HIV Prevention Interventions Standards Manual
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PURPOSE

HIV prevention science and activities are driven by the epidemiology of HIV transmission, research related to behavior change science, and by interventions that have proven effective in reducing risk for HIV infection. HIV prevention activities take into account the following overlaying factors: 1) population (defined by geography, ethnicity, gender, age, socioeconomic status, or other demographic characteristics); 2) route of HIV transmission (sexual, parenteral, or vertical); 3) social units targeted (individual, couple, family, network, community, etc.); and 4) specific life circumstances or co-factors of infection targeted, e.g. persons who are HIV positive, individuals who exchange sex for resources, young men of color who have sex with men (MSM), or sexual partners of injection drug users (IDU).

HIV prevention providers are expected to utilize effective technological, behavioral, and social strategies in assisting their clients to reduce their risk for HIV infection. Providers are expected to develop new strategies and implement targeted interventions that are grounded in sound behavior change science with proven effectiveness. While ongoing research is necessary to ensure that there are a number of successful HIV prevention interventions to employ in combination for the greatest effect, it is equally important that existing activities are evaluated and measured against a set of sound principles for efficiency and effectiveness. The purpose of establishing HIV standards is to ensure consistent quality service provision and to establish benchmarks for evaluation.

CHARACTERISTICS OF SUCCESSFUL HIV PREVENTION PROGRAMS

HIV prevention programs:
- Make HIV prevention interventions available to both HIV negative and HIV positive individuals;
- Target clearly defined target audiences, goals and interventions;
- Are flexible at the administrative level;
- Have sufficient program resources and internal agency support to sustain HIV prevention services;
- Provide HIV prevention and risk-reduction activities that are grounded in sound behavioral and social science theory;
- Offer multiple strategies and interventions for delivering comprehensive HIV and risk-reduction messages;
- Utilize client-centered approaches that are relevant, appropriate and culturally competent; and
- Employ qualified, knowledgeable, trained, culturally competent staff that is committed to providing quality HIV prevention services that respect the clients they serve.

PRINCIPLES OF HIV PREVENTION IN MEN WHO HAVE SEX WITH MEN (MSM)

- Risk assessment and risk-reduction counseling should be undertaken in a direct, non-judgmental manner, with attention to the individual client's needs, insight, and readiness to make specific behavior changes ("client-centered" counseling).
- Providers should be knowledgeable of, and culturally competent regarding, issues related to the varying sub-populations of MSM (self-identified gay men), such as non-self-identifying gay men, young MSM, bi-sexual men, men on the “Down Low,” MSM who are questioning and not necessarily identifying themselves as gay or MSM, and MSM who are either transsexual, transgender, or cross dressers.
- MSM should be advised to know their own HIV infection status and are encouraged to share information with their sexual partners.
- Where MSM are not aware of their HIV status
  - MSM should be encouraged to be tested for HIV and use condoms correctly and consistently for both insertive and receptive anal intercourse with men, and for vaginal or anal intercourse with women.
• MSM who are HIV-infected should be encouraged to enroll in medical treatment with a competent physician who treats individuals with HIV infection.
• MSM should be encouraged to avoid or minimize sex with multiple or anonymous partners, as well as sex in conjunction with drug use, especially crystal methamphetamine, inhaled nitrites ("poppers") or excessive alcohol.
• Providers should assist MSM in acquiring and enhancing the communication, problem-solving and decision-making skills needed to discuss HIV status disclosure with sexual partners.
• Providers should encourage patients infected with HIV, viral hepatitis or other sexually transmitted infections (STDs) to seek treatment from qualified clinicians, to adhere to their medication regimen, and to see affiliation with support groups and other advisory and support services that will assist them in managing infection(s).

PRINCIPLES OF HIV PREVENTION IN DRUG USERS (IDUs)
• Reducing the risk of HIV/AIDS in drug users is an achievable goal.
• A community must start HIV/AIDS prevention programs as soon as possible.
• Effective prevention programs require a comprehensive range of coordinated services.
• Prevention programs should work with the community to plan and implement interventions and services.
• Prevention programs must be based on a thorough, continuing assessment of local community needs, and the effectiveness and impact of these programs must be continually assessed.
• Prevention services can most effectively reach drug-using populations in a variety of locations and during a range of operating times.
• Prevention and treatment efforts should target drug users who already have HIV infection, as well as their sex partners.
• Prevention efforts must not only target individuals, but also couples, social networks, and the broader community of drug users and their sex partners.
• Community-based outreach is an essential component of HIV/AIDS prevention and must be directed to drug users in their own neighborhoods.
• Prevention interventions must be personalized for each person at risk.
• Drug users and their sex partners must be treated with dignity, respect, and with sensitivity to cultural, racial/ethnic, age, and gender-based characteristics.
• As part of a comprehensive HIV prevention program, injection drug users (IDUs) should have ready access to sterile injection equipment to reduce their use of previously used injection equipment.
• In a comprehensive program, interventions that target injection risk must address sharing other injection equipment in addition to syringes.
• While necessary, risk-reduction information alone cannot help drug users and their sex partners make lasting behavioral changes.
• Prevention efforts must address the risks of transmitting HIV and other infections sexually, as well as through drug injection.
• Prevalence rates have been reported as high as fifty (50) percent for hepatitis B virus and sixty-five (65) percent for hepatitis C virus among people who have injected drugs for less than one year. HIV prevention strategies should include hepatitis prevention messages, as well as awareness on the availability of hepatitis testing and immunization.
• HIV/AIDS risk-reduction interventions must be sustained over time.
• Community-based prevention is cost-effective.
PRINCIPLES OF HIV PREVENTION WITH WOMEN

- Implement programs that have been proven effective in changing risky behaviors among women and sustaining those changes over time, maintaining a focus on both the uninfected and infected populations of women.
- Incorporate interventions that are, or include:
  - Women-oriented
  - Supportive behavioral change approaches (non-punitive)
  - Treatment of medical/psychiatric problems (Post Traumatic Stress Disorder, anxiety, depression) and eating disorders
  - Psychotherapy, with focus on women’s role as mother, interpersonal relationships, and parenting; topics to include sexuality, family, culture, empowerment, self-esteem and negotiating skills.
- Increase emphasis on prevention and treatment services for young women and women of color. Knowledge about preventive behaviors and awareness of the need to practice them is critical for each and every generation of young women. Prevention programs should be comprehensive and include participation by parents, as well as the educational system. Community-based programs must reach out-of-school youth in settings such as youth detention centers and shelters for runaways.
- Address the intersection of drug use and sexual HIV transmission. Women are at risk of acquiring HIV sexually from a partner who injects drugs and from sharing needles themselves. Additionally, women who use non-injection drugs (e.g., "crack" cocaine, methamphetamines) are at greater risk of acquiring HIV sexually, especially if they trade sex for drugs or money.
- Develop and widely disseminate effective female-controlled prevention methods. More options are urgently needed for women who are unwilling or unable to negotiate condom use with a male partner. The Center for Disease Control and Prevention (CDC) is collaborating with scientists around the world to evaluate the prevention effectiveness of the female condom and to research and develop topical microbicides that can kill HIV and the pathogens that cause STDs.
- Better integrate prevention and treatment services for women. The prevention and treatment of other STDs and substance abuse and access to antiretroviral therapy must be effectively coordinated.
- Emphasize the identification of pregnant women who are HIV+. Early treatment can prevent perinatal (mother-to-child) HIV transmission. Programs should offer comprehensive reproductive services with an enhanced component adding peer advocate services providing individual and group sessions focusing on condom use with main and non-main partners.

CODE OF ETHICS FOR HIV PREVENTION PROVIDERS

The HIV prevention code of ethics is intended to set a standard of conduct for paid staff and volunteers providing HIV prevention services.

1. Non-discrimination
   An HIV prevention provider shall not discriminate against clients or colleagues based on HIV serostatus, race, ethnicity, country of origin, age, gender, substance use, socioeconomic status, sexual orientation, gender identity, linguistics, disabilities and geographic settings.

2. Competence
   An HIV prevention provider shall adhere to approved standards of practice when implementing HIV prevention interventions and strive to improve personal competence and quality of service delivery. Competence is derived from the synthesis of training and experience. Competence begins with a mastery of knowledge, skills, and requires a commitment to learning and professional improvement that is ongoing.
   a. An HIV prevention provider should be diligent and practice due care in providing HIV prevention services. Diligence involves rendering services in a careful and prompt manner, observing applicable technical and ethical standards.
   b. An HIV prevention provider should recognize the limitation and boundaries of his/her competence and refrain from using techniques or offering services beyond his/her competence.
c. When an HIV prevention provider is aware of unethical conduct or practice on the part of an agency or provider, he/she has an ethical duty to report the conduct or practices to the appropriate authorities.

