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**Session 5: Relationship Violence, HIV Risk, and Safety Measures**

Topics: Conflict resolution in healthy relationships, sexual violence, intimate partner violence, impact of violence on families, safety measures and action planning

Activities: Presentations, discussion, and role-playing on assertive communication with partners and conflict resolution; activities correspond to behavioral determinants 1, 2, 3, and 4

**Session 6: Commencement and Welcome to a Brighter Future**

Topics: Session reviews, sharing what we have learned

Activities: Presentations, discussion, pledge of commitment to a healthier community, thank-you notes, and presentation of certificates; activities correspond to behavioral determinants 1, 2, 3, and 4



## CHAPTER 2

### PRE-IMPLEMENTATION INFORMATION AND ACTIVITIES

It takes time to adequately prepare for and successfully implement an evidence-based HIV prevention intervention. It also takes persistence and commitment to keep the program running successfully. Before implementing SEPA, know what pre-implementation activities need to take place.

Pre-implementation activities are planning and preparation actions that should occur before clients attend the first session of SEPA. It may take up to six months before agencies are ready to implement the intervention. The discussion that follows addresses agency capacity, staffing and budgeting, client recruitment and retention, and adaptation, and provides a suggested timeline for first-year planning, preparation, and implementation activities.

#### **Agency Capacity to Implement SEPA**

If you have received funding from the CDC or another source to implement SEPA, your funder believes you have the capacity to conduct the intervention. However, if you are reviewing SEPA materials to learn about the intervention and whether you want to pursue funding for implementation, you can assess your agency's capacity by referring to the table on the following pages. The criteria listed are examples of criteria used by funding agencies to assess applicants for funding.

Even if you have funding for SEPA, you can enhance your agency's success in serving clients by continuing to strengthen its capacity. You may want to discuss this table with your board of directors and with staff to identify ways to build an even better agency.



## Agency Capacity to Implement SEPA: Criteria to Assess Capacity, Evidence for Criteria, and Explanations

Criterion	Evidence	Explanation
Written mission statement	<ul style="list-style-type: none"> <li>Mission statement is visibly posted in agency</li> </ul>	<ul style="list-style-type: none"> <li>Mission statement references target population and the goals of programs and services</li> <li>Outcomes of SEPA are consistent with the agency's mission</li> </ul>
Written organization chart	<ul style="list-style-type: none"> <li>Organization chart is complete and up to date</li> </ul>	<ul style="list-style-type: none"> <li>Agency organization reflects clear lines of authority and responsibility</li> <li>Staffing is adequate for the number of services the agency provides and for monitoring and evaluation and quality assurance activities</li> </ul>
Actively engaged board of directors	<ul style="list-style-type: none"> <li>Minutes of board meetings</li> <li>By-laws and policies</li> </ul>	<ul style="list-style-type: none"> <li>Board members provide financial support to the agency</li> <li>Board members have skills or expertise in fundraising, behavioral and prevention science, research and evaluation, quality assurance, cultural competence, and the needs of target populations, including Latinas</li> <li>Board members express commitment to evidence-based practice</li> </ul>
Sound fiscal management	<ul style="list-style-type: none"> <li>Reports of financial statements audits</li> </ul>	<ul style="list-style-type: none"> <li>There are multiple and multi-year funding sources</li> <li>Financial management system allows agency to track staff time and costs for specific interventions and across multiple funding sources</li> </ul>
Staffing and leadership	<ul style="list-style-type: none"> <li>Records of staff turnover and new hires</li> <li>Minutes of board meetings</li> </ul>	<ul style="list-style-type: none"> <li>Senior staff articulate a consistent management philosophy and demonstrate cultural competence in hiring and programs</li> <li>On average, staff tenure exceeds three years</li> </ul>
History of providing services to target populations	<ul style="list-style-type: none"> <li>Process monitoring data</li> <li>Reports prepared for funders and board of directors</li> </ul>	<ul style="list-style-type: none"> <li>Reports indicate ability to recruit and retain clients who are members of identified target populations, including English-speaking Latinas</li> </ul>



Criterion	Evidence	Explanation
Track record of program monitoring and evaluation	<ul style="list-style-type: none"> <li>Monitoring and evaluation plans</li> <li>Confidential client-level reporting of data</li> <li>Monitoring and evaluation reports</li> </ul>	<ul style="list-style-type: none"> <li>Agency uses Specific, Measurable, Attainable, Realistic, and Time-based (SMART) objectives and/or program performance indicators for monitoring and evaluation</li> <li>Agency shares monitoring and evaluation reports with board of directors</li> <li>Agency implements changes based on monitoring and evaluation findings</li> </ul>
Track record of quality assurance activities	<ul style="list-style-type: none"> <li>Quality assurance plan</li> <li>Quality assurance reports</li> </ul>	<ul style="list-style-type: none"> <li>Agency shares quality assurance reports with board of directors</li> <li>Agency implements changes based on quality assurance findings</li> </ul>
Active client advisory committee	<ul style="list-style-type: none"> <li>Notes of client advisory committee meetings</li> </ul>	<ul style="list-style-type: none"> <li>There is a client advisory committee that helps staff understand risk-taking behaviors among target populations and contexts for those behaviors</li> <li>Committee helps staff identify recruitment methods and outreach locations for potential clients</li> <li>Committee reviews intervention protocols, especially concerning cultural competence</li> </ul>
Written intervention protocols	<ul style="list-style-type: none"> <li>Written protocols exist for behavior change interventions and public health strategies</li> </ul>	<ul style="list-style-type: none"> <li>Protocols demonstrate understanding of how behavior change theory and determinants of behavior change are incorporated into intervention activities; protocols identify core elements and required activities for behavior change interventions</li> </ul>



Criterion	Evidence	Explanation
Written agency-wide policies and procedures	<ul style="list-style-type: none"> <li>Written documents are current and copies are given to all staff</li> </ul>	<ul style="list-style-type: none"> <li>Policies and procedures are in place for human resource/personnel issues and such topics as client confidentiality, staff safety, and use of client incentives</li> </ul>
System for tracking referrals	<ul style="list-style-type: none"> <li>Written policies and procedures on making and tracking referrals exist, are shared with staff, and are reviewed on a regular basis</li> </ul>	<ul style="list-style-type: none"> <li>Client charts reflect staff understanding of how to conduct needs assessments and make appropriate referrals</li> <li>Process-monitoring data and written reports document how staff monitor referrals</li> </ul>
Ongoing staff training and development	<ul style="list-style-type: none"> <li>Staff training and development policies exist</li> <li>There are records of training and development activities that have taken place in the past 12 months</li> </ul>	<ul style="list-style-type: none"> <li>Agency takes advantage of training, capacity-building, and technical assistance opportunities, and policies support staff development</li> </ul>
Collaborations and partnerships with other organizations, including the state health department	<ul style="list-style-type: none"> <li>Notes from meetings</li> <li>Reports of activities</li> </ul>	<ul style="list-style-type: none"> <li>Collaborations and partnerships address the needs of target populations</li> <li>Collaborations and partnerships support the implementation of evidence-based interventions</li> <li>Working relationships with the health department address evidence-based practice, including funding opportunities, training, and capacity-building assistance</li> </ul>

## Stakeholder Involvement



Community-based organizations need active stakeholder involvement to enhance the success of their programs. In addition to clients, staff, and the agency's board of directors, other individuals and agencies have a stake in the success of SEPA. Examples of other stakeholders include agencies that serve the needs of Latinas, such as social service and health care providers; owners of local businesses; and community advocates. Stakeholders may support SEPA by:

- providing financial support to the agency
- referring at-risk Latinas to the intervention
- serving as a resource to which you can refer participants
- joining your community advisory board
- assisting with advertising or otherwise marketing the intervention
- donating refreshments and incentives to bolster client participation
- maximizing public support for the intervention

Always remember that clients of the interventions you deliver are your primary stakeholders. This means it is incumbent upon all staff to provide high-quality services and interventions and for agency leadership to support staff development and efforts to continually improve the organization's capacity to achieve success.

Important efforts to enhance the success of SEPA are monitoring and evaluation (M&E) and quality assurance. These activities are discussed in Chapter 4. Key stakeholders with an interest in these efforts and their results include the agency's board of directors and funders.



Community-based organizations that are funded by the CDC need to remember that their state health department (or other health department funded by the CDC) is a stakeholder. Share M&E findings with the health department and consider meeting with the department's community planning group for HIV prevention to discuss the intervention and such issues as client recruitment and retention.

## Implementation Summary

An Implementation Summary is a conceptual framework that visually depicts and summarizes how a behavior change intervention is to be implemented or put into practice. In other words, an Implementation Summary depicts in summary fashion the programmatic requirements necessary for implementation of an intervention.

An Implementation Summary relates the **inputs** (resources) that must be secured, developed, and put into use to carry out implementation activities. It also describes the **outputs** (programmatic deliverables or products) that result when implementation activities are conducted.

The Implementation Summary depicted below is a tool that can help with planning. This summary is a companion to the behavior change logic model. By reviewing these models, you will better understand how SEPA is designed to bring about behavior change in clients and what needs to be accomplished to operationalize the behavior change logic. The basic information in the Implementation Summary can be expanded to inform decisions about the intervention's budget, implementation timelines, quality assurance activities, and monitoring and evaluation.

One pre-implementation activity is to review the list of inputs in the Implementation Summary to check that all inputs have been included in your budget for SEPA and that they are in place before implementation begins.



## SEPA IMPLEMENTATION SUMMARY

<p style="text-align: center;"><b>INPUTS</b></p> <p><i>Inputs are the resources needed to operate a program and conduct intervention activities.</i></p>	<p style="text-align: center;"><b>ACTIVITIES</b></p> <p><i>Activities are the actions conducted to implement an intervention.</i></p>	<p style="text-align: center;"><b>OUTPUTS</b></p> <p><i>Outputs are the deliverables or products that result when activities are conducted. Outputs provide evidence of service delivery.</i></p>
<ul style="list-style-type: none"> <li>▪ Bilingual (Spanish and English) Latina with skills and experience in health education, risk reduction, and disease prevention to serve as SEPA facilitator</li> <li>▪ Heterosexually active Latinas between the ages of 18 and 44 at risk of HIV infection due to unprotected sex with male partners (eligible women)</li> <li>▪ Agency policies, plans, and procedures applicable to SEPA (e.g., policy on client confidentiality, policy on working with women who are victims of domestic violence, monitoring and evaluation and quality assurance guides)</li> <li>▪ SEPA Implementation Manual with Facilitators Guide, Participant Workbook, and client recruitment and retention plan</li> <li>▪ SEPA budget (see discussion of costs in</li> </ul>	<p style="text-align: center;"><b>Pre-Implementation/Preparation Activities</b></p> <ul style="list-style-type: none"> <li>▪ Hire (as needed) bilingual (Spanish and English) Latina with skills and experience in health education, risk reduction, and disease prevention to serve as Project SEPA facilitator</li> <li>▪ Arrange training on SEPA for facilitator</li> <li>▪ Determine schedule for group sessions and number of cycles per project year based on intervention budget</li> <li>▪ Write and implement client recruitment and retention plan</li> </ul> <p style="text-align: center;"><b>SEPA Intervention Activities</b></p> <ul style="list-style-type: none"> <li>▪ Conduct six session intervention with groups of Latinas ranging in size from eight to 12 participants according to SEPA Implementation Manual and Facilitators Guide</li> <li>▪ Discuss the impact of HIV and AIDS on the Latino community, human sexuality, male and female anatomy, HIV and STD transmission and prevention, and HIV testing</li> </ul>	<ul style="list-style-type: none"> <li>▪ Number of cycles of SEPA conducted during project year</li> <li>▪ Number of eligible women who attended at least one SEPA session during project year</li> <li>▪ Percent of eligible women who completed all six intervention sessions during project year</li> <li>▪ Percent of eligible women who completed at least half but not all sessions during project year</li> <li>▪ Percent of eligible women who completed less than half of the six sessions during project year</li> <li>▪ Percent of SEPA budget obligated by end of project year</li> </ul>



<p>Implementation Manual)</p> <ul style="list-style-type: none"> <li>▪ Equipment and supplies not included in intervention package:             <ul style="list-style-type: none"> <li>○ LCD player, laptop computer, and screen</li> <li>○ Anatomical figures for condom use demonstrations</li> <li>○ Male latex condoms</li> <li>○ Female condoms</li> <li>○ Magazines for creation of collage for “How Can You Tell if Someone Has HIV” activity</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Demonstrate and practice the use of male and female condoms</li> <li>▪ Identify and discuss characteristics of healthy heterosexual relationships</li> <li>▪ Practice assertive communication</li> <li>▪ Carry out condom negotiation role-playing exercises</li> <li>▪ Describe and discuss safety measures in the event of domestic violence</li> <li>▪ Discuss experiences with and outcomes of homework assignments</li> <li>▪ Write notes of gratitude to fellow participants and pledge commitment to community health</li> </ul>	
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## Staffing



To successfully conduct SEPA, an agency must have qualified staff. Although the facilitator has a crucial role in implementing the intervention, managerial, program, and support staff also play important roles. For example, skilled and culturally competent outreach staff are needed to describe SEPA to potential clients and recruit those who are eligible. Monitoring and evaluation (M&E) and quality assurance (QA) staff who understand the behavior change logic of the intervention and the importance of program fidelity are needed. These individuals should possess requisite skills and expertise in writing M&E and QA plans (discussed in Chapter 4) and such activities as data collection and management and program oversight. Prevention program management staff are critical to the success of SEPA because they are in positions to provide the resources, training, supervision, agency capacity development, and public support needed to deliver effective client services.

As required by core element 5, the facilitator must be female, must understand the language of clients, and must be an experienced professional in health education, disease prevention, and risk reduction. SEPA facilitators should be certified as HIV instructors or counselors and should have received training in domestic and sexual violence. All facilitators in agencies funded by the CDC must attend the official SEPA training sponsored by the CDC before the intervention can be implemented with clients.

A minimum of .20 FTE (full-time equivalent staff) is needed for the facilitator — in other words, at least 20 percent or one-fifth of a staff person's time should be devoted to delivering SEPA. This means that the facilitator would



spend about one complete eight-hour work day during a five-day work week on SEPA, and it assumes the facilitator will have staff support for client recruitment. With .20 FTE, we estimate that approximately 60 high-risk Latinas can complete SEPA each year after year 1 which requires time for pre-implementation activities. This estimate is based on the following assumptions:

- An average of eight women completes each cycle of SEPA (a cycle consists of the six sessions in the intervention).
- There is one session each week (6 weeks to complete a cycle) and no more than one week between cycles.
- Eight cycles are completed during each 12-month period after year 1.

For about 100 high-risk women to complete SEPA each year, 12 - 13 cycles should take place. This means that two cycles will need to run concurrently nine months of the year after year 1. Staffing at the .20 FTE level should be sufficient for serving 100 clients each year because the facilitator will have gained experience conducting the intervention; thus, less time for preparation will be needed after a few cycles have taken place.

Although we suggest that one facilitator conduct each of the six sessions in a cycle to establish rapport with clients, you may want to have two women trained as facilitators. With two trained facilitators, one can serve as a substitute if needed and cycles can run concurrently to serve more clients.

Below is a list of suggested staff positions.



## Suggested Minimum Staffing for SEPA<sup>6</sup>

STAFF POSITION	SUGGESTED NUMBER OF FTEs	COMMENTS
Facilitator	.20	Qualifications must match core element #5.
Prevention program manager	.10	This individual is responsible for supervising the facilitator and overall planning for the intervention.
Outreach/recruitment staff	.40	These staff are responsible for client recruitment and ensuring clients meet eligibility criteria.
Monitoring and evaluation staff; quality assurance staff	.20	Staff (including data-entry staff) are responsible for writing monitoring and evaluation and quality assurance plans. They are also responsible for collecting data for SMART process and outcome objectives and process evaluation and for writing monitoring and evaluation reports. Staff are also responsible for quality assurance activities and writing quality assurance reports.
Administrative and clerical support	.10	These staff assist with logistical arrangements and administrative tasks.
Childcare staff	If you decide to provide childcare during SEPA, you may want to use contractual support; also consider qualified volunteers	Check local policies, rules, and regulations before contracting with or hiring personnel to provide on-site care for babies and young children of participants.

<sup>6</sup> This budget reflects minimum staffing; if there are two facilitators, the FTE percentage for facilitator should be increased.

## Annual Budget



Obtaining and maintaining funding is typically the role of managerial staff. Funding can be obtained through donations, grant awards, cooperative agreements, and contracts.

- **Donations:** Monies are raised through fundraising efforts and assistance from the agency's board of directors.
- **Grants, contracts, and cooperative agreement awards:** The agency receives funding from such sources as the CDC and the state health department.

When applying for funding via a grant, contract, or cooperative agreement, budgets are written to estimate the amount of money needed to support the intervention. Budgets should be realistic and based on the agency's needs and resources. Consider the sample budget below. It contains the categories typically used by federal agencies. The dollar amounts do not suggest salary levels for your staff; they provide an example for writing a budget for SEPA. Following this sample budget is a budget worksheet to help you with calculating your estimated budget.



## Sample Annual Budget for SEPA<sup>7</sup>

### 1. Personnel

Intervention Facilitator	.20 FTE x \$40,000	\$ 8,000
Program Manager	.10 FTE x \$60,000	\$ 6,000
Outreach Workers/ Recruiters	.40 FTE x \$25,000	\$ 10,000
M&E and QA staff	.20 FTE x \$50,000	\$ 10,000
Clerical Support	.10 FTE x \$22,000	\$ 2,200
	Total FTEs: 1.0	
<b>Total Personnel</b>		<b>\$36,200</b>

### 2. Fringe Benefits (25.06 percent)

FICA		
	7.65% x \$36,200	\$ 2,769
State unemployment insurance		
	2.79% x \$36,200	\$ 1,010
Workers Compensation		
	.92% x \$36,200	\$ 333
Health insurance		
	8.70% x \$36,200	\$ 3,149
Retirement		
	5.00% x \$36,200	\$ 1,810
<b>Total Fringe Benefits</b>		<b>\$ 9,071</b>

### 3. Travel

4 day training:		
3 staff (2 facilitators, 1 program manager)		
	3 x \$1,500	\$ 4,500
A national HIV prevention conference		
2 staff (facilitator, program manager)		
for four days	2 x \$1,500	\$ 3,000
Local travel (55 cents/mi. x 400 mi.)		\$ 220
<b>Total Travel</b>		<b>\$ 7,720</b>

<sup>7</sup> Equipment costs will probably not be needed in subsequent annual budgets.



## 4. Equipment

TV (1 wide screen)	\$ 1,200
DVD player (1)	\$ 100
Lap top computer (1)	\$ 800
LCD projector (1)	\$ 700
Screen (1)	\$ 600
<hr/>	
<b>Total Equipment</b>	<b>\$3,400</b>

## 5. Supplies

Penis models @ \$10/model x 100 (To demonstrate how to use the female condom, use a glass bottle or jar)	\$ 1,000
Male and female condoms:	
Male condoms @ \$100/1,000 condoms pack	\$ 100
Female condoms @ \$50/18 condoms x 6	\$ 300
Office supplies (e.g., flip charts, name tags, pens, pencils)	\$ 1,000
Postage	\$ 500
<hr/>	
<b>Total Supplies</b>	<b>\$ 2,900</b>

## 6. Consultants

Registered Nurse for clinical supervision @ \$50/hr. x 20 hrs You may want a registered nurse to meet with facilitators on anatomy and STD issues	\$ 1,000
Child care provider @ \$20/hr. x 96 hrs.	\$ 1,920
<hr/>	
<b>Total Consultants</b>	<b>\$ 2,920</b>

## 7. Construction

Not Applicable

## 8. Other

Telephone/internet/fax	\$ 1,000
Printing (ads for recruitment, flyers, etc.)	\$ 3,000
Incentives	\$ 5,000
<hr/>	
<b>Total Other</b>	<b>\$ 9,000</b>

<b>Total Direct Charges</b> (sum of 1-8)	\$71,211
<b>Indirect Charge</b> 18% x \$71,211	\$12,818
<hr/>	

**TOTAL YEAR 1 SAMPLE BUDGET** **\$84,029**



## Budget Worksheet

### 1. Personnel

Intervention Facilitator	<input type="text"/>	FTE x \$	<input type="text"/>	\$
Program Manager	<input type="text"/>	FTE x \$	<input type="text"/>	\$
Outreach Workers/ Recruiters	<input type="text"/>	FTE x \$	<input type="text"/>	\$
M&E and QA staff	<input type="text"/>	FTE x \$	<input type="text"/>	\$
Clerical Support	<input type="text"/>	FTE x \$	<input type="text"/>	\$

Total FTEs:

---

**Total Personnel** \$

### 2. Fringe Benefits ( percent)

FICA	<input type="text"/>	% x \$	<input type="text"/>	\$
State unemployment insurance	<input type="text"/>	% x \$	<input type="text"/>	\$
Workers Compensation	<input type="text"/>	% x \$	<input type="text"/>	\$
Health insurance	<input type="text"/>	% x \$	<input type="text"/>	\$
Retirement	<input type="text"/>	% x \$	<input type="text"/>	\$

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**Total Fringe Benefits** \$



### 3. Travel

4 day training:		
3 staff (facilitators, program manager)	3 x \$ <input type="text"/>	\$
National HIV prevention Conference		
2 staff (facilitator, program manager)	2 x \$ <input type="text"/>	\$
for four days		
Local travel (cents/mi. x mi.)		\$
<b>Total Travel</b>		<b>\$</b>

### 4. Equipment

TV (1 wide screen)		\$
DVD player (1)		\$
Lap top computer (1)		\$
LCD projector (1)		\$
Screen (1)		\$
<b>Total Equipment</b>		<b>\$</b>

### 5. Supplies

Penis models		\$
Male and female condoms:		
Male condoms		\$
Female condoms		\$
Office supplies (e.g., flip charts, name tags, pens, pencils)		\$
Postage		\$
<b>Total Supplies</b>		<b>\$</b>



## 6. Consultants

Registered Nurse for clinical supervision

@ \$  /hr. x  hrs \$

[To calculate total hours:  hrs/week x  # of weeks]

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**Total Consultants** \$

## 7. Construction

Not Applicable

## 8. Other

Telephone/internet/fax \$

Printing (ads for recruitment, flyers, etc.) \$

Incentives \$

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**Total Other** \$

---

**Total Direct Charges** (sum of 1-8) \$

**Indirect Charge** \$

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**TOTAL YEAR 1 BUDGET** \$

## Location for Delivering SEPA



Community-based organizations may choose to conduct SEPA at their offices or at other facilities that are accessible to clients, such as healthcare clinics and other agencies or centers that serve the Latino community.

Select a room that will comfortably accommodate up to 14 individuals: 12 participants, the facilitator, and a volunteer assistant. To maintain privacy, use a room with a door that can be closed. Arrange comfortable chairs around a table positioned into a U-shape. The room should be large enough to include this U-shape table plus a table for the computer/LCD projector, a table in the back of the room for refreshments and handout materials, a screen, and an easel. The room should also be large enough for clients to rearrange their chairs to face a partner during practice exercises and role plays. Keep the room at a comfortable temperature.

## Client Recruitment and Retention

As discussed previously, the target population consists of Latinas between the ages of 18 and 44 who are at risk of acquiring HIV due to unprotected vaginal and anal intercourse. Participants should be able to understand and read English. When recruiting participants, make sure they meet at least one of the following criteria:

1. Within the six months prior to the start of the intervention, potential client has engaged in at least one episode of unprotected vaginal or anal intercourse with a male sex partner of unknown HIV serostatus, or with a male sex partner who is living with HIV.



2. Within the six months prior to the start of the intervention, potential client has received treatment for at least one sexually transmitted disease.

Client recruitment and retention pose great challenges to community-based organizations funded to deliver evidence-based HIV prevention programs. Recruitment usually includes identifying members of the target population who are at risk for either transmitting or acquiring HIV. SEPA is for women who are not infected with HIV and therefore are at risk for acquiring the virus; their risk stems from unprotected sex. If recruitment/outreach staff are responsible for screening clients for HIV risk according to the criteria discussed above, they must know and understand the reasoning behind the eligibility criteria and they must be trained to solicit information about sexual risk behaviors. It is also beneficial for outreach workers to know how social networking techniques can help with recruitment. For information on social networking for recruiting persons into HIV testing programs, see <http://www.cdc.gov/hiv/resources/guidelines/snt/index.htm>. Social networking strategies can be used to recruit clients for behavior change interventions.

Some community-based organizations have been successful using peer outreach workers for recruitment. CDC suggests that at least two persons conduct recruitment as a team and that there is one supervisor for every 10 outreach workers.

Because client recruitment and retention are essential activities, agencies funded to implement SEPA must prepare client recruitment and retention plan before the intervention is conducted with clients. The purpose of the plan

is to provide written information for recruitment staff, facilitators, and other agency staff so that SEPA sessions can average about 10 participants who meet the intervention's eligibility criteria. The ideal size for a group is 12 participants.

The recruitment and retention plan should be informed by substantive knowledge of how to reach the target population in person and by various types of media, as well as knowledge of how to engage clients in small group-level interventions. Members of the target population or a client advisory committee as well as former clients, intervention staff, and members of your board of directors can help with development of the plan. When creating your agency's recruitment and retention plan for SEPA, review the problem statement in SEPA's behavior change logic model and note the risk behaviors and risk factors.

## Client Recruitment



Methods for recruiting clients include posting flyers at recruitment venues, publishing ads in Latino newspapers and magazines, developing public service announcements for local Latino radio and TV stations, providing information on Web sites popular with Latinos, and writing memoranda of agreement with other agencies that serve Latinas so these agencies can make appropriate referrals to SEPA. See the sample marketing flyer included in this manual to create written information for other agencies.

Your plan's discussion about recruitment should cover:

- Procedures for referring agency clients to SEPA (you need to make sure all intervention staff and all staff who have contact with clients know about the intervention)



- Wording for written materials, such as brochures, flyers, and posters, to advertise the intervention
- Locations where written materials should be distributed
- Media that can be used to advertise the intervention, such as print media (Latino newspapers and magazines), radio, and television
- Direct mailings to members of the target population
- Web sites popular with Latinas where information about SEPA can be placed
- Strategies for approaching potential participants and language for describing SEPA
- Places and locations frequented by potential participants
- Agencies that provide services to the target population that can post materials and whose staff can refer clients to SEPA such as agencies that provide HIV counseling and testing, health care and STD clinics, and agencies that provide prevention programs for persons living with HIV. You may want to write memoranda of agreement with these agencies to facilitate referrals from them

Outreach workers should visit locations where the target population can be found to speak directly with them and to distribute promotional materials.

Examples of venues at which to launch recruitment efforts include:

- Low-income and working class Latino neighborhoods
- Community health clinics in Latino neighborhoods
- STD clinics in Latino neighborhoods
- Offices of doctors that serve the Latino community
- Service agencies that Latinas use, such as planned parenthood, GED programs, ESL programs, subsidized housing developments, and Head Start sites
- Bars, clubs, coffee shops, and restaurants frequented by Latinas
- Grocery stores, laundromats, beauty shops, community centers, and child care centers in the Latino community or specific areas of one or more Latino communities

- Street and/or park locations where Latinas congregate
- Churches attended by Latinos
- Shopping malls popular with Latinos
- Latino community meetings

To identify additional venues, consider conducting focus groups with potential clients or current and former clients. Current and past participants are natural recruiters because they are familiar with the agency and your programs and may have great ideas on how and where to recruit clients. Remember to ask women who completed SEPA to refer at least one friend.



## Client Retention

Discussion of client retention is the second part of your plan. The behavior change objectives of SEPA will never be met if participants are unwilling to stay past the first session and if they are not actively engaged in discussions and activities. Strategies to retain clients include:

- Providing incentives, such as gift cards, public transportation passes, toiletries and cosmetics, children's gifts, and discount coupons for restaurants
- Making reminder calls or sending reminder e-mails after each session
- Assisting with or providing transportation to and from sessions
- Providing refreshments or meals before or after sessions so participants can socialize
- Providing or paying for childcare



One way to maximize retention is to make sure SEPA is conducted at an accessible location and at convenient times for clients. Another suggestion is to ensure that SEPA is facilitated by competent staff who establish relationships of trust and caring with clients. Facilitators should understand the context for clients' HIV risk behaviors and how cultural and gender-specific values affect those behaviors. When facilitators know how to engage clients in discussion and how to motivate them to actively participate in activities, client retention problems will be reduced. Another suggestion is for facilitators to celebrate the accomplishments of clients who consistently do homework and actively participate in sessions with small gifts or notes of congratulations.

Throughout its six sessions, SEPA emphasizes the importance of sharing information on safer sex and healthy behaviors with friends, family, and members of the community. When facilitators communicate this message in a sincere way and with a sense of urgency, clients may be more inclined to attend all sessions of the intervention.

## **Community Advisory Board**

If you do not already have one, we suggest you establish a community advisory board or committee to provide guidance on pre-implementation activities. The committee serves as a liaison between the agency and clients and should be composed of approximately 10 members of the target population. These individuals can help with development of your client recruitment and retention plan and with the actual recruitment. They can also assist with the adaptation activities discussed below, provide advice to staff for improving implementation, and help ensure that participants' rights are protected.



## Program Review Panels

Before SEPA can be implemented with clients, each agency funded by the CDC must have all SEPA materials approved by its Program Review Panel. The role of the review panel is to ensure that materials are appropriate for the intended population, that they do not promote or encourage sexual activity and intravenous substance abuse, and that they are not obscene. You are responsible for providing proof of review and approval status of materials when requested by the CDC. Information on program review panels is available at <http://www.cdc.gov/od/pgo/forms/hiv.htm> and appears in Appendix 6.

## Agency Readiness



You are ready to implement SEPA with clients when the following actions have been accomplished:

- A facilitator has been identified or hired and trained
- Additional intervention staff have been identified or hired and trained
- All intervention staff have read the Implementation Manual
- All equipment, materials, and supplies have been secured; equipment is in good working order
- The location, dates, and times for conducting SEPA have been determined
- The following documents have been written and reviewed with staff:
  - Client recruitment and retention plan with screening criteria and discussion of use of client incentives
  - Monitoring and evaluation plan
  - Quality assurance plan
  - Agency policies on such topics as making and tracking client referrals and client confidentiality
- There are between 10 and 12 eligible clients who are enrolled for the first cycle of the intervention, and eligible clients have been identified for the second cycle

The checklist on the following page is a tool to help determine if you are ready to implement SEPA.



## Agency Readiness Checklist

<b>REQUIRED ACTION</b>	<b>YES</b> Ready to implement	<b>NO</b> Not ready to implement
Facilitator hired and trained		
All intervention staff in place		
All intervention staff have read Implementation Manual		
All equipment and supplies are in place		
Locations, dates, and times for implementation have been determined		
Recruitment and retention plan, M&E plan, and QA plan have been reviewed with staff		
Agency policies have been written and reviewed with staff		
There are between 10 and 12 eligible clients enrolled for the first cycle and eligible clients have been identified for the second cycle		



## Pre-Implementation Timeline

As we have emphasized, it requires preparation time to be ready to serve clients. The following are some of the activities that must take place during your first year of funding before the first session of SEPA is conducted: hiring staff; training facilitators; and writing client recruitment and retention, monitoring and evaluation, and quality assurance plans. A suggested timeline to help agencies with planning and implementation is included below.

### Suggested Pre-Implementation Timeline for SEPA\*

Task	Staff Assigned	Timeline
Inform agency staff about SEPA	Project manager/ supervisor	Within first month of the program year
Inform community or client advisory board about SEPA	Project manager/ supervisor	Within first month of the program year
Inform agency board of directors about SEPA	Project manager/ supervisor or executive director	Within first month of the program year
Agencies directly funded by CDC: Inform health department and community planning group about SEPA	Project manager/ supervisor or executive director	Within first month of the program year
Identify/hire SEPA facilitator	Project manager/ supervisor	Within first two months of the program year
Secure CDC SEPA training for facilitator	Project manager/ supervisor	Within first three months of the program year
Identify/hire other staff for SEPA as needed, such as recruiters, monitoring and evaluation and quality assurance personnel, and administrative support	Project manager/ supervisor	Within first two months of the program year

\* According to this timeline, SEPA will start by the seventh month of the first program year. While recognizing that various factors affect the start date, the project should begin no later than the eighth month of the first program year.

# SEPA Implementation Manual



Task	Staff Assigned	Timeline
Based on budget, determine how many cycles of SEPA to conduct during the program year; determine dates and times for the cycles	Project manager/ supervisor	Within first two months of the program year
Develop client screening criteria and write client recruitment and retention plan (see discussion in this manual)	Project manager/ supervisor and/or SEPA facilitator	Within first three months of the program year
Obtain Program Review Panel approval for SEPA materials	Project manager/ supervisor and/or SEPA facilitator	Within first three months of the program year
Meet with and provide written information on Project SEPA to agencies to which clients may be referred, and write memoranda of understanding with these agencies	Project manager/ supervisor and/or SEPA facilitator	Within first three months of the program year
Meet with and provide written information on SEPA to agencies that serve members of the target population and that may assist with client recruitment	Project manager/ supervisor and/or SEPA facilitator	Within first three months of the program year
Write monitoring and evaluation (M&E) and quality assurance (QA) plans	Project manager/ supervisor and/or SEPA facilitator and/or program evaluator/quality assurance staff	Within first four months of the program year
Write needed agency policies and procedures, such as procedure for making and tracking referrals and policy on client confidentiality	Project manager/ supervisor or executive director	Within first four months of the program year
Secure needed materials, equipment, and supplies (see list in this Implementation Manual)	Project manager/ supervisor and/or SEPA facilitator	Within first four months of the program year



Task	Staff Assigned	Timeline
Identify and/or secure venue/location for SEPA sessions (see discussion of location in this Implementation Manual)	Project manager/ supervisor and/or SEPA facilitator	Within first four months of the program year
Begin recruitment of clients	Outreach or other assigned staff	Begin during month four and continue through the end of the first year and in accordance with client recruitment and retention plan
Implement SEPA	SEPA facilitator	Begin by month seven and continue through the end of the program year
Collect data in accordance with monitoring and evaluation plan	SEPA facilitator and/or program evaluator	From beginning to end of program year
Carry out quality assurance processes in accordance with quality assurance plan	Project manager/ supervisor, SEPA facilitator, and quality assurance staff	From beginning to end of program year
Prepare monitoring and evaluation and quality assurance reports in accordance with M&E and QA plans	Program evaluator/quality assurance staff	In accordance with M&E and QA plans

Agencies may frame first-year planning and preparation activities as SMART objectives — objectives that are specific, measurable, appropriate, realistic, and time-based. For example, using the first task in the suggested timeline, a SMART objective could read, “No later than the end of the first month of the first program year, the prevention project manager will meet with all prevention program staff, including administrative personnel, to discuss SEPA, noting the target population, session topics, and key intervention activities. The prevention program manager also will distribute copies of the SEPA fact sheet and behavior change logic model to all staff.”