3. Integrity
   a. To maintain and broaden public confidence, an HIV prevention provider should perform all responsibilities with the highest sense of integrity.
   b. HIV providers do not garner personal gain and advantage.
   c. An HIV prevention provider should conduct prevention activities fairly and accurately.
   d. HIV prevention providers, who are in positions of authority, should exercise compassion and wisdom to prevent harm to those whom they are pledged to service: people affected by, infected with, or at risk of being infected with HIV.
   e. An HIV prevention provider should not misrepresent, directly or by implication, professional qualifications or affiliations.
   f. An HIV prevention provider should not be associated directly or indirectly with services or products in a way that is misleading or incorrect.

4. Relationships with clients
   HIV prevention providers should do no harm. An HIV prevention provider:
   a. Must be respectful and non-exploitative;
   b. Does not engage in sexual acts with clients;
   c. Does not engage in business relationships with clients, as this represents a conflict of interest; and
   d. Does not exploit relationships with clients in regard to drug taking behavior or the sharing of needles or other injection paraphernalia.

5. Confidentiality
   HIV-related, confidential information that is acquired while rendering HIV prevention services must be safeguarded against disclosure, including, but not limited to:
   a. Verbal or written disclosure; and
   b. Unsecured maintenance of records.
   c. Recording, taping, etc. of activities or presentations without appropriate releases or consent. Federal and State statutes and regulations explicitly govern those circumstances under which HIV-related information might be disclosed. Professional ethics and personal commitment to the preservation of trust may impose even stricter confidentiality guidelines than those reflected in the law.
   d. Where there is evidence of child or other abuse, an HIV prevention provider is expected to comply with statutory reporting requirements.

GENERAL SERVICES
In the context of HIV prevention counseling and testing, referral is the process in which immediate client needs for care and supportive services are assessed and prioritized. Based on their assessment, clients are then provided with assistance (e.g., setting up appointments, providing transportation) in accessing services. Referral should also include follow-up efforts necessary to facilitate initial contact with care and support service providers.

Referral does not include ongoing support or management of the referral or case management. Case management is generally characterized by an ongoing relationship with a client that includes comprehensive assessment of medical and psychosocial support needs, development of a formal plan to address needs, substantial assistance in accessing referral services, and monitoring of service delivery.
1. **Typical referral needs**
   a. Clients should be referred to services that are responsive to their priority needs and appropriate to their culture, language, sex, sexual orientation, age and developmental level. Examples of these services include:

   1. **Comprehensive Risk Counseling Services.** Clients with multiple and complex needs that affect their ability to adopt and sustain behaviors to reduce their risk for transmitting or acquiring HIV should receive or be referred for COMPREHENSIVE RISK COUNSELING SERVICES services, including ongoing prevention counseling. COMPREHENSIVE RISK COUNSELING SERVICES can help coordinate diverse referral and follow-up concerns.
   2. **Medical evaluation, care and treatment.** HIV-infected clients should receive or be referred to medical services that address their HIV infection (including evaluation of immune system function and screening, treatment, and prevention of opportunistic infections). Screening and prophylaxis for opportunistic infections and related HIV conditions (e.g., cervical cancer) are important for HIV-infected persons. In addition, co-infection with HIV and communicable diseases (e.g., TB, STIs and hepatitis) can, if untreated, pose a risk to susceptible community members. Thus, providers of HIV testing should be familiar with appropriate screening tests (e.g., TB), vaccines (e.g., hepatitis A and B), STI and prophylactic TB treatment, and clinical evaluation for active TB disease to ensure that these communicable diseases are identified early and appropriate clinical referrals are made, even if clients forego outpatient HIV treatment.
   3. **Partner counseling and referral services (PCRS).** Persons with HIV-positive test results should receive or be referred to services to help them notify their sex or injection-drug-equipment-sharing partners or spouses regarding their exposure to HIV and how to access counseling, testing and referral (CTR). Guidelines for PCRS are available.
   4. **Reproductive health services.** Female clients who are pregnant or of childbearing age should receive or be referred to reproductive health services. HIV-infected pregnant women should be referred to providers who can provide prevention counseling and education, initiate medical therapy to prevent perinatal transmission, and provide appropriate care based on established treatment guidelines.
   5. **Drug or alcohol prevention and treatment.** Clients who abuse drugs or alcohol should receive or be referred to substance or alcohol abuse prevention and treatment services.
   6. **Mental health services.** Clients who have mental illness, developmental disability, or difficulty coping with HIV diagnosis or HIV-related conditions should receive or be referred to appropriate mental health services.
   7. **Legal services.** Clients who test positive should be referred to legal services, as soon as possible, after learning their test result for counseling on how to prevent discrimination in employment, housing, and public accommodation (disclosing their status only to those who have a legal need to know).
   8. **Sexually transmitted diseases (STDs) screening and care.** Clients who are HIV-infected or at increased risk for HIV are at risk for other STDs and should receive or be referred for STI screening and treatment.
   9. **Screening and treatment for viral hepatitis.** Many clients who are HIV-infected or at increased risk for HIV also are at risk for acquiring viral hepatitis (A, B, and C). Men who have sex with men and IDUs should be vaccinated for hepatitis A. All clients without a history of hepatitis B infection or vaccination should be tested for hepatitis B and if not infected, should receive or be referred for hepatitis B vaccination. In addition, clients who inject drugs should be routinely recommended testing for hepatitis C. All clients who are infected with viral hepatitis should be referred for appropriate treatment. Further guidance is available.
   10. **Other services.** Clients might have multiple needs that can be addressed through other HIV prevention and support services (e.g., assistance with housing, food, employment, transportation, child care, domestic violence and legal services). Addressing these needs can help clients access and accept medical services and to adopt and maintain behaviors that
reduce their risk for HIV transmission and acquisition. Clients should receive referrals, as appropriate, for identified needs.

b. Implement and manage referral services

Clients should receive help accessing and completing referrals, and the completion of referrals should be verified. In the context of HIV prevention counseling and testing, the following elements should be considered essential to the development and delivery of referral services:

1. **Assess client referral needs.** Providers should consult with the client to identify essential factors that a) are likely to influence the client's ability to adopt or sustain behaviors to reduce risk for HIV transmission or acquisition, or b) promote health and prevent disease progression. Assessment should include examination of the client's willingness and ability to accept and complete a referral. Service referrals that match the client's self-identified priority needs are more likely to be successfully completed than those that do not. Priority should be placed on ensuring that HIV-infected clients are assessed for referral needs related to medical care and prevention and support services aimed at reducing the risk for further transmission of HIV. When a provider cannot make appropriate referrals or when client needs are complex, clients should be referred to a case management system.

2. **Plan the referral.** Referral services should be responsive to the client's needs and priorities and appropriate to their culture, language, sex, sexual orientation, age and developmental level. In consultation with clients, providers should assess and address any factors that make completing the referral difficult (e.g., lack of transportation or child care, work schedule, cost, etc.). Research has indicated that referrals are more likely to be completed if services are easily accessible to clients.

3. **Help clients access referral services.** Clients should receive information necessary to successfully access the referral service (e.g., contact name, eligibility requirements, location, hours of operation and telephone number). Research has indicated that providing assistance (e.g., setting up appointments, addressing transportation needs, etc.) for some clients promotes completion of referrals. Clients must give consent before identifying information can be shared to help complete the referral. Outreach workers and peer counselors/educators can be an important and effective resource to help clients identify needs and plan successful referrals. Referrals are more likely to be completed after multiple contacts with outreach workers.

4. **Document referral and follow-up.** Providers should assess and document whether the client accessed the referral services. If the client did not, the provider should determine why; if the client did, the provider should determine the client's degree of satisfaction. If the services were unsatisfactory, the provider should offer additional or different referrals. Documentation of referrals made, the status of those referrals, and client satisfaction with referrals should help providers better meet the needs of clients. Information obtained through referral follow-up can identify barriers to completing the responsiveness of referral services in addressing client needs, and gaps in the referral system.

5. **Ensure high-quality referral services.** Providers of referral services should know and understand the service needs of their clients, be aware of available community resources, and be able to provide services in a manner appropriate to the clients' culture, language, sex, sexual orientation, age, and developmental level, given local service system limitations.