## Adaptation



Adaptation is the process of modifying an evidence-based intervention while maintaining fidelity to the intervention’s core elements. There are two main reasons for an agency to adapt an evidence-based intervention: (1) to meet the prevention needs of a specific population for whom evidence-based interventions are lacking, and (2) to address agency infrastructure and resource constraints. The intervention’s key characteristics, not the intervention’s core elements, can be modified to meet target population and agency needs. Core elements must be maintained because they contribute to the intervention’s success in achieving outcome objectives, including the safer sex behavior changes you want clients to achieve.

Decisions about adaptation and actual adaptation activities, such as making revisions to the intervention’s curriculum, should include agency staff and a community advisory board composed of members of the specific population you want to reach. The reasons for adaptation and all processes used to modify the original evidence-based intervention should be put into writing. If your agency is funded by the CDC’s Division of HIV/AIDS Prevention, you must include your project officer in discussions about adaptation and share written materials with that individual. Your project officer can discuss capacity-building assistance available from the CDC at <http://www.cdc.gov/hiv/cba>. If you are “indirectly” funded by CDC through your health department, check with health department staff to request assistance on adaptation.

Recognize that attitudes about sexual behavior and male and female relationships are influenced by cultural values. Know the culture of the clients you want to serve and use this knowledge if you decide to adapt SEPA for a new population.



To determine whether SEPA can be adapted to meet the needs of a different population and/or to meet agency needs, the agency and members of the community advisory board should review SEPA's behavior change logic model, its core elements, and its key characteristics. The discussion that follows explains how these materials can be used to inform adaptation decisions.

## **Serve a Different Population**

Although SEPA was designed to meet the HIV-prevention needs of Hispanic/Latina women with a specific risk profile, its core elements can be maintained if the target population includes women who are not Hispanic or Latina. This means that SEPA can be adapted for African American, American Indian, Alaska Native, Asian, Black, Native Hawaiian, other Pacific Islander, or White women **if** their prevention needs and determinants of behavior change are congruent with SEPA's behavior change logic model.

The logic model's problem statement reads:

“Hispanic women/Latinas between the ages of 18 and 44 are at risk for HIV and STD infection when they have unprotected sex with male partners. Explanations for unprotected sex include lack of knowledge about sexually transmitted diseases, including HIV; negative attitudes toward condoms; a shortage of effective communication skills; reluctance to discuss condoms due to fear of violence from male partners; the absence of skills to negotiate condom use and to use male and female condoms correctly; and low risk-reduction behavioral intentions. Research suggests that social and cultural factors, such as gender inequality and gender role socialization, including Machismo and Marianismo, are associated with insufficient knowledge about HIV and STD transmission and prevention and inadequate ability to communicate effectively with male partners. These factors are likely sources of disempowerment that contribute to HIV risk among Hispanic women/Latinas.”

If the population in need of HIV prevention consists of women whose primary risk behavior is unprotected vaginal or anal sex with males, and explanations for this behavior include insufficient knowledge about HIV and STDs, negative attitudes toward condom use, inadequate communication skills, fear of violence from male partners, lack of condom use and condom-negotiation skills, and low risk-reduction behavioral intentions, then SEPA may be an appropriate intervention to consider adapting for your target population.



The logic model's determinants of behavior change must apply to your population's HIV prevention needs. If the problem statement fits the population (excluding references to Latino culture), then it is likely that the determinants also will be a good fit. For SEPA clients, the determinants of behavior change are knowledge, attitudes, self-efficacy, and intentions, and the intervention's activities are designed to address these determinants so that the immediate and intermediate outcomes identified in the logic model can be achieved.

SEPA's activities include presentations, discussions, and skill-building activities to increase knowledge of HIV and STDs; to enhance self-efficacy for condom use, condom negotiation, and effective communication; to foster favorable attitudes toward condoms; and to increase intentions for safer sex behaviors. Session content covers HIV and STD transmission and prevention, male and female reproductive anatomy, human sexuality, interpersonal communications, and domestic and intimate partner violence. Skill-building and practice exercises focus on male and female condom use, condom negotiation, and assertive communication.



These activities are designed to affect the determinants of behavior change identified in the logic model and they promote the intervention's expected outcomes. Immediate outcomes are increases in HIV knowledge, favorable attitudes toward condom use; self-efficacy for partner communication skills, condom use skills, and condom-negotiation skills; and increases in risk-reduction behavioral intentions. The intermediate outcome is an increase in correct and consistent condom use with sex partners.

If you believe that SEPA's activities are the activities needed to reduce HIV risk behavior among members of the population you want to serve, and if the outcomes listed in SEPA's behavior change logic model are the outcomes you want the population to achieve, then SEPA is an appropriate intervention to consider for adaptation. It's a good idea to develop a new behavior change logic model to make sure the relationships among determinants, activities, and outcomes are appropriate for the target population. If SEPA does not meet the prevention needs of the "new" target population, you should select another intervention more suitable for the population

## **Modify the Curriculum to Make it Appropriate for the Target Population**

If you have decided that SEPA is appropriate for a population of women who are not Hispanic or Latina, the next step is to review the curriculum found in the Facilitators Guide. It is important to review the curriculum and written materials given to participants for cultural and linguistic compatibility with the target population. The curriculum indicates how presentations, discussions, and skill-building activities are communicated to participants. The curriculum contains the content for information and discussion topics and instructions for activities. You and your client advisory committee should carefully review the language used to convey information and instructions and to prompt discussion, as well as the graphics and images on materials distributed to participants, with an eye toward modifications needed to provide an appropriate and relevant cultural context.



Modifications to the SEPA curriculum cannot change the core elements of the intervention. The following core elements apply to the curriculum or the content of the intervention.

- Provide culturally and linguistically appropriate information to sexually active women at risk of acquiring HIV from unprotected sex with male partners in interactive, small-group sessions that focus on:
  - a. HIV and STD transmission and prevention
  - b. Human sexuality and male and female anatomy
  - c. Interpersonal communications
  - d. Relationship violence
- Incorporate skill-building activities into sessions to enhance women's self-efficacy for safer sex behaviors, including demonstrations and practice exercises on male and female condom use and role-plays on assertive communication with sex partners, such as condom negotiation.
- Build self-efficacy and knowledge for safer sex behaviors, improved communication with partners, and violence management through homework exercises and the sharing of personal experiences.
- Show a culturally appropriate video during the first session that portrays the effects of HIV and AIDS on members of the target population, and discuss what is communicated about the impact of HIV and AIDS on the community, including impacts on families and women.
- Ask participants to write thank-you notes to fellow participants and pledge their commitment to community health during the final session. Present a certificate to each participant who attends at least half of the sessions.

Review of these core elements reveals that changes may not be made to the content contained in the six sessions of the intervention. None of the content can be eliminated. The wording used to communicate the content can be modified for cultural congruence, but the content itself — including discussion topics, skill-building activities, homework assignments, and activities during Session 6 — should not be changed.

There is flexibility in the choice of a video to show during Session 1. The video for Hispanic/Latina women is “Mi Hermano.” You will need to use a different video for a different target population and you will need to revise the discussion questions and references to the Latino community in the current curriculum.

Other changes that need to be made to accommodate a different population for SEPA are as follows:



- Change the name of the intervention.
- Change the HIV and AIDS surveillance data presented in Session 1.
- Modify the list of celebrities for the collage on persons infected with HIV used in Session 1.
- Change the names in “The Story of Juanita” in Session 2.

The Participant Workbook should also be reviewed for needed changes.

## **Serve Older Latinas**

The target ages of 18 through 44 were selected because this was the age group of the women who participated in the original research on the intervention. However, the information provided by SEPA is relevant to women older than 44 who are at risk for HIV infection due to unprotected sex. If you decide to target an older group of Latinas with the HIV-prevention needs identified in SEPA’s behavior change logic model, follow the process described above on adapting SEPA for a different target population. This



means you need to work with a community advisory board composed of Latinas older than 44, and all materials should be reviewed to make sure they are appropriate for older women. Changes to materials must preserve all core elements of the intervention.

If you want SEPA groups to consist of a mix of ages, such as 25 to 55, it is best to conduct a pilot test of the six sessions to assess group participation and interaction before you continue with subsequent groups. As noted, SEPA calls for active client engagement in discussions and activities. If younger and older women are reluctant to share experiences and fully engage in discussions and activities, then additional groups of mixed ages should not be scheduled.

## **Adaptation for Agency Needs**

At times, agencies want to adapt an evidence-based intervention because their infrastructure and resources may not be adequate to support the intervention. For example, an agency may not have the physical space needed to conduct the intervention, or staff with required experience and training may not be available. There is a core element of SEPA that addresses qualifications of the person who conducts the intervention, known as the facilitator. This core element reads:

Use a female facilitator who speaks and understands the language of participants. The facilitator is not a peer of participants but someone who is an experienced professional in health education, disease prevention, and risk reduction.

This means that the facilitator must be a woman who is linguistically competent to conduct the intervention with the specific target population. For example, if an agency in Los Angeles wants to adapt SEPA for Filipino women/Filipinas, the facilitator should be conversant in Tagalog. In addition, she must be an experienced professional in a health-related field.

There are two key characteristics that relate to staffing:



1. Employ facilitators who are certified by the American Red Cross as HIV instructors or who have attended HIV-prevention training sponsored by a health department or prevention training center. Employ facilitators who have received training in domestic violence and sexual violence.
2. Invite a former SEPA participant who completed all sessions to assist with such activities as room setup and the distribution of handout materials.

The first key characteristic conveys what training is desirable for SEPA facilitators in addition to the basic training on the intervention. Although HIV prevention, domestic violence, and sexual violence training are desired, there is no requirement for facilitators to receive this training. Likewise, there is no requirement for former participants to assist current facilitators with logistical tasks.

Although there is no core element that addresses the location or physical space where SEPA should take place, sessions should be held where women can speak confidentially and feel safe.

There is a core element that notes how often SEPA sessions should be held. No more than two sessions are to take place each week because participants need time to complete homework assignments, which entail practicing skills and sharing information learned during the intervention. This means that SEPA cannot take place during a weekend retreat or over consecutive days.

The final key characteristic that relates to agency resources reads: "Provide transportation assistance and childcare services to participants. Provide light refreshments at each session." Some agencies may not have the financial resources to provide assistance with transportation and childcare; some may not be able to afford refreshments for participants.



## **Modify Recruitment Strategies**

Although there is no core element or key characteristic that directly addresses recruitment, information regarding recruitment and retention discussed earlier in this manual should be reviewed and modified so that recruitment strategies are appropriate for the new target population. Your recruitment and retention plan will need to be revised to reflect changes in recruitment venues, messages, and approaches.

## **What Should Be Done After Needed Modifications Are Identified?**

After agency staff and members of the community advisory board (composed of women from the new target population) determine needed modifications to the curriculum/Facilitators Guide and the Participant Workbook, and after selecting a new video, revised documents need to be prepared. In addition to the Facilitators Guide and Participant Workbook, revisions may need to be made to sections of the Implementation Manual.

After all revisions have been made to accommodate a new population, the intervention should be pilot tested in its entirety with eight to 10 members of the target population.<sup>8</sup> Use the evaluation worksheets in the Participant Workbook during the pilot to assess the intervention's acceptability, relevance, and usefulness. Staff and a few members of the advisory board should observe all six sessions and discuss their recommendations to improve cultural and linguistic competence and overall acceptability by the target population.

After review by your CDC project officer, or another funder, final revisions can be made to intervention materials to complete the adaptation process. If a facilitator needs to be hired, she must become thoroughly familiar with all intervention materials before the first session takes place with the new population.

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<sup>8</sup> If an appropriate facilitator has not been hired to conduct the pilot, a female staff member with group facilitation skills should serve as facilitator.

A summary of the key steps in adaptation for a “new” target population appears below.

## Summary of Key Adaptation Steps

Work with a community advisory board composed of members of the “new” population to:

1. Review SEPA’s behavior change logic model and its core elements and key characteristics.
2. Determine whether the problem statement and the logic model’s determinants of behavior change apply to the “new” population’s HIV prevention needs.
3. Determine whether the outcomes identified in the behavior change logic model are the outcomes you want the “new” population to achieve.

*If you answer yes to steps 2 and 3, then the intervention fits your target population; continue to step 4*

4. Review the curriculum found in the Facilitators Guide, as well as written materials given to participants, for cultural and linguistic compatibility with the “new” target population.

*Modifications to the SEPA curriculum cannot change the core elements of the intervention.*

5. Determine needed modifications to the curriculum/Facilitators Guide, the Participant Workbook, and the Implementation Manual.
6. Revise materials as needed.



7. Pilot test the intervention, using the revised materials, with eight to 10 members of the “new” target population. Use client feedback forms to assess acceptability by the “new” population.
8. Revise materials as needed.
9. Submit revised materials and summaries of client and staff feedback to your CDC or other project officer for review.
10. Incorporate the project officer’s comments into materials to complete the adaptation process.

Refer to the technical assistance guide for questions and answers about adaptation.



## Ongoing Implementation Activities

Thorough discussion of implementation is found in the Facilitators Guide which provides a scripted curriculum for each of SEPA’s six sessions. This timeline provides an overview of major implementation activities that should take place over the entire project period. Activities involve the facilitator and other staff such as your prevention supervisor, recruitment staff, and monitoring and evaluation and quality assurance staff.

ACTIVITY	WHEN ACTIVITY SHOULD TAKE PLACE
Telephone and/or email participants to remind them of the session	Before each session of the intervention
Check that all materials, equipment, and supplies are available and in good working order	Before each session of the intervention
Make sure refreshments are available if you supply them to participants	Before each session of the intervention
If on-site child care services are made available for participants, remind providers of the location and times for each session	Before each cycle of the intervention
Meet with supervisor to discuss issues, concerns, successes, and implementation with fidelity to core elements	At least once a month
Check that there are at least 12 eligible women for the upcoming cycle	Before each scheduled cycle of SEPA
Review handout materials to see if updated materials are available	At least twice a year
Meet with program monitoring and evaluation staff and quality assurance staff to review data collection tools and checklists used to monitor fidelity to core elements	At least twice a year
Meet with supervisor and monitoring and evaluation and quality assurance staff to review reports and discuss ways to improve implementation	At least twice a year



## CHAPTER 3 IMPLEMENTING SEPA

Two documents are needed for implementing SEPA with clients: the Facilitators Guide and the Participant Workbook.

The Facilitators Guide is a scripted curriculum for SEPA facilitators. It contains all of the information facilitators need to conduct the intervention.

The Participant Workbook contains worksheets for clients on homework assignments and group activities, as well as evaluation forms. Each client should receive her own copy of the workbook.

The Facilitators Guide appears as a separate document, and the Participant Workbook is included with the guide.



## CHAPTER 4 MAINTAINING SEPA

Three critical activities must take place to maintain — or sustain and enhance — SEPA. The first activity is to secure ongoing funding for the intervention, and we begin by providing information on funding sources for HIV/AIDS programs. The two remaining critical activities are (1) monitoring and evaluation and (2) quality assurance.

Monitoring and evaluation are essential for maintaining SEPA. Findings from monitoring and evaluation can highlight intervention successes, identify challenges, and lead to improvements that further enhance the intervention. Monitoring and evaluation findings can be used to support proposals for funding, which can help to sustain SEPA. An in-depth discussion of monitoring and evaluation is found in the Monitoring and Evaluation Guide for SEPA within Chapter 4.

In addition to monitoring and evaluation, quality assurance is an essential activity for maintaining SEPA. Discussion of quality assurance, including ways to monitor fidelity to core elements, is found in the quality assurance section within Chapter 4.

In addition, chapter 4 contains a technical assistance guide to help answer questions facilitators and managers may have about planning for and implementing SEPA.

## Funding Sources



### Web Sites with Information on Funding for HIV/AIDS Programs

#### U.S. Federal Government

<http://grants.gov/>

<http://aids.gov/funding/index.html>

#### Centers for Disease Control and Prevention

<http://www.cdc.gov/hiv/topics/funding/>

<http://www.cdcpin.org/scripts/search/fundSearch.aspx>

#### Health Resources and Services Administration

<http://www.hrsa.gov/grants/>

#### Substance Abuse and Mental Health Services Administration

<http://www.samhsa.gov/Grants/apply.aspx>

#### U.S. National Library of Medicine

[http://sis.nlm.nih.gov/outreach/aids\\_cio\\_projects.html](http://sis.nlm.nih.gov/outreach/aids_cio_projects.html)

#### U.S. Office of Minority Health

<http://www.omhrc.gov/>

#### Cable Positive

<http://www.cablepositive.org/>

#### The Elton John AIDS Foundation

<http://www.ejaf.org/pages/grants/index.html>

#### Foundation Center

<http://foundationcenter.org/>

#### U.S. Conference of Mayors

<http://www.usmayors.org/hivprevention/>



# **MONITORING AND EVALUATION GUIDE FOR SEPA**

*A STEP-BY-STEP APPROACH FOR IMPLEMENTING AGENCIES*



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## I. Introduction

This document provides community-based organizations that are implementing SEPA with information on program monitoring and evaluation (M&E) activities to enhance the success of your work. Since we assume that you have already selected the appropriate intervention for your at-risk target population, we do not cover formative evaluation for intervention selection (adoption) or adaptation. What we do cover are fundamental M&E activities for accountability and intervention enhancement with a focus on process and outcome monitoring and process evaluation.

**When you conduct program monitoring and evaluation and use the results to strengthen interventions for enhanced client outcomes, you are doing your best to advance HIV prevention.**



### **Intended Audience**

This guide was written for use by agencies that implement SEPA. Specific users include:

- Intervention facilitators
- Program managers and administrators
- Evaluators
- Quality assurance staff
- Data entry and data management staff

While this guide is not intended for use by community stakeholders, the results of program monitoring and evaluation can be shared with the many stakeholders who are invested in the success of your work.

## Definitions of Terms

Definitions for the three major M&E activities we discuss – process monitoring, process evaluation, and outcome monitoring – are found in Appendix A.

## Requirements

Some activities, such as process monitoring, are required if your agency receives funding directly from the CDC for HIV prevention, or if you receive CDC funding “indirectly” from your health department. An overview of these requirements is provided below.

Although some of the M&E activities discussed here may not be required by CDC or other funding sources, *it is sound management to assess how well your interventions are working with clients and to use the findings to make them even better.*

**So that you know where to begin, information is organized into steps that show how basic M&E activities progress for process and outcome monitoring and process evaluation. These sequential steps range from deciding what you want to know to analyzing and interpreting data.**

## II. How Monitoring and Evaluation Can Help You Answer Important Questions about SEPA

**The most important thing is not to stop questioning**

Albert Einstein

***Monitoring and evaluation are information gathering and analysis activities that provide answers to important questions about HIV prevention program implementation and outcomes.*** For example, M&E can tell you if enrolled clients belong to the target population you want to reach and to what extent clients enhanced their skills for safer sex behaviors.

***M&E start with the identification of questions and variables.*** Identifying questions and the data needed to answer them is the beginning of monitoring and evaluation. Variables are what we want to measure to answer questions about the intervention, and they assume different numerical values or other types of value. You can think of variables as characteristics that can differ – or vary -- from individual to individual and agency to agency. Variables are measured through data collection with various tools or instruments, such as surveys and questionnaires.

Data are measurements of variables, and a data set is a structured collection of data, with values for each variable, that is stored in a computer where a query language can arrange the data to answer questions. The computer program used to manage and query a database is a database management system. Statistics, a branch of applied mathematics concerned with the interpretation of quantitative data, are used to describe data and present them as useful information.



## **What Questions do you Want to Ask?**

There are many stakeholders interested in SEPA who likely have questions about it. These stakeholders include agency staff, the Board of Directors, funders, legislators, clients, and the research and academic communities that design and evaluate HIV prevention interventions.

By providing answers to essential questions, the results of M&E can be used for accountability to stakeholders, particularly funding agencies. *M&E findings are especially important for you to analyze and use to improve the*



*implementation of the intervention and to inform planning for other interventions and programs.*

*To start M&E, identify questions relevant to stakeholders.* At a minimum, you need to identify questions about SEPA that are important to your agency.

Essential questions concern:

- resources expended for the intervention (i.e., annual budget with number of full-time equivalent staff – FTEs)
- client recruitment
- characteristics of clients who participated in the intervention
- the extent of client participation
- how the intervention was delivered
- outcomes clients experienced

For each of these areas, you may want to know what actually happened compared to what you planned. Process evaluation is the activity for this determination. For example, by comparing resources expended to resources budgeted, you will have data for subsequent budget preparation and for current fiscal management.

The following table shows how process monitoring, process evaluation, and outcome monitoring can be used to answer fundamental questions about client recruitment, the target population, client retention, implementation, and client outcomes.

**TABLE 1: M&E ACTIVITIES TO ANSWER FUNDAMENTAL QUESTIONS ABOUT SEPA**

<b>QUESTIONS</b> 	<b>M&amp;E ACTIVITIES</b>	<b>DATA/DOCUMENTS THAT CAN ANSWER QUESTIONS<sup>9</sup></b>	<b>HOW ANSWERS CAN BE USED TO IMPROVE THE INTERVENTION</b>
<b>Recruitment</b>			
How many clients did we plan to recruit? <sup>10</sup>		Budget and staff allocation plan for SEPA  Recruitment plan  SMART process objectives	Data can be used to strengthen recruitment efforts and inform more accurate planning.
How many clients did we actually recruit? <sup>11</sup>	Process monitoring	Number of clients recruited documented by session sign-in sheets to measure SMART process objectives	Data can be used to strengthen recruitment efforts and inform more accurate planning.
Was there a difference?	Process evaluation	Comparison between planned and actual numbers of clients recruited	Data can be used to strengthen recruitment efforts and inform more accurate planning.

<sup>9</sup> Your monitoring and evaluation plan is the core document that addresses M&E activities for Project SEPA and it contains the SMART objectives that provide the data to answer questions.

<sup>10</sup> You need to use a consistent time frame such as project year or six months of project year.

<sup>11</sup> You need to define “recruit;” for example, an individual can be considered recruited if she agrees to participate in the intervention either verbally or in writing.



<b>QUESTIONS</b> 	<b>M&amp;E ACTIVITIES</b>	<b>DATA/DOCUMENTS THAT CAN ANSWER QUESTIONS</b>	<b>HOW ANSWERS CAN BE USED TO IMPROVE THE INTERVENTION</b>
<b>Target Population</b>			
What are the characteristics (e.g., race, ethnicity, age, risk behaviors, and risk factors) of our target population?		Behavior change logic model's problem statement	Data can be used to target recruitment activities and provide evidence of prevention needs for additional at-risk populations.
What were the characteristics of the persons who participated in the intervention?	Process monitoring	Client demographics and risk factors collected with a client intake form	Data can be used to target recruitment activities and provide evidence of prevention needs for additional at-risk populations.
Was there a difference?	Process evaluation	Comparison between the characteristics of clients you planned to recruit and actual characteristics of clients who participated	Data can be used to target recruitment activities and provide evidence of prevention needs for additional at-risk populations.



<b>QUESTIONS</b> 	<b>M&amp;E ACTIVITIES</b>	<b>DATA/DOCUMENTS THAT CAN ANSWER QUESTIONS</b>	<b>HOW ANSWERS CAN BE USED TO IMPROVE THE INTERVENTION</b>
<b>Client Retention</b>			
How many clients did we think would complete all sessions? Less than half of the sessions? Between half but less than all sessions?		SMART process objectives	Data can be used to strengthen recruitment efforts, inform agency policies on use of client incentives, and foster discussion of strategies for client engagement.
What actually happened regarding client participation?	Process monitoring	Sign-in/attendance sheets from each session	
Was there a difference?	Process evaluation	Attendance data from each session to measure SMART process objectives  Comparison between planned and actual client participation	



<b>QUESTIONS</b> 	<b>M&amp;E ACTIVITIES</b>	<b>DATA/DOCUMENTS THAT CAN ANSWER QUESTIONS</b>	<b>HOW ANSWERS CAN BE USED TO IMPROVE THE INTERVENTION</b>
<b>Fidelity of Implementation</b>			
Was SEPA carried out in accordance with the Implementation Manual and with fidelity to core elements?	Process monitoring and process evaluation (can also be considered quality assurance)	Fidelity checklist on required activities and core elements  Quality assurance plan  Notes from facilitators  Notes from persons who observed the intervention	Completed fidelity checklist and other sources of information will indicate whether the evidence-based intervention was implemented properly and can be used to understand subsequent outcome monitoring data.
<b>Outcomes</b>			
What outcomes did we expect clients to achieve?		Behavior change logic model's immediate and intermediate outcomes  SMART outcome objectives	Positive outcomes can be used to demonstrate intervention success. Post test data that reveal unwanted outcomes indicate that changes are needed in either intervention design or intervention delivery or both design and delivery.

<b>QUESTIONS</b> 	<b>M&amp;E ACTIVITIES</b>	<b>DATA/DOCUMENTS THAT CAN ANSWER QUESTIONS</b>	<b>HOW ANSWERS CAN BE USED TO IMPROVE THE INTERVENTION</b>
<b>Outcomes</b>			
What outcomes did clients actually experience?	Outcome monitoring	Data that measure SMART outcome objectives: mediating variables and variables for behavior change collected with a pre- and post-test instrument	Positive outcomes can be used to demonstrate intervention success. Post test data that reveal unwanted outcomes indicate that changes are needed in either intervention design or intervention delivery or both design and delivery.
Was there a difference?	Analysis of pre- and post-test data	Comparison between planned and actual client outcomes	Positive outcomes can be used to demonstrate intervention success. Post test data that reveal unwanted outcomes indicate that changes are needed in either intervention design or intervention delivery or both design and delivery.

### III. Monitoring and Evaluation Plan

By writing a monitoring and evaluation plan, you will have a document to help you manage all of the M&E activities discussed in this guide.

Your M&E plan should contain a description of SEPA, and it should identify:

- M&E questions
- variables you need to measure to provide answers to your identified questions
- SMART process and outcome objectives

- data collection tools for measuring variables
- processes for data collection and data management
- how resulting data and information will be used



A monitoring and evaluation plan is similar in nature to a quality assurance plan. Whereas a quality assurance plan spells out how quality assurance activities should be conducted, your M&E plan outlines how monitoring and evaluation activities are to take place. There can be one monitoring and evaluation plan for the agency that covers each of the interventions or public health strategies you are funded to deliver, or there can be individual M&E plans for each intervention and public health strategy.

The following outline provides topics for your monitoring and evaluation plan. Try to incorporate the 16 steps discussed below.

- I. Introduction
  - Brief overview of intervention
  - Behavior change logic model that identifies specific target population and variables for process and outcome objectives
  - Intervention staffing, including monitoring and evaluation staff (e.g., evaluator, data entry staff)
  - Annual intervention budget, including monitoring and evaluation annual budget
- II. M&E Questions
- III. Variables for Data Collection
- IV. SMART Objectives
- V. Process Monitoring
- VI. Process Evaluation
- VII. Outcome Monitoring
- VIII. Data Collection and Management
- IX. Reports and Use of Data



## IV. Overview of CDC Requirements and the National HIV Prevention Program Monitoring and Evaluation Data Set

CDC's national HIV prevention program monitoring and evaluation strategy has two components: PEMS -- the Program Monitoring and Evaluation System -- and the National HIV Prevention Program Monitoring and Evaluation Data Set (NHM&E DS). PEMS is secure web-based software available to CDC grantees for data entry and management. NHM&E DS consists of standardized variables on agencies, interventions, and clients.

For information on NHM&E DS, contact the CDC PEMS staff at <http://team.cdc.gov>, your CDC project officer, or refer to the document "National HIV Prevention Program Monitoring and Evaluation Guidance." This guidance also discusses CDC's framework for program evaluation in public health (see <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm>). There are also CD-ROMs for all software and data collection trainings.

In addition to agency level and program planning level variables, much of the data you are required to submit to the CDC are process monitoring data about clients and the interventions in which they participated. Coupled with planning data, process monitoring data can be used for process evaluation.

### Required Variables

Tables 2 through 9 in Appendix B contain variables that CDC funded agencies must report on for evidence-based behavior change interventions. Variables cover agencies, funding, program planning, interventions, and client characteristics. These standardized variables are part of the NHM&E DS. The tables do not indicate variables required for system functions; e.g., to populate other parts of the system and to link data within the system.



## Data Collection and Reporting

To collect data for required NHM&E variables or any other variables you want to measure, you need data collection forms. Data on client characteristics and risk factors can be collected with a form like the one found in Appendix B. This form includes NHM&E variables, can be used as a client intake form, and can determine if a client has the risk reduction needs SEPA is designed to address. When used this way, the client intake form serves as a screening tool to make sure there is a good fit between the intervention and the client's HIV prevention needs.

Data on planning, intervention plan characteristics, and client intervention characteristics are often informed by your jurisdiction-wide comprehensive HIV prevention plan. Specific sources of these data include SEPA's behavior change logic model, the Implementation Manual, and other planning documents.

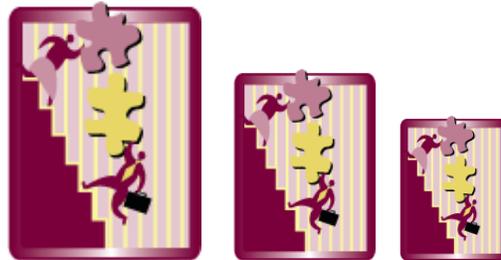
*PEMS software users will have the ability to produce a number of useful reports from all required data entered for discussion with staff and your Board of Directors. Findings from these reports should be used to enhance the intervention and bring about better outcomes for clients.*

PEMS software reports can tell you:

- Number of clients you planned to serve and number of clients actually served
- Proposed target populations
- Demographic, risk behaviors, and risk characteristics of clients served
- Clients reached who were not members of target populations
- Number of cycles planned and delivered (for multi-session interventions)
- Number of sessions planned and delivered

## V. STEPS IN MONITORING AND EVALUATING YOUR CDC-FUNDED EVIDENCE-BASED INTERVENTION

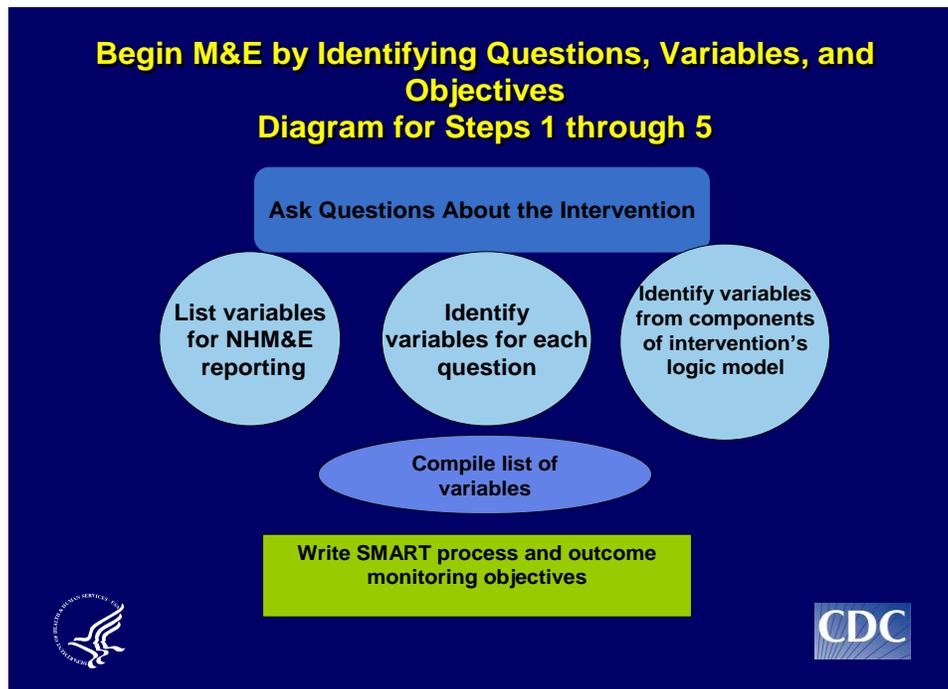
To provide a succinct and user-friendly format, fundamental program monitoring and evaluation information is presented in a series of steps. The steps follow a logical sequence and build upon each other. By following these steps, agencies that implement SEPA will put their best feet forward to advance HIV prevention.



1. Review what you are required to report to CDC
2. Meet with staff and other stakeholders to create a list of questions you would like to answer about SEPA and how it is working with clients
3. Review the behavior change logic model and implementation summary to identify variables for monitoring and evaluation and to write SMART<sup>12</sup> objectives
4. Compile a list of variables that can be used to answer questions, meet CDC NHM&E reporting requirements, and write SMART process and outcome objectives
5. Write SMART process and outcome objectives

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<sup>12</sup> Objectives should be specific, measurable, appropriate, realistic, and time-based.



6. Identify and select data collection tools/instruments that cover all of the variables you want to measure
7. Decide how data will be collected for each variable
8. Create a schedule for data collection and entry
9. Establish a database management program
10. Establish processes for data confidentiality, security, and quality assurance
11. Create a schedule for collecting data to report to CDC and generating reports for agency use
12. Conduct process monitoring, process evaluation, and outcome monitoring

13. Determine how reports will be formatted, how data will be analyzed and presented, and how interpretations and conclusions will be made
14. Establish a mechanism for using interpretations and conclusions for program improvement and future intervention planning, and to share findings with stakeholders
15. Review intervention protocol, SMART objectives, and your quality assurance and monitoring and evaluation (M&E) plans in light of M&E findings to determine if changes are needed
16. Incorporate modifications into intervention protocol and other materials as needed; conduct training on the changes, implement intervention, and continue quality assurance and M&E activities

Each step is discussed below.

## A. Decide What you Want to Know about the Intervention



**When you're curious, you find lots of interesting things to do**

**Walt Disney**



### **Steps 1 and 2**

By carrying out Steps 1 and 2, you are beginning monitoring and evaluation by deciding what you want to know about SEPA. These steps are:

- 1) Review what you are required to report to CDC
- 2) Meet with staff and other stakeholders to create a list of questions you would like to answer about the intervention and how it is working with clients

Since you must report NHM&E data to CDC, list each variable you need to report on, including variables for program performance indicators. Once you decide on the questions you want to answer about the intervention, identify the variables for these questions that NHM&E DS does not cover.

## B. Use SEPA's Behavior Change Logic Model for M&E



### Step 3

Review SEPA's behavior change logic model and implementation summary<sup>13</sup> in the Implementation Manual to identify variables for monitoring and evaluation and to write SMART objectives.

***The behavior change logic model and the implementation summary can help you identify variables for monitoring evidence-based interventions.***

For example, the logic model's activities can be used as variables for process monitoring, and the variables can be written in terms of objectives that can be measured. **When intervention activities reflect core elements of the intervention, then it is especially important to frame these activities as variables and to measure them because of the importance of maintaining fidelity to core elements.**

***M&E can assess how the domains of the implementation summary (i.e., inputs, activities, and outputs) are operationalized or put into practice.*** By comparing your intervention as it is actually implemented to how the intervention was planned according to the logic model and implementation summary, you can gauge to what extent actual implementation was in sync with design. This comparison, called process evaluation, can lead to changes in the logic model or the intervention or both.

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<sup>13</sup>Definitions for behavior change logic models and implementation summaries are found in Appendix A.

## C. Identify Variables and Write SMART Objectives



### Steps 4 and 5

When you complete step 5, you will have objectives to use for process and outcome monitoring.