6. **Authority.** Staff members providing referrals must have the authority necessary to accomplish a referral. Supervisors must ensure that staff members understand referral policy and protocol and have the necessary support to provide referrals. This requires the authority of one provider to refer to another (e.g., through memoranda of agreement) or to obtain client consent for release of medical or other personal information.
INTERVENTION DEFINITIONS
INTERVENTION CATEGORIES

HIV Prevention Intervention Categories

Individual Level Outreach

Health Communication/ Public Information (Social Marketing)

Hotlines
Internet Chat Rooms

PSAs, Electronic or Print Media, Media Campaigns, Clearinghouses, Internet Web Sites

Group Educational Presentations, Lectures, Health Fairs (Group Outreach)

Interventions Delivered to Individuals (IDI - including RESPECT)

Interventions Delivered to Groups (EBI or other CDC approved curricula)

Comprehensive Risk Counseling Services (CRCS - including CLEAR)

Partner Services

Partner Elicitation

Partner Notification

Partner Counseling and Referrals

Community Level Interventions

Other Interventions

Patient Incentive Program (PIP)
Integration of IDU opioid treatment & HIV/STD/hepatitis prevention services

HIV Screening

Needle Exchange

Policy and/or Structural Interventions
THE IDEAL CONTINUUM OF HIV PREVENTION AND TREATMENT
Effective programs work on many levels simultaneously: individual levels, social network and community levels, and at the societal structure level. They address the needs and issues relevant to both people at risk and those already infected in support of a continuum of HIV prevention and treatment where:

- Individuals use a full array of existing services and interventions to adopt and maintain risk-reduction behaviors;
- Individuals determine their HIV status through voluntary counseling and testing as early as possible after possible exposure to HIV;
- If HIV negative, individuals use the full array of existing services and interventions to adopt and maintain risk-reduction behaviors;
- If HIV positive, individuals use quality prevention services and work to adopt and sustain lifelong protective behaviors to avoid transmitting the HIV/STD and/or hepatitis to others;
- If HIV positive, individuals enter the care system as soon as possible to reap the benefits of ongoing care and treatment;
- Once in the care system, individuals benefit from comprehensive high quality services, including primary medical care, mental health and substance abuse treatment services, treatment for HIV infection, and treatment of opportunistic and other infections like STDs, hepatitis and TB; and
- With their providers and support networks, individuals develop strategies to optimize adherence to their prescribed therapies.

DEFINITIONS

Client-centered
Counseling is tailored to the behavior, circumstances and special needs of a person. Focus on personal risk assessment, development of a personalized action plan, and the decision to test for HIV is important.

Harm reduction
Harm reduction is a set of strategies and tactics that encourage high-risk individuals to reduce harm to themselves and to the community as a result of their HIV risk behavior and illicit substance use. In allowing users to access tools to become healthier, they are given the power to protect themselves, their loved ones and their communities.

COMPREHENSIVE RISK COUNSELING SERVICES (CRCS)

Comprehensive Risk Counseling Services is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. It is intended for persons (positive or negative) having, or likely to have difficulty initiating or sustaining practices that reduce or prevent the acquisition, transmission, or re-infection of HIV. The goal of CRCS is to prevent and stop the spread of HIV.

Cultural competence/proficiency/responsiveness
Providers of CRCS should strive toward proficiency regarding culture and other aspects of diversity, as measured by an assessment of the target population and in accordance with the New Jersey CLAS Standards.

Who should receive CRCS?
CRCS is a voluntary, confidential, client-centered intervention intended for persons (regardless of HIV status) who are having, or who are likely to have, difficulty initiating and sustaining safer sexual and drug use behaviors. CRCS is intended for persons at highest risk of transmitting or acquiring HIV whose needs are not met, nor is behavior influenced by less intensive HIV prevention interventions, such as individual-level health education, group-level strategies, or HIV counseling and testing.
CHARACTERISTICS OF A POTENTIAL CRCS PARTICIPANT

- Habitually retesting for HIV
- Failure to respond to other, less-intensive interventions
- High likelihood of having transmitted HIV to others, or indifference to risks posed to sexual and needle-sharing partners
- Childhood trauma related to sexual/physical or emotional abuse
- Cognitive or developmental disability
- Severe and persistence mental illness, particularly bipolar disorder or sexual addiction
- Other acute mental health issues
- Substance abuse
- Exchange of sex for money
- Low self-esteem or feelings of hopelessness
- Chronically dysfunctional living situations
- Chronic history of STD infections
- Multiple unplanned pregnancies
- Extreme difficulty or inability to negotiate safer behaviors (sexual, needle sharing)

SEVEN ESSENTIAL COMPONENTS OF CRCS

1. **Client recruitment and engagement.** The intent of this component is to bring clients into CRCS and to engage them as to the nature of the service and its potential benefit to him/her. Recruitment and engagement includes:
   - Creating referral mechanisms
   - Building relationships/partnering with other agencies, and
   - Actively requesting referrals for the benefit of the client.
   Effective recruitment and engagement should be an active process and should address the clients risk behavior as a public health concern; the client’s own concerns about his/her risky behavior; the process of change, and the client’s past and present behaviors beyond HIV risk.

   Building trust and rapport is a critical outcome of recruitment and engagement, and this often takes multiple sessions to accomplish.

2. **Client assessment.** The intent of this component is to engage clients to gauge client needs, strengths and weaknesses in nine key areas:
   - Engagement in HIV-related clinical and case management services
   - Connections with partners and other personal support systems
   - Physical and emotional health status
   - Personalization of HIV risk
   - Financial, legal and housing situations
   - Cultural issues

   The assessment should be tailored to meet the client’s immediate need, provide a baseline for CRCS, and be a measure for future progress. The assessment should be prospective, as well as retrospective, with clarification as to future directions and ways to proceed.

   Screening and assessment should include a comprehensive assessment of HIV, hepatitis and STD risks, and medical and psychosocial service needs, including STD evaluation and treatment, and substance abuse treatment.

3. **Development of a client-centered prevention plan.** The intent of this component is to provide an HIV-prevention focus on future interactions with the client and a mapping of future direction of CRCS sessions. A prevention plan should be in writing, in a format approved by the DHAS, and it should be collaboratively developed with the client. The plan should include three to ten objectives--the majority
of which clearly reduce HIV-related harm or reduce HIV risk. The objectives must be SMART: Specific, measurable, achievable, realistic, and time-phased. For those living with HIV/AIDS, the objectives should include adherence.

Objectives should include actions of the client, service providers and the case manager. Objectives should change when needed and should include referrals to known and trusted providers. At the onset, the prevention plan should include planning for eventual self-sufficiency and discharge from CRCS. For clients who do not know their HIV status, the prevention plan must address eventual HIV testing and periodic retesting. A written plan must be included in every client record.

4. **Multiple-session HIV risk-reduction counseling.** Ongoing risk-reduction counseling should be the intent of ensuing CRCS sessions. Within the larger context of HIV risk-reduction, CRCS should address critical issues, such as the pros and cons of disclosure, condom issues and use of condoms, symptoms of psychosocial distress and how this impacts their risky behaviors, and alternate ways of dealing stress.

Written documentation on every client record must include:
- Progress made on the objectives in the prevention plan
- Major HIV-related changes or incidents arising in each session or reported as occurring between sessions
- Results of previous referrals and referral to new services
- Other information deemed relevant by the case manager

5. **Active coordination of services with follow-up.** The intent of this component is to ensure that the services provided to the client are well coordinated and focused on the achievement of the objectives in the prevention plan. All services provided to the client should be coordinated, including, but not limited to:
- Services in support of the client’s employment, housing, legal, and economic situation;
- Services related to the client’s relationships;
- Substance use and mental health services; and
- Clinical services.

Referrals must be active, involving an assessment of whether the referral worked for the client, facilitation of the active referral, and developing a follow-up plan after giving the referral.

Client records must include written notes regarding coordination of services and active follow-up.

Positive clients must be connected to Ryan White case management services and all case management service should be coordinated by the Ryan White case manager (RWCM) to avoid duplication of services. Comprehensive Risk Counselors (CRC) should establish formal communication with the (RWCM) to coordinate care.

6. **Continuous reassessment.** Assessment is an ongoing process that must be documented and performed routinely.

7. **Discharge from CRCS.** This component ensures that clients eventually become self-sufficient, not dependent on continuous CRCS to maintain HIV risk-reduction.

Client notes must include written comments on progress leading to CRCS discharge, a follow-up plan for each clients, and client perceptions of future needs as they maintain lower HIV risk behavior.

**WHEN**
CRCS is conducted at a time of day appropriate to the clients needs.
WHERE
CRCS is conducted in a variety of settings, all private and confidential, appropriate to the clients needs.