- 4) Compile a comprehensive list that includes required NHM&E variables and variables needed to answer agency questions based on a review of variables from the intervention's logic model
- 5) Write SMART process and outcome objectives to reflect key questions

### SMART Process Objectives

*SMART process objectives address what needs to happen (what “processes” need to take place) before HIV prevention outcome objectives can be met.*

SMART process objectives identify specific activities to be completed by specific dates, such as number of clients to be screened for an intervention and number of clients to complete the intervention. To be **SMART**, objectives must be specific, measurable, appropriate, realistic, and time- phased.

When you collect data to track your progress in meeting SMART process objectives, you are conducting process monitoring and gathering the data needed for process evaluation.

*For process monitoring, you may want to have SMART objectives each year that cover:*

- The number of potential clients you need to tell about the intervention so that you end up with the number you planned to reach based on your budget for the intervention
- The number of clients you want to participate in the intervention
- The number/percent of clients you think will complete all of the sessions in a group-level intervention, less than half of the sessions, and at least half but not 100 percent of the sessions

Remember that your client-level NHM&E reporting will include characteristics of clients and will tell you who participated in each session so you can have unduplicated counts of the numbers of clients served.

*Examples of SMART process objectives for SEPA include:*

- By September 30, (year), at least 50 Latinas who frequent the lounges and clubs in zip code 30308 will be given a flyer and told about the intervention.
- By the end of project year one, at least 60 percent of clients will attend all sessions of the intervention.
- By the end of the project year, no more than 25 percent of clients will complete less than half of the required sessions.

By collecting NHM&E client-level data on client characteristics such as race, ethnicity, gender, HIV status, and risk factors, and by supplementing NHM&E with the numbers of clients recruited and the number of actual clients served, you will have important information for process evaluation. You will also be able to gauge how many clients you need to recruit as you implement more cycles of the intervention.

## Use Core Elements for Monitoring



If activities in the intervention's behavior change logic model include core elements of the intervention, you might want to write a SMART process objective for each measurable activity that is also a core element and for which there are available data.

Table 10 illustrates how two of the core elements in SEPA can be used to write SMART process objectives.

Another way to monitor fidelity to core elements is to use the fidelity checklists in the quality assurance guide in the Implementation Manual.



**TABLE 10: EXAMPLES OF SMART PROCESS OBJECTIVES TO MONITOR FIDELITY TO CORE ELEMENTS IN SEPA ACTIVITIES**

CORE ELEMENT ACTIVITY	VARIABLE	SMART PROCESS OBJECTIVE	DATA SOURCES TO MEASURE SMART OBJECTIVES
Incorporate skill-building activities into sessions to enhance women’s self-efficacy for safer sex behaviors, including demonstrations and practice exercises on male and female condom use and role playing on assertive communication with sex partners, including condom negotiation.	Percent of SEPA clients who attended session 3	By June 30 (end of project year), at least 80 percent of women enrolled in SEPA will have participated in practice exercises on male and female condom use	Number of clients who attended session 1 of SEPA during the project year
	Percent of SEPA clients who attended session 4	By June 30 (end of project year), at least 70 percent of women enrolled in SEPA will have participated in role plays on condom negotiation	Number of clients who attended session 3 of SEPA during the project year  Number of clients who attended session 4 during the project year
Ask participants to write thank you notes to fellow participants and pledge their commitment to community health during the final session. Present a certificate during the final session to each participant who attended at least three sessions of the intervention.	Percent of SEPA clients who attended session 6	By June 30, (end of project year), at least 60 percent of women enrolled in SEPA will have pledged their commitment to community health	Number of clients who attended session 1 of SEPA during the project year  Number of clients who attended session 6 during the project year

## SMART Outcome Objectives

*SMART outcome objectives identify what the intervention hopes to achieve through its SMART process objectives.* The outcomes identified in SEPA's behavior change logic model should be used to identify variables for SMART outcome objectives. Like process objectives, outcome objectives must be specific, measurable, appropriate, realistic, and time-phased.

By writing SMART objectives and collecting data to track progress in achieving them, you are performing outcome monitoring. In general, outcome monitoring answers two fundamental questions:

- Did the expected outcomes occur?
- What changes were noted in participants' behaviors?

The goal of all HIV prevention evidence-based interventions is to bring about positive behavior change in clients through increases in protective behaviors and decreases in risky behaviors. As noted in the Implementation Manual, activities in SEPA affect determinants of behavior change for the target population.

Variables on determinants of behavior change can be measured immediately before clients attend the first session of Project SEPA and at the end of the last session. Variables relating to actual behaviors, such as condom use, can be measured before the first session when variables on determinants are measured and at the final session if the intervention lasted at least six weeks (one session each week). If possible, it is ideal to measure behavior at three and six month intervals after the end of session 6.

Referring again to SEPA's behavior change logic model, we note the following variables on determinants of behavior change, also referred to as immediate outcomes:

- HIV knowledge
- Attitudes toward condom use
- Partner communication skills (self-efficacy)



- Condom use skills (self-efficacy)
- Condom negotiation skills (self-efficacy)
- Risk-reduction behavioral intentions

The intermediate outcome, or outcome devoted to behavior change, is correct and consistent condom use with sex partners during vaginal and anal sex

Examples of tools that can be used for pre and post tests for outcome monitoring are found in Appendix E.



Examples of SMART immediate outcome objectives include:

- By the end of the five year funding cycle, at least 90 percent of SEPA participants will show an increase in their knowledge of HIV, as measured by a pre and post test instrument.
- By the end of the project year, at least 80 percent of SEPA participants will show an increase in favorable attitudes toward condom use, as measured by a pre and post test instrument.
- By the end of the project year, at least 80 percent of SEPA clients will show an increase in their confidence to communicate with male sex partners.
- By the end of the project year, at least 70 percent of SEPA clients will report an increase in their confidence to correctly use condoms as measured by pre and post tests.
- By the end of the project year, at least 60 percent of the clients who attended at least half of the intervention's sessions will report an increase in their confidence to negotiate condom use with male sex partners as measured by pre and post tests.
- By the end of the project year, at least 80 percent of SEPA clients will show an increase in their risk reduction behavioral intentions as measured by pre and post tests.

An example of a SMART intermediate outcome objective is:

- By the end of the project year, at least 60 percent of the clients who attended at least half of SEPA's six sessions will report an increase in the number of times they correctly used condoms for vaginal and anal sex with male partners as measured by pre and post tests.

Outcome monitoring should not take place until agencies have conducted process monitoring and process evaluation because the intervention must be

delivered correctly in order for the right outcomes to occur. As noted, by monitoring fidelity to core elements and required activities, you can determine whether the intervention was implemented correctly.

## D. Identify and Select Data Collection Tools



### Step 6

Identify and select data collection tools/instruments that cover all of the variables you need to measure.

Data collection is part of the process used to measure variables. Data collection instruments, also called tools, are usually questionnaires or surveys for clients. The same questionnaire should be used with all clients so that data can be captured in a consistent way for subsequent analysis.

Data collection tools for SEPA outcome monitoring are found in Appendix E, and Appendix F identifies resources for tools that can be used for other programs.

Information on instrumentation and quality criteria for data collection tools is available at <http://oerl.sri.com/instruments>.

## E. Establish Data Collection Processes



### Step 7

Decide how data will be collected for each of the variables you need to measure.

For each variable, the data collection process entails:

- 1) Using the most appropriate data collection tool
- 2) Identifying the source(s) of data
- 3) Deciding who will be responsible for data collection
- 4) Determining how data will be collected
- 5) Collecting data and arranging for entry into a computer database

*You need to decide whether you want clients themselves to complete data collection tools or whether staff should interview clients and record the data.* The type of information being collected, the location for data collection, and the timing of data collection, such as intake or post-testing, influence these decisions. Staff who collect data need to be trained on interviewing techniques such as motivational interviewing, how to use data collection tools, and how to protect client confidentiality.

## F. Write a Schedule for Data Collection and Entry



### Step 8

Activities to secure data need to take place at specific times. Recruitment data are obviously collected before the intervention begins, and data on client participation are collected during each session of a multi-session group level intervention. Outcome monitoring data on behavioral determinants are collected during the first session before the intervention begins and immediately following the last session. If possible, agencies are encouraged to

collect outcome monitoring data on behavior change one to six months after the last session of the intervention in addition to the start of the first session.

*Before you begin data collection, check with your health department to find out if Institutional Review Board approval is necessary for collecting client-level data and whether consent forms are needed for youth as well as adults.*



The table below provides an example of how you can organize data collection tasks based on the variables you want to measure.

**TABLE 11: EXAMPLE OF DATA COLLECTION TASKS ORGANIZED BY VARIABLES**

Variable	Data Collection Tool(s)	Data Source	Responsible Staff	When and How Data will be Collected	Arranging for Computer Entry
Client's race	Agency's standard client intake form or form from Appendix C	Client	Intake worker	During the client's first visit to the agency, intake staff collect data by interviewing clients and writing or checking off data on the agency intake form and attaching documentation to the client chart	Each day, copies of intake forms are given to data entry staff who keep the forms in a locked file cabinet when they are not being used
Client's confirmed HIV test result	Documented lab or HIV test results from physician  Agency's standard client intake form	Client	Intake worker	During the client's first visit to the agency, intake staff collect data by interviewing clients and writing or checking off data on the agency intake form and attaching documentation to the client chart; staff may need to request written documentation for the client's file	Each day, copies of intake forms and written documentation are given to data entry staff who keep the forms in a locked file cabinet when they are not being used the computer

## G. Establish a Database Management Program



### Step 9

The data collection process yields data for use in your computer's database management program. Examples of applications software for a database management program are Microsoft Access and Microsoft SQL Server. Another example is Epi Info, CDC's public domain software package. NHM&E has its own database management program referred to as PEMS.

Follow the instructions for NHM&E data submission regarding the database management program you need to use.

## H. Develop Processes for Data Confidentiality, Security and Quality Assurance



### Step 10

*If your agency doesn't already have written policies on client confidentiality, data security, and data quality assurance (QA), you need to write these documents and train staff on them.*

Quality assurance processes help ensure confidence in the validity and reliability of the data you report to CDC and use for your own reporting and analysis. Quality assurance applies to sampling and measurement issues as well as data processing. There are online materials on data auditing, and two common data processing QA activities are double entry and post data entry verification.

## I. Create Reporting Schedules

Create a schedule for reporting data to funding agencies and generating reports for your own use



### Step 11



Use CDC's due dates for NHM&E data as the starting point for determining a schedule for data collection, entry, quality assurance, and reporting. In addition to scheduling around CDC's deadlines, you might want to develop a schedule with your Board of Directors for internal agency reports. Reports on progress in meeting SMART objectives could be prepared biannually; at a minimum, there should be an annual report that includes data on and analysis of SMART process and outcome objectives.

## J. Conduct Process Monitoring, Process Evaluation, and Outcome Monitoring



### Step 12



The preceding 11 steps have set the stage for performing the key M&E activities discussed in this document: process monitoring, process evaluation, and outcome monitoring. M&E should take place according to your monitoring and evaluation plan, with qualified staff and an appropriate level of funding.

## K. Devise Strategies for Reporting, Analyzing, and Interpreting Data



### Step 13



Determine how reports will be formatted, how data will be presented, and how interpretations and conclusions will be made.

*Data collection is futile unless data are analyzed and interpreted in reports stakeholders find useful.* Reports must be user-friendly. Data can be presented in such formats as tables, charts, and graphs, and clear narrative discussion should explain what the data mean. After time, your reports can compare progress with SMART objectives and program performance indicators from year to year.

An annual report should answer the questions that lay the foundation of your M&E efforts and the report should discuss implementation and M&E challenges and successes. The most critical part of your annual report is the interpretation that accompanies data analysis because it provides the basis for deciding what changes may need to be made about recruitment, retention, and intervention delivery as well as M&E and quality assurance. Therefore, *an annual report should discuss how analysis of data led to ideas for program improvement and what specific actions were taken to enhance the intervention to achieve better client outcomes while maintaining fidelity to the core elements of the intervention.*

To be as comprehensive as possible, intervention staff -- in addition to evaluation and quality assurance support -- should be involved in interpreting data.

## L. Develop Mechanisms for Using M&E Findings



### Step 14



Establish a mechanism for using interpretations and conclusions for program improvement and future intervention planning, and to share findings with stakeholders.

It's essential that reports – whether positive or negative -- be discussed with recruitment and intervention staff. For example, you may need to enhance recruitment by devising new strategies and conducting these strategies in additional communities where potential clients congregate. Discussion of M&E reports should take place at Board of Directors meetings so that the suggestions of Board members for program improvement can be considered and ideas about new prevention projects can be exchanged.

Other audiences for your M&E reports include members of your jurisdiction's HIV prevention community planning group (CPG), your CDC project officer, and CDC "DEBI" intervention staff.

You may want to present M&E findings at an HIV prevention conference, or findings can be published in a peer-reviewed journal.

## M. Determine Need for Change Based on M&E Findings



### Step 15



Review intervention protocol, SMART objectives, and your monitoring and evaluation (M&E) plan in light of M&E findings to determine if changes are needed.

Use suggestions from staff, members of your Board, and your funding agency to decide what changes you want to make to improve SEPA. For example, changes in the Participant Workbook may need to be made to update

information. You may need a more accessible location for the intervention and decide to include an incentive for perfect attendance. You may decide to revise your process or outcome objectives so they are more realistic, and you may want to change your schedule for M&E reporting so that you have information to use at fundraising events.

You may decide to leave things the way they are and strengthen quality assurance activities before changes are made.

## **N. Modify Processes and Procedures Based on M&E Findings**



### **Step 16**

Incorporate modifications into materials as needed, conduct training, implement intervention, and continue quality assurance and M&E activities.

If you decide to make changes to how you deliver the intervention while maintaining fidelity to core elements, or if you revise existing materials, the next step is to determine who is responsible for putting the agreed-upon changes into writing. If you change materials that clients receive, you need to follow CDC content review procedures and subsequently make sure all affected staff learn about the changes.<sup>14</sup>

## **VI. CONCLUSION**

The work that goes into monitoring and evaluation and writing an M&E plan is well worth the effort. Monitoring and evaluation are now considered routine activities in HIV prevention. By developing and implementing an M&E plan for SEPA, you place staff and the agency as a whole in a competitive position for sustaining high-quality HIV prevention services.

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<sup>14</sup> For information on program review panels, see <http://www.cdc.gov/od/pgo/forms/hivpanel.htm> and <http://www.cdc.gov/od/pgo/forms/hiv.htm>

## APPENDIX A Glossary of Terms

### **Behavior Change Logic Model:**

A conceptual framework for a specific intervention and target population that visually depicts the:

- intent of the intervention (what behavioral problem is to be changed for the target population)
- determinants of behavior change
- intervention activities expected to lead to behavior change
- anticipated immediate and intermediate outcomes
- relationships among determinants, activities, and outcomes

### **Evaluation:**

The systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future programming.

### **Formative Evaluation:**

The process of testing program plans, messages, materials, strategies, or modifications for weaknesses and strengths before they are put into effect. It may also be used when an unanticipated problem occurs after beginning to implement the intervention.

### **Implementation Summary:**

A conceptual framework for a specific intervention and target population that visually depicts:

- how the intervention is to be put into practice
- the inputs or resources needed for the specific intervention
- fundamental activities needed to prepare for implementation of the intervention
- intervention activities expected to lead to behavior change
- anticipated outputs or deliverables that result when intervention activities are conducted
- relationships among inputs/resources, activities, and outputs

**Monitoring:**

The assessment of whether or not a program is (1) operating in conformity to its design; (2) reaching its specific target population; and (3) achieving anticipated effects.

**Outcome Evaluation:**

The collection of data about outcomes before and after the intervention for clients as well as a similar group that did not participate in the intervention being evaluated (i.e., control group); determines if the intervention resulted in the expected outcomes.

**Outcome Monitoring:**

The routine documentation and review of program-associated outcomes (e.g., individual-level knowledge, attitudes and behaviors or access to services; service delivery; community or structural factors) in order to determine the extent to which program goals and objectives are being met.

**Process evaluation:**

Assesses planned versus actual program performance over a period of time for the purpose of program improvement and future planning.

**Process monitoring:**

The routine documentation and review of program activities, populations served, or resources used in order to inform program improvement and process evaluation.



## APPENDIX B Variables for CDC Reporting

**TABLE 2: REQUIRED NHM&E VARIABLES FOR AGENCY & FUNDING DATA**

<b>Agency Information (NHM&amp;E DS Table A)</b>	
Agency Name	Agency Type
Agency ID	Faith-based
Community Plan Jurisdiction	Race/Ethnicity Minority Focused
Employer Identification Number (EIN)	Directly Funded Agency
Street Address 1	Agency Contact Last Name
Street Address 2	Agency Contact First Name
City	Agency Contact Title
State	Agency Contact Phone
Zip Code	Agency Contact Fax
Agency Website	Agency Contact Email
Agency DUNS Number	
<b>PA Information (NHM&amp;E DS Table B)</b>	
CDC HIV Prevention PA Number	Annual CDC HIV Prevention Award Amount Expended
CDC HIV Prevention PA Budget Start Date	Amount Allocated for Community Planning
CDC HIV Prevention PA Budget End Date	Amount Allocated for Prevention Services
CDC HIV Prevention PA Award Number	Amount Allocated for Evaluation
Total CDC HIV Prevention Award Amount	Amount Allocated for Capacity Building
<b>Contractor Information (NHM&amp;E DS Table C)</b>	
Agency Name	Race/Ethnicity Minority Focused
City	Contract Start Date-Month
State	Contract Start Date-Year
Zip Code	Contract End Date- Month



Employer Identification Number (EIN)	Contract End Date- Year
DUNS Number	Total Contract Amount Awarded
Agency Type	CDC HIV Prevention Program Announcement Number
Agency Activities	CDC HIV Prevention PA Budget Start Date
Faith-based	CDC HIV Prevention PA Budget End Date

**TABLE 3: REQUIRED NHM&E VARIABLES FOR SITE & PLANNING DATA**

<b>Site Information (NHM&amp;E DS Table S)</b>	
Site ID	State
Site Name	Zip Code
Site Type	Use of Mobile Unit
County	
<b>Program Name - Planning (NHM&amp;E DS Table D)</b>	
Program Name	
Community Planning Jurisdiction	
Community Planning Year	
<b>Program Model and Budget - Planning (NHM&amp;E DS Table E1)</b>	
Program Model Name	Target Population
Evidence Base	Program Model Start Date
CDC Recommended Guidelines	Program Model End Date
Other Basis for Program Model	Proposed Annual Budget
<b>Intervention Plan Characteristics (NHM&amp;E DS Table F)</b>	
Intervention Type	Planned Number of Cycles
Intervention Name/ID	Number of Sessions
HIV+ Intervention	Unit of Delivery
Perinatal Intervention	Delivery Method
Total Number of Clients	Level of Data Collection
Sub-Total Target Population	



Tables 4 through 7 identify standardized variables for client-level reporting.

**TABLE 4: REQUIRED NHM&E VARIABLES ON CLIENT CHARACTERISTICS – DEMOGRAPHIC DATA (NHM&E DS Table G1)**

Date collected
PEMS client unique key
Date of birth (year)
Ethnicity
Race
State/territory of residence
Assigned sex at birth
Current gender identity

**TABLE 5: REQUIRED NHM&E VARIABLES ON CLIENT CHARACTERISTICS – RISK PROFILE DATA (NHM&E DS Table G2)**

Date collected
Previous HIV test
Self reported HIV test result
In HIV medical care/treatment (only if HIV+)
Pregnant (only if female)
In prenatal care (only if pregnant)



**TABLE 6: REQUIRED NHM&E VARIABLES FOR CLIENT RISK FACTOR DATA (activities within past 12 months) (NHM&E DS Table G2)**

Injection drug use
Sex with transgender
Sex with female
Sex with male
No risk identified
Share injection drug equipment
Not asked
Declined to answer
Other (specify)

**TABLE 7: REQUIRED NHM&E VARIABLES FOR ADDITIONAL CLIENT RISK FACTOR DATA: RISK FACTORS IN THE PAST 12 MONTHS THAT INVOLVE SEXUAL ACTIVITY (NHM&E DS Table G2)**

No additional risk information specified
Exchange sex for drugs/money/or something they needed
While intoxicated and/or high on drugs
With person who is an IDU
With person who is HIV positive
With person of unknown HIV status
With person who exchanges sex for dugs/money
With person who is an MSM
With anonymous partner
With person who has hemophilia or transfusion/transplant recipient
Without using a condom
Recent STD (not HIV)
Not asked
Declined to answer



**TABLE 8: REQUIRED NHM&E VARIABLES FOR DATA ON CLIENT INTERVENTION CHARACTERISTICS (NHM&E DS Table H)**

Intervention ID
Intervention name
Cycle (planned number of cycles)
Session number
Session Date
Site name
Recruitment source
Recruitment source – service/intervention type
Incentive provided
Unit of delivery
Delivery method

**TABLE 9 REQUIRED NHM&E VARIABLES FOR DATA ON REFERRALS<sup>15</sup> (NHM&E DS Table X7)**

Referral date
Referral service type
Referral outcome
Referral close date
HIV test performed
HIV test result

<sup>15</sup> Check with agency leadership and consult agency policies to determine if you need to report data on referrals.



## APPENDIX C

### Example of an Intake Form that Can Serve as a Tool for Monitoring SEPA Client Eligibility

#### Section I: Participant Demographics

1. Year of birth \_\_\_\_\_
  
2. What best describes your ethnicity?
  - Hispanic or Latino
  - Not Hispanic or Latino
  - Don't know
  - Not Asked
  - Refused to answer
  
3. What best describes your race?  
*(check all that apply)*
  - American Indian or Alaska Native
  - Asian
  - Black or African-American
  - Native Hawaiian or Other Pacific Islander
  - White
  - Don't know
  - Not Asked
  - Refused to answer
  
4. In what state or territory do you currently reside?
  
5. What is your country of origin?
  
6. What was your sex at birth?
  - Male
  - Female
  - Don't know
  - Not Asked
  - Refused to answer



- 7. How do you view yourself now?**
- Male
  - Female
  - Transgender – Male to Female
  - Transgender – Female to Male
  - Don't know
  - Not Asked
  - Refused to answer
- 8. What is your marital status?**
- Never married
  - Married
  - Widowed
  - Separated
  - Divorced
  - Don't know
  - Not Asked
  - Refused to Answer
- 9. Do you have children?**
- No
  - Yes
- 10. Are you currently pregnant?**
- No (*skip to question 10*)
  - Yes
  - Cannot get pregnant
  - Don't Know
  - Not Asked
  - Refused to Answer
- 11. Are you receiving prenatal care?**
- No
  - Yes
  - Don't Know
  - Not Asked
  - Refused to Answer



**12. Have you ever had an HIV test?**

- No (*skip to question 13*)
- Yes
- Don't know (*skip to question 13*)
- Not asked (*skip to question 13*)
- Refused to answer (*skip to question 13*)

**13. What is your HIV status?**

- HIV-Positive (HIV+)
- HIV-Negative (HIV-) (*skip to question 13*)
- Don't know (*skip to question 13*)
- Not asked (*skip to question 13*)
- Refused to answer (*skip to question 13*)

**14. Are you currently receiving medical care or treatment for HIV?**

- No
- Yes
- Don't Know
- Not Asked
- Refused to Answer



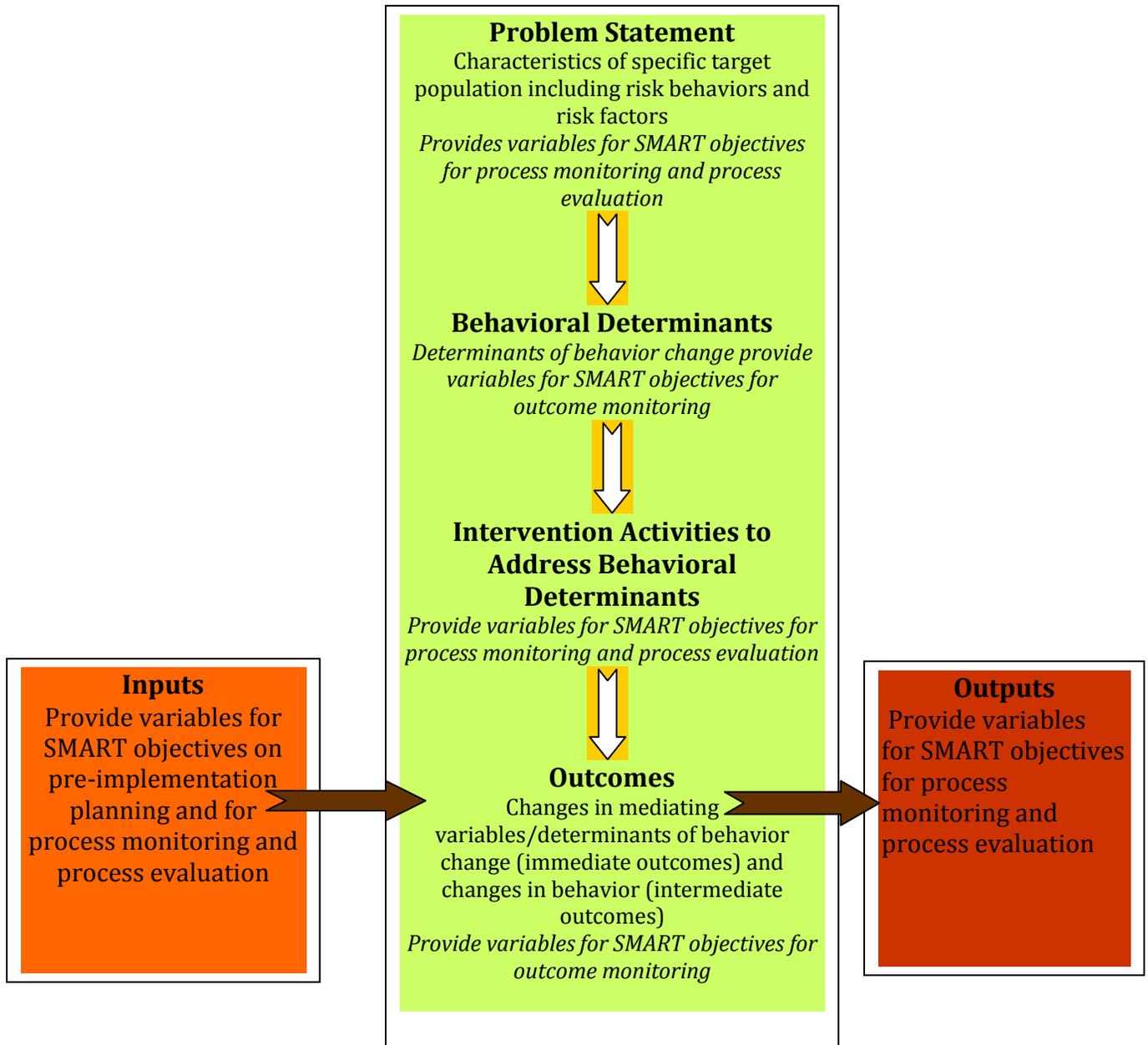
## Section II: Participant Risk Factors

15. Thinking back over the last 90 days, please check each of the items listed below that applies to you.

<b>Risk Factors in last 90 days – <i>Check all that apply</i></b>	
<input type="checkbox"/>	<b>Sex with male</b>
<input type="checkbox"/>	<b>Sex with female</b>
<input type="checkbox"/>	<b>Sex with transgender</b>
<input type="checkbox"/>	<b>Sex with multiple partners</b>
<input type="checkbox"/>	<b>Sex with an injection drug user (IDU)</b>
<input type="checkbox"/>	<b>Sex with an HIV-positive person</b>
<input type="checkbox"/>	<b>Sex with a person of unknown HIV serostatus</b>
<input type="checkbox"/>	<b>Sex with a person who exchanges sex for money and/or drugs</b>
<input type="checkbox"/>	<b>Sex with an anonymous partner</b>
<input type="checkbox"/>	<b>Sex with a person who is a known MSM</b>
<input type="checkbox"/>	<b>Sex with a person who has hemophilia or who received a transfusion or transplant</b>
<input type="checkbox"/>	<b>Exchanged sex to get drugs and/or money</b>
<input type="checkbox"/>	<b>Sex while intoxicated and/or high</b>
<input type="checkbox"/>	<b>Sex without using a condom</b>
<input type="checkbox"/>	<b>Injected drugs or injected other substances</b>
<input type="checkbox"/>	<b>Shared injection drug equipment</b>
<input type="checkbox"/>	<b>Been diagnosed with an STD (including Syphilis, Gonorrhea or Chlamydia)?</b>

## APPENDIX D

### Template for an Integrated Behavior Change Logic Model and Implementation Summary for HIV Prevention Planning, Implementation, and Monitoring and Evaluation





## **APPENDIX E**

### **Sample Tools That Can Be Used As Pre And Post Tests For SEPA Outcome Monitoring**

- **Pre and Post Test Tool to Measure Partner Communication Skills**
- **Pre and Post Test Tool to Measure Condom Use Skills**
- **Pre and Post Test Tool to Measure Condom Negotiation Skills**
- **Pre and Post Test Tool to Measure Risk Reduction Behavioral Intentions**
- **Pre and Post Test Tool to Measure Condom Use With Sex Partners During Vaginal And Anal Sex**



## SAMPLE PRE AND POST TEST TOOL TO MEASURE HIV KNOWLEDGE

Please tell us whether the following statements are “True” or “False”	True	False	Don’t Know	Refused To Answer
1. Birth control pills protect against the AIDS virus				
2. If a man pulls out right before orgasm (coming), condoms don’t need to be used to protect against the AIDS virus				
3. Most people who have the AIDS virus look sick				
4. Vaseline and other oils should not be used to lubricate condoms				
5. Latex is the best material a condom can be made of for protection against the AIDS virus				
6. Cleaning injection needles with water is enough to kill the AIDS virus				
7. Most people who carry the AIDS virus look and feel healthy				
8. Hand lotion is not a good lubricant to use with a condom				
9. A woman is not likely to get the AIDS virus from having sex with a man unless he is gay or bisexual				
10. Condoms cause men physical pain				
11. If you’re seeing a man and if he agrees not to have sex with other people, it is not important to use a condom				
12. Always leave some room or slack in the tip of a condom when putting it on				



## SAMPLE PRE AND POST TEST TOOL TO MEASURE ATTITUDES TOWARD CONDOM USE

	Strongly Disagree	Sort of Disagree	Sort of Agree	Strongly Agree
1. Most of my closest male and female friends use condoms when they have sex				
2. Using condoms is viewed by my closest male and female friends as the right thing to do				
3. My closest male and female friends will say “no” to sex if their partners won’t use a condom				
4. My closest male and female friends will talk about condoms with their partners				
5. If I wanted to have sex, I would first talk with my partner about using a condom				
6. I will use a condom the next time I have sex				
7. I will say “no” to sex if a condom is not used				
8. I do not plan to use condoms				
9. Sex is not as good with a condom				
10. Using condoms means you don’t trust the other person				
11. I do not have a need to use condoms				
12. My partner would react badly if I suggested the use of a condom				



## SAMPLE PRE AND POST TEST TOOL TO MEASURE PARTNER COMMUNICATION SKILLS

In the past three months, have you:	Partner 1	Partner 2	Partner 3
	Initials:	Initials:	Initials:
1. Asked your partner(s) how they felt about using condoms before you had intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Asked your sex partner(s) about the number of past sex partners they had?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Told your sex partner(s) about the number of sex partners you have had?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Told your sex partner(s) that you won't have sex unless a condom is used?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Discussed with your sex partner(s) the need for both of you to get tested for the HIV/AIDS virus before having sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Talked with your sex partner(s) about not having sex until you have known each other longer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Asked your sex partner(s) if they have ever had some type of STD like herpes, clap, syphilis, gonorrhea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Asked your sex partner(s) if they ever injected drugs like heroin, cocaine, or speed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Talked about whether you or your sex partner(s) ever had homosexual experiences?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Talked with your sex partner(s) about birth control before having sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



## SAMPLE PRE AND POST TEST TOOL TO MEASURE CONDOM USE SKILLS

	Strongly Disagree	Sort of Disagree	Sort of Agree	Strongly Agree
1. I feel confident in my ability to put a condom on my partner				
2. I am able to carry condoms with me on a date in case I decide to have sex				
3. I know where to get condoms				
4. I feel confident I could purchase condoms without feeling embarrassed				
5. I feel confident I could remember to carry a condom with me should I need one				
6. I feel confident in my ability to use a female condom correctly				
7. I feel confident in my ability to incorporate putting a condom on my partner into foreplay				
8. I feel confident I could stop to put a condom on my partner even in the heat of passion				



## SAMPLE PRE AND POST TEST TOOL TO MEASURE CONDOM NEGOTIATION SKILLS

	Yes	No
1. In the past three months, have you bought condoms or have you gotten some free somewhere?		
2. Do you have a condom with you right now?		
3. Do you have a condom at your home?		
4. In the past three months, how many times have you talked with a sex partner about using a condom?		
5. In the past three months, how many times have you talked with a sex partner about HIV/AIDS concerns?		



## SAMPLE PRE AND POST TEST TOOL TO MEASURE RISK REDUCTION BEHAVIORAL INTENTIONS

	Strongly Disagree	Sort of Disagree	Sort of Agree	Strongly Agree
1. Over the next three months, I will always have condoms handy so they can be used when I have sex.				
2. Over the next three months, I will discuss using condoms with my sex partners.				
3. Over the next three months, I will always use condoms when I don't know if my partners have HIV.				



## **SAMPLE PRE AND POST TEST TOOL TO MEASURE CONDOM USE WITH SEX PARTNERS DURING VAGINAL AND ANAL SEX**

1. Over the past three months, about how many times did you have vaginal and anal sex with male partners? Think about the number of times you had intercourse, not the number of partners you had.

Example: 20 times

2. Now think about the number of times either you or your male partners used a condom when you had vaginal and anal sex. Remember we are talking about the past three months and the number of times a condom was used during intercourse.