HOW OFTEN
CRCS must occur once per month for the case to remain an active. Recommendation for CRCS are as follows:
• First two months of CRCS the client should be seen weekly with a minimum duration of 30 minutes per session
• Depending on individual client progress, CRCS can taper sessions to twice per month until discharge
• A minimum of 60 minutes is the standard for CRSC in increments of no less than 30 minutes
• Multiple sessions are intended to be carried out over a six-month period
• Reassessment must occur at the end of six months to evaluate whether or not a client still meets the criteria for CRCS. If the client needs more/less intensive care, they should be referred/transfered to more appropriate services.

CASELOAD
DHAS/agency will negotiate optimum case load as per agency need/resources and intervention mix.

OPTIMUM QUALIFICATIONS FOR CRCS STAFF
• Minimum of either a B.S./B.A degree in human services, behavioral sciences or other related field. Education may be substituted with extensive experience in the field of HIV prevention.
• Demonstrate competence in regard to basic HIV facts, client-centered and risk reduction counseling. Such competency could be demonstrated through training, certification or other acceptable means.
• Competence in regard to cultural and other diversity
• Must be able to present the materials in an understandable and non-judgmental manner
• Regular and ongoing supervision by a qualified manager.

QUALITY ASSURANCE
Providers must:
• Develop a mechanism for client feedback;
• Provide evidence of internal and external quality assurance measures;
• Adhere to ascribed standards will ensure quality services; and
• Utilize and file participation records.

FORMATIVE EVALUATION
Formative evaluation methods are used in the planning and development phase of an intervention, as well as throughout its implementation, to gain a more in-depth understanding of the target population, its risk behaviors, the context of those behaviors, and the best way to help persons in the target population lower their risk.

Examples of formative evaluation are:
• Interviews
• Focus groups
• Pre-testing new materials

Formative evaluation methods used in intervention development and revision should be listed and briefly described in intervention plans and progress reports submitted to DHAS.

PROCESS EVALUATION
Agencies must describe for whom, what, when, and how data will be collected to document activities, as well as demographic information on clients served.
OUTCOME EVALUATION
Outcome evaluation is a report of results from pre/post intervention tests, behavioral change surveys, etc. Agencies must describe outcome measure mechanisms to be used in the project.

ADDITIONAL INFORMATION ON CRCS
- Providers of CRCS should have protocols in regard to safety of clients, volunteers, and staff.
- Each provider shall develop a plan for crisis intervention.
- Each provider shall develop and follow sound ethical standards, particularly with regard to doing harm to clients in the following areas:
  - Confidentiality
  - Boundaries
  - Dual relationships
  - Conflict of interest
  - Duty to warn and protect
  - Duty of adhere to the Human Service Code of Ethics
  - Duty to report unethical behavior
  - Referral to other services as needs change
  - Structuring a relationship with the Ryan White Care Act case manager to best detail how to transfer and/or share clients within the confidentiality provisions set by state and federal entities

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<thead>
<tr>
<th>Intervention</th>
<th>Implementation</th>
<th>Unit of Service</th>
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| CRCS         | • Recruit and engage client  
• Screen, assess and discuss risk behaviors  
• Develop client-centered service plan to also include a risk or harm reduction plan.  
• Signed consent in file  
• Provide HIV risk-reduction counseling by a DHAS-trained prevention case manager  
• Coordinate client services with active follow-up  
• Monitor and reassess clients’ needs and progress  
• Coordinate with Ryan White Care Act case manager  
• Comply with CRCS standards  
• Comply with DHAS data collection and reporting  
• Assess client needs for more extensive services  
• If found to be inappropriate for COMPREHENSIVE RISK COUNSELING SERVICES, the client must be referred, and documented, to more appropriate services. | To remain active the client must be seen a minimum 1 hr. (cumulative) per month. Minimum duration of a CRCS session will be 30 minutes |

OUTCOME INDICATORS
1. Client recruitment and engagement goals achieved
2. CRCS includes seven criteria for case management for all participants
3. Increased access to medical care and support services
4. Increased access to substance abuse treatment
5. Increased condom use
6. Decrease in injection activity, or increased use of clean syringes.
ADDITIONAL COMPONENTS FOR CRCS WHEN WORKING WITH HIV POSITIVE CLIENTS

There is no single intervention that should be used for a PWP program. A PWP program should:
- Be multifaceted;
- Offer choices (e.g., where to go for services);
- Be life-long; and
- Involve PLWH from the ground up.

Components specifically requested by persons living with HIV/AIDS (PLWH) include:
- Staying healthy and feeling good;
- Looking good;
- Empowerment;
- A sense of community responsibility;
- Having fun; and
- Accepting their new identity (e.g., they are now gay and HIV+).

From the field
- Alignment with other prevention providers
- HIV treatment regimens and side effects
- Consistent noted attempts to create a plan to notify sex/needle sharing partners (i.e. NAP)
- Substance use and substance abuse methodologies
- Sexual risk methodologies
- Skills at discussing sex and drug use at client level
- Learning stress reduction strategies
- Knowledge of HIV disease progression
- Knowledge of service agencies
- Medication adherence issues
- Disclosure skills
- Dating skills
- Opportunistic infections
- Maintaining health by ensuring procurement of needed entitlements, education, information on clinical care and mental health services.
- Eligibility and referrals to Ryan White case management services
- Evaluation/referral for HIV/STD/hepatitis screening and vaccinations/treatment
- Evaluation/referral to substance abuse treatment, mental health and housing

CONCERNS OF PLWH
- PLWH have a preference for professionally facilitated support groups, rather than those that are peer lead.
- PLWH experience feelings of isolation in social activities but would like to be more involved (e.g., concerts, picnics, dances, ball games, movies, etc.).
- PLWH would like to see new and interesting programs. Incentives, off-site activities and spirituality were specifically cited in feedback DHAS program staff have received.

IMPLEMENTATION AND EVALUATION
- Protection of client confidentiality
- Sexual and drug history upon intake
- Client-centered approaches
INDIVIDUAL LEVEL OUTREACH (ILO)

Individual level outreach consists of HIV/AIDS educational and skills building interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients’ neighborhoods or other areas where clients typically congregate. In addition to the above standard, ILO usually includes distribution of condoms, bleach, sexual responsibility kits and educational materials. Outreach also includes referrals to counseling and testing and other social services and incorporates peer opinion models.

NOTE: Distribution of materials, condoms, and safe sex kits will not be considered an ILO.

GOAL OF OUTREACH
ILO seeks to lower risk behavior in individuals by providing motivation, knowledge, risk-reduction materials and referrals to services that support behavior change.

CULTURAL COMPETENCE/PROFICIENCY
Providers of ILO should strive toward proficiency in regard to culture and other aspects of diversity as measured by an assessment of the target population and in accordance with the New Jersey CLAS Standards.

WHO
ILO is directed toward a clearly defined target population of individuals at high risk for acquiring or spreading HIV. Such populations are further characterized by gender, age, race, ethnicity, risk behavior, physical or mental disability, and/or geographic location.

WHERE
Formative evaluation and a community needs assessment provides agencies with areas of concentration based on targeted behavior, i.e., drug use. ILO programs access at-risk individuals on the street, in malls, parks or other settings where members of the target population are likely to be found. The provider makes ILO accessible by going into the community.

WHEN
ILO occurs at times when members of the target population are likely to be present, as determined in the planning stage of the intervention.

HOW OFTEN
ILO strives for consistency, ongoing contact and reinforcement with individuals.

WHAT
- ILO should be provided in a client-centered and harm reduction manner, tailored to the behavior, circumstances and special needs of a person.
- ILO involves one-on-one contact, which includes:
  - Educational materials (brochures, safer sex kits, bleach kits, etc.),
  - Referrals, and
  - Informative discussions on sexual risk, needle-sharing behaviors and the overall relationship between substance use and risk behavior.
- Outreach workers strive to help clients develop skills and motivation to adopt and maintain safer behaviors over time. They disseminate information (verbal, written or recorded) that is accurate, up-to-date, culturally appropriate and non-judgmental. They distribute materials (approved by the DHAS), which are of good/effective quality, current and appropriate to the need of the target population. Outreach workers provide referrals to appropriate services that follow a process of:
  - Helping the client define their priorities,
  - Discussing and offering options,
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- Offering referrals,
- Making referrals to known and trusted services,
- Assessing whether suggested referrals worked for the client,
- Facilitating an active referral
- Follow-up on success

OPTIMUM QUALIFICATIONS OF STAFF

- Outreach workers are usually peers or have extensive experience in working with the target population, are able to refer clients to services of which they are knowledgeable.
- Outreach workers speak the language of the clients.
- Providers of outreach should be able to demonstrate competence in regard to basic HIV facts. Such competence could be demonstrated through training, certification or other acceptable means.
- The peers and professionals providing outreach must be competent in regard to culture and other diversity and be able to present the materials in an understandable and non-judgmental manner.