Example: 16 times

*Divide response from question #1 by response from question #2 to calculate self-reported condom use over the past three months. For example,  $16/20 = .8 = 80$  percent. Over the past three months, client used a condom during vaginal and anal sex 80 percent of the time.*



## APPENDIX F

### Resources on Instruments/Tools/Measures for HIV Prevention Program Monitoring and Evaluation

[http://www.popcouncil.org/horizons/AIDSquest/surveys\\_2/html](http://www.popcouncil.org/horizons/AIDSquest/surveys_2/html)

AIDS Quest: The HIV/AIDS survey library

<http://www.eval.org/Resources/instruments.asp>

American Evaluation Association

<http://www.apa.org/science/faq-findtests.html#findtype>

American Psychological Association, Testing and Assessment

<http://www.apa.org/pi/aids/introprogrameval.html>

American Psychological Association, HIV Prevention Program Evaluation

<http://buros.unl.edu/buros/jsp/search.jsp>

Buros Institute of Mental Measurements

<http://www.caps.ucsf.edu/tools/surveys/>

Center for AIDS Prevention Studies (CAPS) Instruments

[http://www.tmg-web.com/modules/eval\\_mods\\_main.htm](http://www.tmg-web.com/modules/eval_mods_main.htm)

The Measurement Group

<http://www.utsouthwestern.edu/preventiontoolbox>

Monitoring Outcomes of HIV Prevention Programs Question Bank (there are questions on such issues as risk behaviors, risk appraisal, self-efficacy, intentions, expected outcomes, communication and negotiation skills, group norms, peer pressure, social support, HIV/AIDS knowledge)

<http://www.synergyaids.com/apdime/index.htm>

Assessment, Planning, Design, Implementation, Monitoring, and Evaluation of HIV/AIDS Interventions Toolkit



<http://libraries.uta.edu/helen/Test&meas/testmainframe.htm>

Tests and Measures in the Social Sciences

Compiled by Helen Hough, Health Sciences Librarian

University of Texas at Arlington

## Client Risk Assessments

<http://www.health.state.mn.us/divs/idepc/diseases/hiv/riskassessment/hivstdhepriskassessmenttool.pdf>

[http://www.mass.gov/Eeohhs2/docs/dph/substanceabuse/modelcase/adult\\_admissionformssphereassessment.pdf](http://www.mass.gov/Eeohhs2/docs/dph/substanceabuse/modelcase/adult_admissionformssphereassessment.pdf)

<http://www.columbia.edu/~fc15/risk%20assessment%20questions.pdf>

<http://www.vpul.upenn.edu/ohe/library/Sexhealth/hiv/riskassesment.htm>

## Community Assessment/Community Identification

[http://www8.utsouthwestern.edu/vgn/images/portal/cit\\_56417/20/24/205339CID.pdf](http://www8.utsouthwestern.edu/vgn/images/portal/cit_56417/20/24/205339CID.pdf)

<http://qhr.sagepub.com/cgi/reprint/6/1/23>

## Resources Organized by Variables

Variables	Data Collection Tool
Client demographics	see Appendix C
Client risk factors (sex and injection drug)	see Appendix C
<b>HIV/AIDS Knowledge</b>	
AIDS knowledge	<a href="http://chipts.ucla.edu/assessment/IB/List_Scales/aids_knowledge_attitude_survey.htm">http://chipts.ucla.edu/assessment/IB/List_Scales/aids_knowledge_attitude_survey.htm</a>
HIV/AIDS knowledge survey	<a href="http://www.mcw.edu/display/">http://www.mcw.edu/display/</a>
AIDS knowledge and attitude survey	<a href="http://chipts.ucla.edu/assessment/">http://chipts.ucla.edu/assessment/</a>



HIV information	“Correlates of condom use intentions and behaviors among a community-based sample of Latino men in Los Angeles” in Journal of Urban Health, vol. 83, no. 4, 2006, The New York Academy of Medicine
<b>Condoms</b>	
Condom use among Hispanics (male and female)	<a href="http://www.caps.ucsf.edu/tools/surveys/">http://www.caps.ucsf.edu/tools/surveys/</a> <a href="http://chipts.ucla.edu/assessment/ib_directory.asp">http://chipts.ucla.edu/assessment/ib_directory.asp</a>
Female condom attitudes scale	<a href="http://www.caps.ucsf.edu/tools/surveys/">http://www.caps.ucsf.edu/tools/surveys/</a>
Norms for condom use, college students	<a href="http://chipts.ucla.edu/assessment/">http://chipts.ucla.edu/assessment/</a>
Attitudes toward condom use, college students	<a href="http://chipts.ucla.edu/assessment/">http://chipts.ucla.edu/assessment/</a>
Condom comfort survey	<a href="http://www.mcw.edu/display/">http://www.mcw.edu/display/</a>
Attitudes toward condom use, college students	<a href="http://chipts.ucla.edu/assessment/">http://chipts.ucla.edu/assessment/</a>
Attitudes toward condoms (Latino men)	“Correlates of condom use intentions and behaviors among a community-based sample of Latino men in Los Angeles” in Journal of Urban Health, vol. 83, no. 4, 2006, The New York Academy of Medicine
Attitudes toward condom use (women’s attitudes)	“Predictors of condom-related attitudes among at-risk women” in Journal of Women’s Health, vol. 13, No. 6, 2004
Condom comfort survey	<a href="http://www.mcw.edu/display/">http://www.mcw.edu/display/</a>
Thought processes associated with condom use	<a href="http://chipts.ucla.edu/assessment/">http://chipts.ucla.edu/assessment/</a>
Condom knowledge survey	<a href="http://www.mcw.edu/display/displayFile.asp?docid=6269&amp;filename=/User/msauer/CAIR/arw/ARWassessments.pdf">http://www.mcw.edu/display/displayFile.asp?docid=6269&amp;filename=/User/msauer/CAIR/arw/ARWassessments.pdf</a>
<b>Attitudes</b>	
Measures of sexual attitudes and behavior of Latino adults	<a href="http://www.caps.ucsf.edu/tools/surveys/">http://www.caps.ucsf.edu/tools/surveys/</a>



Attitudes toward the enjoyment of safer sex and sexual self-efficacy	Mpowerment implementation manual
<b>Vulnerability</b>	
Perceived vulnerability for contracting HIV, college students	<a href="http://chipts.ucla.edu/assessment/">http://chipts.ucla.edu/assessment/</a>
Perceived susceptibility for contracting HIV, adolescents	<a href="http://chipts.ucla.edu/assessment/">http://chipts.ucla.edu/assessment/</a>
<b>Self-efficacy</b>	
Self-efficacy for sexual discussion, adolescents (self-efficacy)	<a href="http://chipts.ucla.edu/assessment/">http://chipts.ucla.edu/assessment/</a>
Refusal skills for sexual behavior (self-efficacy)	<a href="http://chipts.ucla.edu/assessment/">http://chipts.ucla.edu/assessment/</a>
Self-efficacy for negotiating condom use, adolescents	<a href="http://chipts.ucla.edu/assessment/">http://chipts.ucla.edu/assessment/</a>
Self-efficacy for limiting HIV risk behavior, adolescents	<a href="http://chipts.ucla.edu/assessment/">http://chipts.ucla.edu/assessment/</a>
Condom use self-efficacy	<a href="http://chipts.ucla.edu/assessment/">http://chipts.ucla.edu/assessment/</a>
Condom use self-efficacy (Latino men)	“Correlates of condom use intentions and behaviors among a community-based sample of Latino men in Los Angeles” in Journal of Urban Health, vol. 83, no. 4, 2006 The New York Academy of Medicine
Self-efficacy survey	<a href="http://www.mcw.edu/display/">http://www.mcw.edu/display/</a>
<b>Expectations</b>	
Behavioral expectations to resist unsafe sex, college students (self-efficacy)	<a href="http://chipts.ucla.edu/assessment/">http://chipts.ucla.edu/assessment/</a>



Outcome expectations for suggesting condom use	“Correlates of condom use intentions and behaviors among a community-based sample of Latino men in Los Angeles” in Journal of Urban Health, vol. 83, no. 4, 2006 The New York Academy of Medicine
<b>Intentions</b>	
Condom use intentions	“Correlates of condom use intentions and behaviors among a community-based sample of Latino men in Los Angeles” in Journal of Urban Health, vol. 83, no. 4, 2006 The New York Academy of Medicine
Condom intentions survey	<a href="http://www.mcw.edu/display/">http://www.mcw.edu/display/</a>
<b>Communications</b>	
Health-protective sexual communication	“Correlates of condom use intentions and behaviors among a community-based sample of Latino men in Los Angeles” in Journal of Urban Health, vol. 83, no. 4, 2006 The New York Academy of Medicine



**QUALITY ASSURANCE GUIDE FOR SEPA**

## Quality Assurance

All community-based organizations (CBOs) should have written quality assurance plans for their CDC funded interventions. CDC asks CBOs and health departments to carry out quality assurance (QA) activities so that HIV prevention interventions can be as successful as possible in helping clients reduce their risks of acquiring or transmitting HIV. If you are not funded by CDC and are not required to have QA plans, the discussion on quality assurance for SEPA can help you get started. Think of the tremendous importance of quality assurance work in medical care, airplane maintenance, and automobile manufacturing to appreciate the impact of QA activities.

## What is Quality Assurance for a Behavior Change Intervention?

Quality assurance is a systematic process of review to instill confidence in all stakeholders (e.g., agency Board of Directors, clients, CDC, mayor) that HIV prevention interventions are implemented with qualified staff according to a written intervention protocol or curriculum, applicable requirements and standards, and in accordance with the best known prevention practice and science.



## What is a Quality Assurance Plan?

A quality assurance plan is a management tool that enables supervisors and intervention staff to do the best job possible. The activities you conduct based on your quality assurance plan provide answers to the crucial question, “*How do we know if SEPA is being implemented correctly?*” Quality assurance can



help you identify training and capacity-building assistance needs for ongoing staff and agency improvement in addition to ways to improve client outcomes.

Before you write your QA plan, review SEPA's behavior change logic model and implementation summary to check for pertinent areas to cover, especially inputs and activities. Achievement of outputs and outcomes depends, in part, on how well you conduct quality assurance.

## **What Topics Should be Discussed in a Quality Assurance Plan?**

### **Intervention Staffing**

Your quality assurance plan needs to cover such staffing issues as:

- Required experience, expertise, and skills for intervention staff, including facilitators, outreach workers, and monitoring and evaluation and quality assurance staff;
- Staff supervision, and
- Training and staff development.

### **Requirements and Standards**

Requirements and standards can be legal or regulatory and are usually issued by governmental or legislative bodies and professional associations. They can also be issued by your funder and your own agency. Examples include having a current CLIA (Clinical Laboratory Improvement Amendments of 1988) waiver for HIV rapid testing, conducting partner services for HIV positive clients, policies and procedures for client assessments and referrals, and providing required reports and data to funders.

Standards usually relate to professional practice. Examples include the social work code of ethics, mandated reporting requirements for mental health professionals, and standards for program evaluation. Requirements and standards that apply to SEPA should be covered in the QA plan especially when facilitators are social workers and certified domestic abuse advocates.



Because the intervention covers intimate partner violence, your QA plan should address relevant issues in domestic violence that are subject to state law or codes of professional conduct, such as the limitations of confidentiality and mandated reporting. Supervisors play an important role in identifying relevant issues and making sure intervention staff meet standards of professional practice and conduct.

## **Implementation with Fidelity to Core Elements**

SEPA has been shown to be efficacious; that is, it reduces risky sexual behaviors among at-risk Latinas who participate in the intervention. As an evidence-based intervention, SEPA reflects the best prevention science currently available and your practice – how you plan, carry out, and monitor the intervention – directly affects how well the intervention will work with your clients. Therefore, it is crucial that you establish processes to help ensure that the intervention is implemented correctly.

Your QA plan is the document that describes the processes you use to help ensure correct implementation. Correct implementation is described in the Facilitators Guide. If an evidence-based intervention is adapted, the revised intervention should be described in a written intervention protocol or a revised curriculum that spells out how each activity of the intervention should be conducted with the specific target population.

Correct implementation requires fidelity to the core elements of SEPA. Core elements are those identified aspects of an evidence-based intervention that must not be changed so that the intervention can produce successful client outcomes. Core elements are often intervention activities.

Checklists that facilitators and/or supervisors can use to monitor fidelity to core elements and key activities in each of SEPA's six sessions are found at the end of this document on quality assurance.



## Outline for a Quality Assurance Plan

Here are headings and topics you can use for your quality assurance plan for SEPA. The narrative provides examples of discussion for a quality assurance plan.

### I. **Overview of intervention**

Brief overview of SEPA from the fact sheet on SEPA

### II. **Staffing and professional development**

Discussion can cover required staff competencies, staff training, continuing education, and professional development; for example:

- A. Facilitators must receive CDC training on SEPA and use the Facilitators Guide for implementation.
- B. Facilitators should have expertise, skill, and experience in HIV prevention education, health education, and risk reduction counseling and a track record of effective communication with the target population. Training in domestic and sexual violence is preferred.
- C. Group facilitation skills training may be a required competency.
- D. You may want to establish a policy on continuing education and professional development (e.g., intervention staff must attend at least one national HIV prevention conference each year; intervention staff must receive refresher training on HIV prevention education at least every three years).

### III. **Staff supervision**

- A. Supervisors should meet with staff and review clients' records to make sure requirements and standards, including legal and ethical issues, are handled appropriately.
- B. One-on-one meetings between facilitators and the immediate supervisor should occur on a regular basis.
- C. Supervisors should review client charts, fidelity checklists, and staff notes and reports.
- D. Supervisors can meet with all intervention staff to review process monitoring data and quality assurance reports.
- E. Supervisors may want to observe the intervention and discuss observations with facilitators.

### IV. **Requirements and standards**

- A. Discussion can include or reference agency and funder policies applicable to SEPA, such as client confidentiality, making and tracking referrals, and data collection.
- B. Discussion can include or reference codes of ethics and standards that apply to facilitators and other staff, such as the Code of Ethics for Certified Domestic Abuse Advocates and codes of ethics for social workers.
- C. Discussion can include or reference laws and regulations that apply to facilitators based on their professional affiliation, such as mandated reporting of child abuse and neglect.

### V. **Monitoring fidelity to intervention activities and core elements**



You must make sure the intervention is being carried out in accordance with the Facilitators Guide. In particular, you want to make sure that all

intervention activities take place and that fidelity to core elements is maintained. Ways to do this include:

- A. Observation of the intervention
- B. Client feedback
- C. Facilitator use of a fidelity checklist (see below)
- D. Review of facilitators' reports or notes of (e.g., account of activities conducted during each group session with comments on successes and challenges)
- E. Client chart review (e.g., is there documentation of referrals made and appointments kept?)
- F. Meetings with intervention staff

## VI. **Client record-keeping and client record reviews**

The QA plan can include or reference the agency's written policies on:

- A. What information to include in client charts/records, such as intake form, risk assessment, release of information form, and notations of referrals made and kept
- B. How client charts/records should be organized and maintained
- C. How client charts/records will be kept confidential (e.g., returned to locked file cabinet immediately after use)

## VII. **Quality assurance reports**

Quality assurance reports should be written at least twice a year and should contain the following content:

- A. Overview of QA activities that took place
- B. Findings from QA activities
- C. How findings will be used; for example:
  - 1. Discussion with agency Board of Directors
  - 2. Discussion with SEPA staff



3. Changes made in QA activities and/or changes made in curriculum or other documents such as monitoring and evaluation plan
  4. Identification of staff training and technical assistance needs
  5. Identification of agency capacity-building assistance needs
  6. Schedule for receiving training, technical assistance, and/or capacity-building assistance
- D. Suggestions from discussions with your Board and staff on findings from QA reports should be used to further improve SEPA.

All stakeholders committed to the success of SEPA want to know that the intervention was implemented the right way so that clients can receive the greatest possible benefit from their participation. If SEPA is implemented with trained and culturally competent staff who deliver the intervention in accordance with the Facilitators Guide, without skipping or changing key activities and with fidelity to core elements, then there is reason to believe that HIV infection, as well as infection from other sexually transmitted diseases, will decline among Latinas. HIV and STD prevention is the goal of SEPA. Quality assurance can help you achieve that goal.



## SEPA Session-by-Session Checklist to Assess Fidelity to Core Elements and Key Activities

*Core elements appear in red italics.*

### Session 1: The Impact of HIV and AIDS on Our Community

Subject/Activity	Completely Carried Out	Partially Carried Out	Not Carried Out	Facilitators' Explanations (all "partially carried" out and "not carried out" responses should be explained)
<i>Presentation and discussion of "Mi Hermano"</i>				
Exercise on knowing who has HIV				
<i>HIV transmission</i>				
<i>Perinatal prevention</i>				
<i>HIV testing</i>				
Review of key messages				



## SEPA Session-by-Session Checklist to Assess Fidelity to Core Elements and Key Activities

*Core elements appear in red italics.*

Session 2: HIV and AIDS, Other Sexually Transmitted Diseases, Human Anatomy, and Human Sexuality

Subject/Activity	Completely Carried Out	Partially Carried Out	Not Carried Out	Facilitators' Explanations (all "partially carried out" and "not carried out" responses should be explained)
Session 1 review				
Homework review				
True-or-false exercise on HIV and AIDS				
<i>Human reproductive anatomy</i>				
<i>Human sexuality</i>				
The story of Juanita				
<i>STD testing, transmission, and treatment</i>				
True-or-false activity on STDs				
Review of key messages				



## SEPA Session-by-Session Checklist to Assess Fidelity to Core Elements and Key Activities

*Core elements appear in red italics.*

### Session 3: How To Prevent HIV and Other Sexually Transmitted Diseases

Subject/Activity	Completely Carried Out	Partially Carried Out	Not Carried Out	Facilitators' Explanations (all "partially carried out" and "not carried out" responses should be explained)
Session 2 review				
Homework review				
<i>The ABCs of HIV prevention</i>				
Activity on defining abstinence				
True-or-false activity on condoms				
<i>Male condom practice exercise</i>				
<i>Female condom practice exercise</i>				
Review of key messages				



## SEPA Session-by-Session Checklist to Assess Fidelity to Core Elements and Key Activities

*Core elements appear in red italics.*

### Session 4: Ways To Improve Communication With Our Partners

<b>Subject/Activity</b>	<b>Completely Carried Out</b>	<b>Partially Carried Out</b>	<b>Not Carried Out</b>	<b>Facilitators' Explanations</b> (all "partially carried out" and "not carried out" responses should be explained)
Session 3 review				
Homework review				
Self-esteem and relationships				
Types of communication				
<i>Assertive communication role-play</i>				
<i>Condom negotiation role-play</i>				
<i>Condom negotiation practice exercise</i>				
Review of key messages				



## SEPA Session-by-Session Checklist to Assess Fidelity to Core Elements and Key Activities

*Core elements appear in red italics.*

### Session 5: Relationship Violence, HIV Risk, and Safety Measures

Subject/Activity	Completely Carried Out	Partially Carried Out	Not Carried Out	Facilitators' Explanations (all "partially carried out" and "not carried out" responses should be explained)
Session 4 review				
Homework review				
Dare To Say role-play activity				
<i>Conflict resolution</i>				
<i>Relationship violence</i>				
<i>Intimate partner violence</i>				
<i>Strategies to deal with relationship violence</i>				
Review of key messages				



## SEPA Session-by-Session Checklist to Assess Fidelity to Core Elements and Key Activities

*Core elements appear in red italics.*

### Session 6: Closing and Welcome to a Brighter Future

<b>Subject/Activity</b>	<b>Completely Carried Out</b>	<b>Partially Carried Out</b>	<b>Not Carried Out</b>	<b>Facilitators' Explanations</b> (all "partially carried out" and "not carried out" responses should be explained)
Homework review				
Session 1 review				
Session 2 review				
Session 3 review				
Session 4 review				
Session 5 review				
<i>Ways to help prevent HIV activity and pledge</i>				
<i>Thank you notes activity</i>				
<i>Presentation of certificates</i>				



**TECHNICAL ASSISTANCE GUIDE FOR SEPA**



This technical assistance guide provides answers to frequently asked questions. If you have additional questions about SEPA, contact your CDC project officer.

## Staffing



1. *If I can't locate staff with the skills needed to facilitate SEPA, what can I do?*

Proper facilitation is critical to the success of group-level interventions, and SEPA has a core element – a requirement – on the skills facilitators must have. The core element reads:

“Use a female facilitator who speaks and understands the language of participants. The facilitator is not a peer of participants but someone who is an experienced professional in health education, disease prevention, and risk reduction.”

In addition, there is a key characteristic concerning facilitators:

“Employ facilitators who are certified by the American Red Cross as HIV instructors or who have attended HIV prevention training sponsored by a health department or prevention training center; employ facilitators who have received training in domestic violence and sexual violence.”

Although facilitators are not required to have had the training specified in the key characteristic, it is preferred that they do.

If an agency can not employ a facilitator who meets the core element that addresses facilitators, then it should not conduct SEPA.



2. *May I use volunteers instead of agency staff?*

Volunteers who are former participants in SEPA can help facilitators with logistical arrangements and administrative support, but they cannot facilitate the intervention. Note the following key characteristic:

“Invite a former SEPA participant who completed all sessions to assist with such activities as room-set up and the distribution of handout materials.”



3. *May I use former participants to facilitate SEPA?*

No. As stated in question #1 above, the facilitator is not a peer of participants; she must be an experienced professional in health education, disease prevention, and risk reduction.



4. *Do staff who conduct the intervention need to be the same race and ethnicity as the clients?*

Again, the core element concerning facilitators comes into play:

“Use a female facilitator who speaks and understands the language of participants. The facilitator is not a peer of participants but someone who is an experienced professional in health education, disease prevention, and risk reduction.”

Facilitators must be female and they must speak and understand the language of participants. When SEPA is implemented with Latinas, the facilitator must speak and understand Spanish. If SEPA is adapted for African American women, the facilitator is not required to be African American, but she must be culturally competent. Facilitators must be able to communicate with participants, establish relationships of trust and caring with them, and understand the cultural context of participants' risky behaviors.



5. *Is it okay to bring in guest speakers; for example, speakers on domestic violence and STDs?*

All of the material in the Facilitators Guide should be covered in six two-hour sessions, so there is not time to bring in a guest speaker as part of SEPA. However, your agency could invite former SEPA participants to hear speakers on topics of interest to them, but this would be separate from the actual intervention.



6. *May facilitators deliver SEPA in Spanish?*

SEPA is written in English and at-risk clients who participate should understand English and be able to speak English. At times, the facilitator may translate words, key concepts, and specific HIV prevention messages into Spanish to facilitate understanding and, at times, participants may use Spanish to communicate important issues. However, the English version should be delivered in English. When a Spanish version of the intervention is available, then it will be completely appropriate for facilitators to deliver SEPA in Spanish.

## Target Population



7. *Do we have to target the same populations served in the original research?*

SEPA addresses the HIV and STD prevention needs of Latinas. Mexican and Puerto Rican women participated in the original research on SEPA, but all Hispanic women/Latinas who meet the eligibility criteria can participate. Eligible women are those who had at least one episode of unprotected sex with a male partner living with HIV or a male partner whose serostatus was unknown during the six months prior to enrollment in the intervention. Women are also eligible if they had at least one STD for which they received treatment during the six months prior to the intervention.

If you are considering adapting SEPA for women who are not Hispanic, you need to read the discussion on adaptation in the Implementation Manual. SEPA can be adapted for at-risk women other than Hispanic women and Latinas if the process described in the Implementation Manual is followed.



8. *Can we include African American and white women or Asian or Native American women in sessions with Latinas?*

No. SEPA is based on understanding of cultural factors that affect Hispanic women/Latinas and their behaviors. The intervention can be adapted for other at-risk women if the adaptation process described in the Implementation Manual is followed.



9. *Can SEPA be modified or adapted for Hispanic women who are injection drug users?*

No. SEPA specifically addresses risky sexual behaviors, not injection drug use. The changes that would be needed for this new target population would constitute reinvention, not adaptation.



10. *Do all potential clients need to be screened to determine their risk for HIV infection?*

Yes. SEPA and other evidence-based behavior change interventions target persons at risk of acquiring or transmitted HIV. Women are eligible to participate in SEPA if they had at least one episode of unprotected sex with a male partner living with HIV or a male partner whose serostatus was unknown during the six months prior to enrollment in the intervention. Women are also eligible if they received treatment for at least one STD during the six months prior to the intervention.



11. *Can we include Latinas who do not speak English?*

As noted in the response to question #6 above, SEPA is written in English and at-risk women who participate should understand English and be able to speak English.



12. *Can male partners of participants attend some of the sessions?*

No. SEPA is an intervention for at-risk women. Your agency or other agencies in the community may have programs for couples on HIV prevention and other topics such as communication and healthy relationships and referrals to these programs would compliment SEPA.



13. *Can children of participants attend sessions?*

SEPA is designed for women between the ages of 18 and 44, and the intervention includes discussion of personal and sexual issues as well as discussion of intimate partner violence. Agencies are encouraged to provide or otherwise support child care services for participants who need them. If childcare is not available, agency leadership should discuss whether children over the age of two can sit in with their mothers.



14. *Can a group consist of Latinas of different ages; for example, women in their early 20s and women in their 40s?*

At-risk Latinas between the ages of 18 and 44 are eligible to participate in SEPA. You need to decide whether women of varying ages, such as young women in their early 20s and more mature women in their early 40s, in one group would inhibit active participation and discussion by all clients. Younger and older women can learn from each other, but the age mix should not impede the active discussion called for by SEPA.



15. *Can someone join SEPA after the first session; e.g., during the second or third session?*

Check to see if your agency has a policy on enrollment in interventions and services. It's important that SEPA clients attend each session because the sessions build on each other and each session contains valuable information. You may decide that someone can join at session 2, but it is problematic to join later than that.

## Number of Sessions/Duration of Intervention



16. *Is it okay to decrease the total number of sessions by combining sessions (for example, reduce the six sessions to four)?*

It's possible to complete SEPA in its entirety in less than six sessions, but each session would need to last longer than two hours. Some clients may not feel comfortable participating in intensive sessions for more than two hours, and it may be difficult for some to digest all of the information if the session exceeds two hours. Five sessions would require close to three hours, and this may be suitable for your clients. We do not recommend less than five sessions. Remember that no more than two sessions should be held each week.



17. *Can we consolidate the sessions into a weekend retreat?*

No. There is a core element that there should not be more than two sessions each week. The reason for this requirement is that participants need time to complete homework assignments and practice new skills.



18. *Can we add a session or two to cover more information, such as how drug use affects HIV risk?*

SEPA is an efficacious intervention. This means that it was successful in significantly reducing HIV risk behaviors among the Latinas who participated in the research trial. If information delivered in additional sessions is added to the curriculum, we do not know whether the intervention will remain efficacious. We suggest that women who complete SEPA be encouraged to attend other programs at your agency or special events with guest speakers or agency staff that provide information to supplement the material in SEPA.



19. *Can we delete material or topics that do not apply to our target population?*

No. If the material or topics does not apply to your target population, then SEPA is not the right intervention for that population.



20. *Is it okay for a session to last longer than two hours if clients want to stay and continue discussions?*

If clients have questions and are actively engaged in discussion when the session is scheduled to end, it is okay to continue. However, we suggest that the session not last longer than 2 and one-half hours.



21. *Is it okay if a session is completed in less than two hours?*

It is possible to complete a session in less than two hours, but it is unlikely. Participants should be actively engaged in discussions and activities, so each session should last about two hours. If facilitators have covered all of the material and done their best to engage clients, then a session may end in less than two hours.



22. *If participants don't want to do homework, can I eliminate the homework assignments?*

No. There is a core element that requires homework assignments. Some participants will not complete the homework, but the assignments can not be eliminated.



23. *Can new participants join the group after the first session?*

As noted under question #14, we suggest that you check to see if your agency has a policy on enrollment. It's important that SEPA clients attend each session because the sessions build on each other, and each contains valuable information. You may decide

that someone can join at session 2, but it is problematic to join later than that.

## Setting/Venue for Carrying Out the Intervention



24. *Is it okay to conduct SEPA in a correctional setting, such as a prison, jail, or detention center?*

No. Although there are at-risk women in correctional settings who would benefit from SEPA, the homework assignments and practice exercises preclude the delivery of SEPA in these settings.



25. *Can we use any setting or location that is accessible to clients?*

Yes -- if the setting or location allows participants to feel safe and they know that their privacy is protected. This means that no one outside of the SEPA group can hear what participants say.



26. *Can we conduct the intervention at participants' homes?*

Yes -- if participants feel safe and they know their privacy is protected. This means that no one outside of the SEPA group can hear what participants say.

## Intervention Materials



27. *All of the materials are in English, but can we conduct the intervention in Spanish?*

SEPA is written in English and at-risk clients who participate should understand English and be able to speak English. At times, the facilitator may translate words, key concepts, and specific HIV prevention messages into Spanish to facilitate understanding, and at times, participants may use Spanish to communicate important issues. However, the English version should be delivered in English. When a Spanish version of the intervention is available, then it will be completely appropriate for facilitators to deliver SEPA in Spanish.



28. *If we want to change something in a written handout or a video, how should we go about making those changes?*

You may change something in a handout or a video as long as you do not violate any of SEPA's core elements. Proposed changes should be reviewed by members of a client advisory board and your CDC project officer.



29. *Does someone at CDC need to review or approve changes we want to make to intervention materials?*

Yes. You must discuss proposed changes with your project officer.



30. *Do we need permission to translate intervention materials into another language?*

Yes. You need to talk to your CDC project officer. Some interventions in CDC's "DEBI" project have been translated into Spanish, and there are plans to continue Spanish translations. If you want to translate the intervention into a language other than Spanish, talk to your project officer.



31. *When facilitators discuss STDs, should they recommend Gardasil and hepatitis B vaccinations?*

Gardasil is a cervical cancer vaccine that helps protect against four types of human papillomavirus. It is recommended for girls and women between the ages of 11 and 26 who have not already received the three injections of the vaccine.

The hepatitis B vaccine, usually given as a series of 3 or 4 injections, can prevent hepatitis B and the consequences of infection from the virus, including liver cancer and cirrhosis of the liver. All unvaccinated adults at risk for hepatitis B infection should be vaccinated.

The Centers for Disease Control and Prevention recommends both vaccines. However, facilitators should encourage SEPA participants to discuss vaccination with their health care providers.



## **APPENDIX 1**

### **Sample SEPA General Information Flyer**



## WHAT IS SEPA?

**SEPA is an evidence-based HIV prevention intervention for Hispanic women/Latinas at risk of HIV infection due to unprotected sex with male partners.**

### WHAT IS THE EVIDENCE BASIS OF SEPA?

Based on Social Cognitive Theory, **SEPA** produced significant outcomes among low-income Mexican and Puerto Rican women between the ages of 18 and 44 in Chicago where the intervention was tested. Compared to members of the control group, **SEPA** participants showed significant increases in:

- HIV knowledge
- Communication with partners about HIV issues
- Risk-reduction behavioral intentions
- Condom use

In addition, **SEPA** participants had significant decreases in perceived barriers to condom use.

### WHO IS THE AUDIENCE FOR SEPA?

**SEPA** was developed to educate Hispanic women/Latinas between the ages of 18 and 44 about HIV and other STDs and to help them build the skills necessary for behavioral changes that lead to more healthy relationships and safer sex.

Although the intervention's efficacy trial included Mexican and Puerto Rican women, researchers believe **SEPA** can be of benefit to at-risk women of diverse races and ethnicity if their prevention needs can be addressed by **SEPA**'s activities.

*"Everyone needs a strong sense of self. It is our base of operations for everything that we do in life."*

Julia T. Alvarez  
Writer, Poet, and Diplomat

### WHAT HAPPENS DURING SEPA?

**SEPA** consists of six two-hour sessions that include presentations, group discussions, and practice exercises on male and female condom use, condom negotiation, and assertive communication. Session content covers HIV and STD transmission and prevention, male and female reproductive anatomy, human sexuality, interpersonal communications, and domestic and intimate partner violence.

*"I change myself, I change the world."*

Gloria Anzaldua  
Writer and Poet

### WHO SHOULD IMPLEMENT SEPA?

Agencies that serve the Latino community should employ a female facilitator who speaks and understands the language of participants to implement **SEPA**. The facilitator is not a peer of participants but someone who is an experienced professional in health education, disease prevention, and risk reduction.

### WHAT ARE THE BENEFITS OF SEPA?

Agencies, clients, and the Latino community can all benefit from **SEPA**. By implementing **SEPA**, agencies know they provide HIV prevention that works to reduce risky sexual behavior. Clients benefit because they learn how to protect their health and improve relationships with partners. When women in the community are healthy and there are reduced rates of HIV and STDs, the entire Latino community benefits.

*"Deserve your dream."*

Octavio Paz  
Writer, Poet, and Diplomat

For more information on **SEPA**, contact:



## **APPENDIX 2**

### **Sample SEPA Recruitment and Marketing Flyer**



## **Join Fellow Latinas for Weekly Discussions of How to Help Yourself, Your Family, and the Community**

**Learn about important health issues and ways to improve your relationship with your husbands or boyfriends and with family and friends.**

**For information on Latina discussion groups call or email:**

**Name/Agency**

**Email address**

**Phone number**

### **Do you know that . . .**

- HIV/AIDS was the fourth leading cause of death among Hispanic/Latino men and women between the ages of 35 and 44 in 2005?
- There's a way to communicate with other people that makes it easier to talk about your thoughts and feelings?
- Some men and women have sexually transmitted diseases and don't even know it?
- Over a million women in the United States are assaulted by intimate partners each year?
- There's a law called the Violence against Women Act that can help undocumented women who are the victims of domestic violence?



**LEARN MORE INTERESTING AND HELPFUL  
INFORMATION AT OUR WEEKLY DISCUSSION  
GROUPS FOR LATINAS**

## APPENDIX 3

### Resources on HIV and STD Prevention and Information for Victims of Domestic Violence

The following resources can be used by staff and clients.

#### **HIV and STD Prevention**

<http://www.cdcnpin.org/scripts/index.asp>

<http://www.cdc.gov/condomeffectiveness/brief.html>

<http://www.cdc.gov/hiv/resources/qa/index.htm>

<http://www.aidsinfo.nih.gov/>

<http://sis.nlm.nih.gov/hiv.html>

<http://www.4woman.gov/hiv/>

#### **Perinatal Prevention**

National Perinatal HIV Consultation and Referral Service

1-888-448-8765

#### **STDs and STD Testing**

<http://www.cdc.gov/STD/>

<http://hivtest.org/>

[http://yourstdhelp.com/free\\_clinic\\_locator.html](http://yourstdhelp.com/free_clinic_locator.html) (free STD clinics)



## **HIV and HIV Testing**

<http://www.cdc.gov/hiv/>

<http://hivtest.org/>

## **Health Care**

<http://findahealthcenter.hrsa.gov/> (federally funded health centers for persons who do not have health insurance)

<http://www.rxassist.org/patients/res-free-clinics.cfm> (state and regional free clinic associations)

## **Domestic and Sexual Violence**

Stalking Resource Center of the National Center for Victims of Crime  
1-800-394-2255, M-F, 8:30 am–8:30 pm, EST

National Domestic Violence Hotline  
1-800-799-7233

<http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html>

<http://www.cdc.gov/ncipc/dvp/SVPrevention.htm>



## APPENDIX 4

### CDC Required Documents

- **The ABC's of Smart Behavior**
- **Content of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in Centers for Disease Control and Prevention (CDC) Assistance Programs**
- **Notice to Readers: CDC Statement on Study Results of Produce Containing Nonoxynol-9**
- **Nonoxynol-9 Spermicide Contraception Use---United States, 1999**
- **Fact Sheet for Public Health Personnel; Male Latex Condoms and Sexually Transmitted Diseases**



## **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.



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.



Weekly

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) (1). 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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Page converted: 8/10/2000



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**MMWR**

Weekly

May 10, 2002 / 51(18);389-392

## 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 nonoxynol-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)
<b>Total</b>	<b>4,315,040</b>	<b>527,248</b>	<b>(12)</b>	<b>92,997</b>	<b>(2)</b>

\*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 nonoxynol-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			
					Film	Insert	Jelly	Foam
Puerto Rico	15,103	148,072	5,000	12,900	0	NA*	12,841	2,400
New York†	283,200	1,036,084	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	57,999	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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