QUALITY ASSURANCE

Providers must:

- Develop a mechanism for client feedback (surveys, complaints);
- Make certain supervisors and/or project management officers (PMOs) should assure quality of outreach through periodic observations;
- Schedule regular meetings to be held among outreach workers and supervisors to discuss relevant issues (barriers, successes, problems, etc.). Documentation and action plans resulting from such meetings will provide quality improvement for the program; and
- Adhere to ascribed standards will ensure quality services.

FORMATIVE EVALUATION

Formative evaluation methods are used in the planning and development phase of an intervention, as well as throughout its implementation, to gain a more in-depth understanding of the target population, their risk behaviors, the context of those behaviors, and the best way to help them lower their risk.

Examples of formative evaluation are:

- Interviews
- Focus groups
- Pre-testing new materials

Formative evaluation methods used in intervention development and revision should be listed and briefly described in intervention plans and progress reports submitted to the DHAS.

PROCESS EVALUATION

Agencies must describe who, what, when, and how data will be collected to document activities, as well as demographic information on clients served.

OUTCOME EVALUATION

Outcome evaluation includes the report of results from pre/post intervention tests, behavioral change surveys, etc. Agencies must describe outcome measure mechanisms to be used in the project.

OTHER COMPONENTS

Outreach programs must have a field safety plan in place to protect outreach workers.
### Intervention

<table>
<thead>
<tr>
<th>Individual level outreach (face-to-face client contact)</th>
<th>Implementation</th>
<th>Unit of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Identify target population</td>
<td></td>
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<tr>
<td>- Conduct outreach during the hours that will reach most of the targeted population (evening or early morning)</td>
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<tr>
<td>- Assess client needs</td>
<td></td>
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<tr>
<td>- Document client demographics and risk behaviors</td>
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</tr>
<tr>
<td>- Provide health education messages and skills for risk reduction information/supplied and referrals</td>
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<tr>
<td>- Promote agency services; recruit clients to participate in CRCS, GLI, C&amp;T, etc., and document/track clients accessing services</td>
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<tr>
<td>- Sixty to seventy percent of outreach workers’ time is in the field</td>
<td></td>
<td>10 to 20 min.</td>
</tr>
</tbody>
</table>

### OUTCOME INDICATORS

1. Evidence that high risk target areas have been reached
2. Evidence that the target population has been reached
3. Increase HIV testing
4. Number of successful referrals as a result of outreach
5. Requests for outreach activities in the community
Health communication/public information (often referred to as social marketing) involves elements of large (TV, radio, newspaper) and small (pamphlets, brochures, handouts, etc.) media. It can be used to target a narrow segment of the population or to reach broad audiences within a city, state, or country. Activities vary by the size of the target group and the interactive-level of the medium being used. This intervention type is most effective among low risk individuals and it is useful to maintain and reinforce low risk behaviors (Holtgrave, Qualls, Curran, et al., 1995). It is also effective among those at high risk, when accompanied by more intensive, face-to-face contact.

GOAL OF PUBLIC INFORMATION
Public information seeks to:
- Dispel myths about HIV transmission;
- Support volunteerism for HIV prevention programs;
- Reduce discrimination toward persons with HIV/AIDS or persons perceived to be at risk for HIV infection;
- Promote support for strategies and interventions that contribute to HIV prevention in the community; and,
- Offer support and referrals leading to behavior change.

CULTURAL COMPETENCE/PROFICIENCY
Providers of public information should strive toward proficiency in regard to culture and other aspects of diversity, as measured by an assessment of the target population and in accordance with the New Jersey CLAS Standards.

WHO
Public Information can target the general population, as well as specific populations. Audiences are targeted as a result of formative evaluation and community needs assessment.

WHERE
Public Information should be delivered in key locations as determined by the formative evaluation process and community needs.

WHEN
Public Information programs are delivered at the most appropriate times for the target population.

HOW OFTEN
Public information campaigns with repeated messages, delivered over an extended period of time, are more effective.

WHAT
- Methods include one-on-one or group discussions, distribution of risk-reduction materials, small media and other social marketing strategies.
- Messages are tied to the specific goals of PI and are tailored to the target population or general audience.
- Messages and materials must be sensitive and appropriate to the target audience’s values, needs, and interests and must be pre-tested to assure understanding by, and relevance to, the target audience. All materials must be pre approved by the DHAS.
- PI should reflect the principles of harm reduction.
OPTIMUM QUALIFICATIONS OF STAFF

- Programs are designed by a combination of professionals and peers. For PI to be effective, community representatives must be involved in the planning and development of activities.
- Providers of outreach should be able to demonstrate competence in regard to basic HIV facts. Such competence could be demonstrated through training, certification or other acceptable means.
- The peers and professionals providing outreach must be competent in regard to culture and other diversity and be able to present the materials in an understandable and non-judgmental manner.

QUALITY ASSURANCE

Providers must:
- Develop a mechanism for client feedback;
- Provide evidence of internal and external quality assurance measures;
- Adhere to ascribed standards will ensure quality services; and

FORMATIVE EVALUATION

Formative evaluation methods are used in the planning and development phase of an intervention, as well as throughout its implementation, to gain a more in-depth understanding of the target population, their risk behaviors, the context of those behaviors, and the best way to help them lower their risk.

Examples of formative evaluation are:
- Interviews
- Focus groups
- Pre-testing new materials

Formative evaluation methods used in intervention development and revision should be listed and briefly described in intervention plans and progress reports submitted to DHAS.

PROCESS EVALUATION

Agencies must describe for whom, what, when, and how data will be collected to document activities, as well as demographic information on clients served.

OUTCOME EVALUATION

Outcome evaluation is a report of results from pre/post intervention tests, behavioral change surveys, etc. Agencies must describe outcome measure mechanisms to be used in the project.

OTHER COMPONENTS

Providers of PI must have written protocols in regard to the safety of clients, staff, volunteers and staff.

Expected immediate outcomes may include:
- Greater awareness and/or knowledge of HIV/STD issues
- Knowledge of personal risk
- Knowledge of how to access HIV/STD-related services
- Greater trust of the prevention service workers
**INTERVENTION DELIVERED TO INDIVIDUALS**

**What is an Intervention Delivered to Individuals (IDI)?**
IDI’s purpose is to provide client-centered counseling session based on a person’s needs, resources, readiness to change and circumstances. Individual counseling blends motivational interviewing with public health education and skills building for reduction of HIV risk. It emphasizes delivery of information and teaching strategies for behavior change. IDI a gateway intervention to introduce client to agency services, establish rapport and build motivation.

IDI is one-on-one interaction with the intent to assist clients in learning and applying skills aimed at reducing a risk behavior or addresses a factor(s) which influence(s) a risky behavior. **This category does not include comprehensive risk counseling services or individual level outreach.** An IDI provider should always attempt to discuss issues surrounding HIV risk.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Implementation</th>
<th>Unit of Service</th>
</tr>
</thead>
</table>
| Individual risk-reduction counseling session | • Document client demographics and behavioral risk  
• Document discussion of presenting issues and HIV risk behaviors in a progress note using a DAP format  
• Provide counseling and document length of time spent in session  
• Provide skills-building exercises  
• Document client referrals and outcomes  
• Provide active follow-up | 30 minutes |
INTERVENTIONS DELIVERED TO GROUPs (IDG)

Interaction with a group of clients with the intent to assist clients in learning and applying skills aimed at reducing a risk behavior. Interventions Delivered to Groups (IDG) must have a skills development component. Many of the Effective Behavioral Interventions (EBIs) are small group and are multi-session. Research has demonstrated that programs using multiple sessions are more effective than single-session interventions. However, there are EBIs, such as VOICES/VOCES, that are one time interactions.

GOAL OF IDG
IDG seeks to lower risk behavior among small groups of individuals who are at highest-risk of acquiring or transmitting HIV infection.

WHO
IDG occurs in small group settings with approximately five (5) to fifteen (15) individuals who are at high-risk of acquiring or transmitting HIV infection.

CULTURAL COMPETENCE/PROFICIENCY
Providers of IDG should strive toward proficiency in regard to culture and other aspects of diversity, as measured by an assessment of the target population and in accordance with the New Jersey CLAS Standards.

WHERE
IDG locations are convenient and accessible to members of the target group.

WHEN
Meeting times are convenient to members of the target group.

HOW OFTEN
Multiple sessions are preferred as they allow for opportunities to develop and discuss topics in more depth (such as real experiences between sessions) and time for skills reinforcement. As the DHAS has specific formats outlining multiple and retreat-type settings, agencies must describe and submit the selected format with the rationale for the chosen method.

WHAT
Curricula and assorted materials used for the intervention must be pre-approved by the DHAS.

Educational interventions include:
- Promotion and reinforcement of safer behaviors
- Interpersonal skills training and support in negotiating safer sexual and needle-sharing behaviors
- Emphasis on the relationship between substance use and risky behaviors
- Appropriate written materials
- Referral and follow-up system

Educational methods may include:
- Role plays
- Skills building exercises
- Games
- Demonstrations
- Appropriate referrals
OPTIMUM QUALIFICATIONS OF STAFF

- IDG providers should be able to demonstrate competence with regard to basic HIV facts, eff. This competence could be demonstrated through training, certification or other acceptable means.
- IDG providers may be peers or professionals who are competent in regard to culture and other diversity and able to present the material in an understandable and non-judgmental manner.

QUALITY ASSURANCE
Providers must:

- Develop a mechanism for client feedback;
- Provide evidence of internal and external quality assurance measures;
- Adhere to ascribed standards will ensure quality services; and
- Utilize and file participation records.

FORMATIVE EVALUATION
Formative evaluation methods are used in the planning and development phase of an intervention, as well as throughout its implementation, to gain a more in-depth understanding of the target population, their risk behaviors, the context of those behaviors, and the best way to help them lower their risk.

Examples of formative evaluation are:

- Interviews
- Focus groups
- Pre-testing new materials

Formative evaluation methods used in intervention development and revision should be listed and briefly described in intervention plans and progress reports submitted to the DHAS.

PROCESS EVALUATION
Agencies must describe for whom, what, when, and how data will be collected to document activities, as well as demographic information on clients served.

OUTCOME EVALUATION
Outcome evaluation is a report of results from pre/post intervention tests, behavioral change surveys, etc. Agencies must describe outcome measure mechanisms to be used in the project.

Expected immediate outcome

- Increased proficiency by the client to put into practice taught skills.

OTHER

Providers of IDG should have protocols in place to protect the safety of clients, volunteers and staff.
<table>
<thead>
<tr>
<th>Intervention</th>
<th>Implementation</th>
<th>Unit of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single or Multiple session groups</td>
<td>• Document client demographics and behavioral risk</td>
<td>Minimum 5 clients per group; format to</td>
</tr>
<tr>
<td>A structured workshop or support group</td>
<td>• Must have formal, written and DHAS-approved curricula</td>
<td>be determined by grantee</td>
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<tr>
<td>with a skilled facilitator and an approved curriculum</td>
<td>• Document discussion of risk behaviors</td>
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<td></td>
<td>• Provide HIV/STD/hepatitis C information</td>
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<td></td>
<td>• Provide skills-building exercises</td>
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<td></td>
<td>• Document issues discussed</td>
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<td></td>
<td>• Ensure ground rules are created and implemented</td>
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<tr>
<td></td>
<td>• Staff should be available before and after group sessions to provide referrals to other prevention services</td>
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<td></td>
<td>• Comply with DHAS reporting</td>
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<td></td>
<td>• Sign-in sheets required</td>
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<tr>
<td></td>
<td>• Describe the length of time each client spends in group sessions</td>
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</table>
COMMUNITY-LEVEL INTERVENTIONS (CLIs)

CLIs seek to change the attitudes, norms, and values as well as the social and environmental context of risk behaviors of an entire community, not simply individual members of the community. CLIs are based upon research among community members and incorporate community input and involvement in program design, implementation, and evaluation. Ideally, CLI programs utilize peer networks within a community as a means of increasing the effectiveness of the CLI and of sustaining intervention efforts after professional service providers are gone.

GOAL OF COMMUNITY-LEVEL INTERVENTIONS (CLI)
CLI seeks to change the attitudes, norms and values, as well as the social and environment context of risk behaviors, of an entire community. They are meant to move the members of the community, incrementally, closer to healthier sexual and needle-use behaviors.

WHO
The target audience is a well-defined community or target population that can be distinguished according to geography, ethnicity, sexual orientation, gender, age, behavior or some self-defining criteria.

CULTURAL COMPETENCE/PROFICIENCY
Providers of CLI’s should strive toward proficiency in regard to culture and other aspects of diversity, as measured by an assessment of the target population and in accordance with the New Jersey CLAS Standards.

WHERE
Interventions are delivered in convenient and appropriate community settings. Programs must be accessible to the target population.

WHEN
Interventions are delivered at times that are appropriate to the target audience (as determined by the formative evaluation).

HOW OFTEN
CLIs are meant to saturate the environment on a consistent and ongoing basis with prevention messages.

WHAT
- CLI is based on the concept that certain norms, values, beliefs and social environmental factors influence how members of the community act. This includes influence on sexual and drug use behaviors.
- The content and methods of the intervention are based on the needs of the community as identified through the formative evaluation. Community members at all levels are enlisted to participate in some capacity in the delivery and reinforcement of the intervention.
- Activities that research has found effective include:
  - Community outreach
  - Mobilization and organization of community efforts
  - Widespread dissemination of appropriate prevention materials (condoms, bleach kits, role model storied, and written material approved by the DHAS)
  - Peer discussions
  - Community-wide events
- A community-level intervention influences and saturates the whole community (not individuals or groups) with prevention messages and materials on a consistent and on-going basis to support healthier behavior among members of the targeted community.
OPTIMUM QUALIFICATIONS OF STAFF
- Formal and informal community leaders and peer networks deliver the messages throughout the entire community by means of CLI’s various activities.
- Providers of CLI should be able to demonstrate competence in regard to basic HIV facts. Such competence could be demonstrated through training, certification or other acceptable means.
- The peer and professionals providing CLI must be competent in regard to culture and other diversity and be able to present the materials in an understandable and non-judgmental manner.

QUALITY ASSURANCE
Providers must:
- Have in place a system for client feedback (satisfaction surveys),
- Adhere to ascribed standards,
- Provide evidence of internal and external quality assurance measures, and
- Utilize and file participation records.

FORMATIVE EVALUATION
Formative evaluation methods are used in the planning and development phase of an intervention, as well as throughout its implementation, to gain a more in-depth understanding of the target population, their risk behaviors, the context of those behaviors, and the best way to help them lower their risk.

Examples of formative evaluation are:
- Interviews
- Focus groups
- Pre-testing new materials

Formative evaluation methods used in intervention development and revision should be listed and briefly described in intervention plans and progress reports submitted to the DHAS.

PROCESS EVALUATION
Agencies must describe for whom, what, when, and how data will be collected to document activities, as well as demographic information on clients served.

OUTCOME EVALUATION
Outcome evaluation is a report of results from pre/post intervention tests, behavioral change surveys, etc. Agencies must describe outcome measure mechanisms to be used in the project.

OTHER COMPONENTS
Providers of community-level interventions should have protocols to protect the safety of clients, volunteers and staff.
HIV prevention counseling is a client-centered, harm-reduction-oriented exchange designed to support individuals in making behavior changes to help reduce their risk of acquiring or transmitting HIV and to have clients test to learn their antibody status.

The objectives of a brief HIV prevention counseling session is to assess actual and self-perceived HIV/STI risk, to help the participant recognize barriers to risk-reduction, to negotiate an acceptable and achievable risk-reduction plan, and to support patient-initiated behavior change.

**Client-centered**
Counseling is tailored to the behavior, circumstances and special needs of a person. A focus on personal risk assessment, development of a personalized action plan, and the decision to test for HIV is important.

**Harm reduction**
Harm reduction is a set of strategies and tactics that encourage high-risk individuals to reduce harm to themselves and to the community as a result of their HIV risk behavior and illicit substance use. In allowing users to access tools to become healthier, they are given the power to protect themselves, their loved ones and their communities.

**GOALS FOR COUNSELING, TESTING AND REFERRAL**
- To provide a convenient opportunity for persons to learn their serostatus;
- To allow such persons to receive client-centered and harm reduction HIV prevention counseling to help initiate incremental behavior change to prevent the transmission or acquisition of HIV;
- To help persons obtain client-centered, specific and facilitated referrals to receive additional medical care, prevention, psychosocial counseling and other needed;
- To provide prevention services and client-centered referrals for sex and needle-sharing persons;
- Ensure that HIV-infected persons and persons at increased risk offer HIV:
  - Have access to HIV testing to promote early knowledge of their HIV status;
  - Receive high-quality HIV prevention counseling to reduce their risk for transmitting or acquiring HIV; and
  - Have access to appropriate medical, preventive, and psychosocial support services.

**GENERAL PRINCIPLES**
Effective HIV CR+TR is based on the following principles:
- Protect confidentiality of clients who are recommended or receive HIV CTR services
- Obtain informed consent before HIV testing
- Provide clients the option of anonymous HIV testing
- Provide information regarding the HIV test to all who are recommended the test and to all who receive the test, regardless of whether prevention counseling is provided
- Adhere to local, state, ad federal regulations and policies that govern provision of HIV services
- Provide services that are responsive to client and community needs and priorities
- Provide services that are appropriate to the client’s culture, language, sex, sexual orientation, age and development
- Ensure high quality services

**WHO**
- Individuals who have a history of one or more of the following high-risk behaviors:
  - Injection drug use
  - Sex partner of an HIV-infected individual
  - Sex with men who have sex with men
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Division of HIV, STD and TB Services 
Prevention and Education Unit

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- Sex with an injection drug user
- Persons with Tuberculosis, hepatitis B and/or C, or are diagnosed with an STI.
- Exchange sex for drugs or money

- A special emphasis should be placed on members of groups displaying high/increased risk behaviors:
  - Young men who have sex with men
  - People of color
  - Women

CULTURAL COMPETENCE/PROFICIENCY
Providers of counseling, testing and referral should strive toward proficiency in regard to culture and other aspects of diversity, as measured by an assessment of the target population and in accordance with the New Jersey CLAS Standards.

WHERE
Possible sites for counseling and testing are:
- Local health departments
- Community-based organizations
- Substance abuse treatment centers
- STD clinics
- Outreach
- Family planning clinics
- Drop-in centers

WHEN
- Counseling and testing traditionally takes place during regular working hours. Programs are encouraged to provide evening, weekend and walk-in services.

HOW
The six-step, intervention method process proven to be effective:
1. Introduces and orients the client to the session;
2. Identifies the client’s personal risk behaviors and circumstances;
3. Identifies if and how the client can reduce his/her risk;
4. Assists in the development of the risk-reduction plan; and
5. Makes referrals and supplies support.

STANDARDS FOR GIVING RESULTS
- Assess the client’s readiness.
- Interpret the results.
- Renegotiate or reinforce the client’s existing plan for reducing risk.
- Clients must be offered counseling and testing and provided HIV antibody test results in person from a counselor. Results must not be given over the phone or by mail.
- Make referrals and provide support.

Positive HIV test results
- An HIV test should be considered positive only after both screening (ELISA) and confirmatory (Western Blot) tests are positive. A confirmed positive test result indicates that a person has been infected with HIV. False positive results are rare. However, the possibility of a mislabeled sample or laboratory error must be considered, especially for a client with no identifiable risk for HIV infection. The New Jersey Public Health Laboratory recommends that if the screening and confirmatory tests are reported as positive, the patient should be counseled as positive. However, a second specimen should be drawn and submitted to eliminate any possible handling, labeling or clerical errors. "Previous positive" or "inconclusive" should be noted on the laboratory slip.
• All HIV positive individuals should be counseled about contact elicitation and partner notification. If appropriate, the HIV counselor should take notes about possible partner contacts to give to the Notification Assistance Program (NAP). However, it is not the job of the HIV counselor to contact partners. If possible, an NAP will be on site when positive results are given. This would enable the NAP to compile contact lists, with client consent, after a positive result is given.
• HIV positive patients must be referred or screened for tuberculosis, Hepatitis, and other sexually transmitted infections. As with negative test results, HIV antibody positive test results are to be given to the client only. If a client would like a support person to accompany them to hear results, the counselor must first give the results to the client alone and then the support person can be brought in. HIV counselors who are in need of support when giving positive results back can have a backup person waiting in a separate area, but can only invite that person in with client permission.
• Separate arrangements should be made for the patient to be referred to a private physician (or other care provider) for a more extensive medical or mental evaluation. Individuals with inadequate resources to cover the cost of these services should be referred to the Ryan White CARE grant program.

Services
• Partner referral, as well as any other appropriate referrals, will be provided for all HIV positive clients regardless of whether they test anonymously or confidentially. However, early medical intervention services (such as the Ryan White CARE grant program) require name-linked documentation of their HIV positive status. Clients who test positive anonymously and seek early intervention services may re-test confidentially at the public health site or through their primary care provider.

Negative HIV test results
• A negative test result usually indicates that a person is not infected. Most infected persons will develop a detectable HIV antibody by 3 months after exposure. Because it is likely that a negative test truly indicates the absence of infection, a negative test should seldom be repeated in clients in settings with low HIV prevalence. For clients with a recent possible exposure to HIV who are tested during this "window period," HIV cannot be definitively excluded without follow-up HIV testing.

Indeterminate HIV test results
• Almost all HIV-infected persons with initial indeterminate Western Blot results will develop detectable HIV antibody within one month. All persons with initial indeterminate results should retest in one month.

Inconclusive HIV test results
• Test results are inconclusive when nonspecific or insufficient antibody is present.

No result
• Tests that give a “no result” reading may be the consequence of a sample of insufficient quantity (QNS), a test that has been lost in transit, a sample that has a broken tube or some other error.

ANONYMOUS VERSUS CONFIDENTIAL TESTING
The NJDHSS expects that all publicly funded counseling and testing sites offer confidential testing. Anonymous testing (persons ordering and performing the test do not maintain a record of the name or other personal identifiers of the person whose specimen they are testing) may offer important benefits for the health of individuals and the public, such as earlier entry into medical care. Some persons who would otherwise not have been tested may seek anonymous HIV testing to learn their HIV status. Confidential testing (testing information, including identification, is documented in the client's medical record) is preferred when the client has no clear preference regarding testing format. Confidential testing may facilitate linkage to follow-up counseling and referral for needed services after test results are received.

A personal presentation of the test results:
• Does not involve potentially serious risk to the individual’s privacy.
• Permits the counselor to assess the individual's emotional reaction and provides an opportunity for a private and sensitive explanation of the test result's implications.
• Permits a person with HIV to understand the probability of his/her infectiousness to others and the importance of providing information to those who may have been infected.
• Provides a person with a positive test the opportunity to review material designed to help them live with the infection and apply for assistance.
• Permits a person at risk for HIV infection that has a negative result to understand the methods of reducing the personal risk and the risk to others of exposure to HIV.
• Provides the counselor an opportunity to make referrals to appropriate services.

QUALIFICATIONS FOR HIV PREVENTION COUNSELORS
Who should deliver prevention counseling?
In any setting where HIV testing is provided, existing personnel can be effective counselors if they have the desire, appropriate training and employ the essential counseling elements. Advanced degrees or extensive experience are not necessary for effective HIV prevention counseling, though training is requisite. Counseling training is available (see Ensuring High-Quality HIV Prevention Counseling). In situations where primary health-care providers (e.g., physicians) might not be able to provide prevention counseling, auxiliary health professionals trained in HIV prevention counseling can provide this service. Although peer counseling has been successful in certain situations, research does not support an explicit risk-reduction need or benefit to matching clients with counselors based on the same or similar backgrounds, sex, ethnicity, age or peer group for intervention efficacy.

http://www.cdc.gov/hiv/pubs/ovid/article1table1L.htm
The following skills and counselor characteristics were identified by specialists in the field as important for effective HIV prevention counseling (Technical Expert Panel Review of CDC HIV Counseling, Testing, and Referral Guidelines; February 18--19, 1999; Atlanta, Georgia):

- Completion of standard training courses in client-centered HIV prevention counseling or other risk-reduction counseling models
- Belief that counseling can make a difference
- Genuine interest in the counseling process
- Active listening skills
- Ability to use open-ended rather than closed-ended questions
- Ability and comfort with an interactive negotiating style, rather than a persuasive approach
- Ability to engender a supportive atmosphere and build trust with the client
- Interest in learning new counseling and skills-building techniques
- Being informed regarding specific HIV transmission risks
- Comfort in discussing specific HIV risk behaviors (i.e., explicit sex or drug behaviors)
- Ability to remain focused on risk-reduction goals
- Support for routine, periodic, quality assurance measures
- Counselors may be paid staff
- Staff counselors at publicly funded sites providing counseling, testing and referral services must have successfully completed the CDC course "Fundamentals of HIV Prevention Counseling" or an approved equivalent. All equivalents need to be approved by the DHAS. All counselors are required to participate in yearly training updates and will be evaluated annually. NJDHSS/DHAS will provide client-centered counseling training to qualified individuals at no cost (normally held on a quarterly basis).

QUALIFICATIONS FOR PUBLICLY FUNDED HIV TEST SITES
Organizations may apply to the NJDHSS/DHAS to receive financial assistance for providing counseling and testing services. Preference will be given to organizations that demonstrate the capacity to work with high-risk clientele. The following are some of the criteria used to evaluate a site:

- Staff/organizational capacity to provide services
- Organizational reputation with high-risk clientele
- Americans with Disabilities Act compliance
- Hours of operation/availability to clientele
- Ability to provide confidential services

CONFIDENTIALITY

- Information gathered from the testing or counseling of individuals must be kept strictly confidential. HIV test results should be kept in a separate, locked file. DO NOT keep HIV test results or completed forms with other patient information, such as their medical chart.
- Release of test results to anyone other than the client will not occur without a written consent form from the client or a court order in the face of legal action.
- Counseling of patients wishing to be tested for HIV must be conducted in an area where patient confidentiality and privacy can be assured.
- A patient wanting a copy of his/her HIV test results must be given the information in a form letter (see Forms). Patients will not be given a copy of the original laboratory specimen form, as it is anonymous and easily altered. All patients wanting copies of their results should be counseled as to the ramifications of having this form for possible breaches of confidentiality. HIV counselors must make a copy of this form to put in the patient file.

INFORMED CONSENT
Minors may receive services at New Jersey HIV counseling and testing sites without knowledge or consent of their parent(s) or guardian(s). These protocols are designed for adolescents and adults and are dependent on the individual's capacity to understand the prevention messages. Youth--age 13 and older--are to be
provided services if they are sought freely and without coercion on the part of parents or others. Youth receive their results according to the protocol; results are not shared with parents or guardians.

Other situations, such as language barriers and mental handicaps, may hinder obtaining informed consent. In these instances, please use your best judgment and obtain consent from a translator or guardian, if needed. If special services are needed such as sign language interpretation, or a translator, please contact the WDH HIV/AIDS Program to coordinate these services.

REFERRAL
For HIV-infected clients and those not infected but at increased risk for HIV, linkage with appropriate medical, prevention and other supportive services increases the likelihood of maintaining health, enhancing longevity and quality of life, and reducing the risk of transmitting or acquiring HIV. Advances in medical treatment and prevention interventions underscore the critical and essential role that referral plays in efforts to decrease illness and death associated with HIV infection and AIDS.

All publicly funded counseling and testing sites will be expected to keep an accurate and current list of referral sources for the following typical referral needs, such as:
- Medical evaluation, care and treatment
- Reproductive health services
- Drug or alcohol prevention and treatment
- Mental health services
- STI screening and care
- Screening and treatment for viral hepatitis
- HIV/STI risk-reduction, skills-building activities, if available
- Domestic violence

QUALITY ASSURANCE
Providers must:
- Have in place a system for client feedback (satisfaction surveys),
- Adhere to ascribed standards,
- Adhere to OraQuick protocol,
- Report data, and
- Provide evidence of internal and external quality assurance measures.

EVALUATION
CTR services should be continually evaluated to improve services to clients and provide accountability to stakeholders. Evaluation should be interactive and involve individual persons and organizations affected by the services. In public health settings, the community goals outlined in community health planning processes and other relevant local planning processes could be incorporated.

Written quality assurance protocols should be developed, made available to all staff members providing CTR services, and routinely implemented. All staff members should receive training and orientation regarding quality assurance.

Compliance with written protocols for provision of service to an individual client needs (e.g., appropriate counseling protocols, timely return of HIV test results, referral for services responsive to client's priority needs) is as follows:
- Services and materials appropriate to the client's culture, language, sex, sexual orientation, age and developmental level;
- Staff performance/proficiency (e.g., competence, skills, credentials, and training)
- Supervision of staff members, including routine, timely feedback
- Compliance with program guidelines and performance standards
HIV counseling and testing sites will be evaluated in the following manner:

1. The NJDHSS/DHAS will conduct annual site visits to assess compliance with guidelines outlined in this protocol and will provide a written report to the site manager within 30 days after completion of the site visit.

2. Counseling and testing sites will be expected to complete anonymous patient surveys on services. These surveys will be returned to the NJDHSS. Clients should be asked to fill out the survey after completion of the counseling and testing session. Clients who refuse to fill out the survey can check "declined" at the bottom of the survey. After completing the survey or declining, the client should be given a manila envelope in which to place the survey. Surveys should be mailed to the HIV Prevention Program on a quarterly basis.

3. HIV/AIDS counselors will be evaluated on an annual basis by the NJDHSS (most likely in conjunction with their immediate supervisor) and are required to participate in yearly counselor updates sponsored by the NJDHSS. Evaluation of counseling sessions will be completed with client permission only.

Note: New Jersey Department of Health Public Health Nursing sites are periodically subject to an internal quality assurance process for HIV counseling and testing.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Implementation</th>
<th>Unit of Service</th>
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| Pre-test counseling| • Provide a private and confidential setting  
|                    | • Collaborate on the development of a risk-reduction plan  
|                    | • Signed consent  
|                    | • Facilitate referrals and support  
|                    | Follow OraQuick protocols                                                      | Minimum 20 minutes          |
| Testing            |                                                                                   | 10 minutes                 |
| Post-test counseling| • Provide private and confidential setting  
|                    | • In-person delivery of results   
|                    | • Follow-up on referrals  
|                    | • Assess needs for additional referrals  
|                    | • Reinforce risk-reduction plan                                                  | 30 minutes for HIV-  
|                    |                                                                                  | 60 minutes for HIV+          |
PARTNER NOTIFICATION AND REFERRAL

Partner elicitation is a process of presenting partner referral options (Health Department notification or self-notification) and collecting the identifying and locating information for purposes of NJDHSS partner notification.

Partner notification is the activity of locating and verifying the identity of sex and needle-sharing partners (identified through partner elicitation) in order to inform them of their possible risk of exposure to HIV or other STDs. Options for counseling, testing and treatment are offered at this time. All community-based organizations (CBOs) providing HIV prevention counseling services are required to have a memorandum of understanding (MOU) with their local public health entity that perform partner notifications for their organizations.

Partner counseling is the provision of counseling, testing and treatment of partners notified through partner notification.

**Expected immediate outcomes:**
- Provision of services to partners of positive clients
- Provision of health education and risk-reduction messages to partners of positive clients
- Referral to appropriate HIV/STD/HCV prevention programs and services

**GOAL OF PARTNER NOTIFICATION AND REFERRAL SERVICES**
The goal of partner notification is to stop the unintentional spread by persons who are infected with HIV by negotiating a client-centered risk-reduction plan and by providing referrals to medical and other prevention services. Additionally, it is the goal of partner notification to help those who are at risk of infection gain earlier access to individualized counseling, testing, medical evaluation, treatment options and other prevention services.

**WHO**
- People who test positive for HIV or have been diagnosed as having AIDS,
- Sex and needle-sharing partners of HIV clients,
- Perinatally exposed children
- Other individuals at high risk of acquiring HIV infection.

**CULTURAL COMPETENCE/PROFICIENCY**
Providers of partner notification and referral should strive toward proficiency in regard to culture and other aspects of diversity, as measured by an assessment of the target population and in accordance with the New Jersey CLAS Standards.

**WHERE**
Partner notification can be carried out in a variety of settings appropriate to the client’s needs, accessible and private.

**WHEN**
Partner notification should be carried out at the earliest time appropriate to the environmental conditions and needs of the client.

**HOW OFTEN**
Partner notification is typically conducted in one or more sessions, with the number of sessions and duration of services based on the client’s needs and the provider’s assessment.
WHAT
Partner notification should be delivered in a client-centered manner, tailored to the behavior, circumstances and special needs of the person served. Partner notification involves one-on-one, confidential client-centered discussion between the primary client and the training counselor. At a minimum, the discussion should involve:

- Confidentiality
- Assessment of risk
- The course of infection,
- Options for healthcare follow-up
- Measures to reduce disease transmission
- Risk of sexual and needle-sharing transmission

Primary clients may choose to inform their own partners of an unsafe exposure themselves, with assistance from the DHAS, or may elect a combination approach. Clients will be given a six-week period to notify their partners. Partner notification counselors will develop a client-centered system to verify that partners have been informed of an unsafe exposure.

OPTIMUM QUALIFICATIONS OF STAFF
- All partner notification counselors will have completed a course concerning partner counseling and referral services.
- All partner notification counselors will have completed the DHAS-mandated training to provide partner notification counseling.
- All partner notification counselors will attend training opportunities to provide culturally competent services to appropriately assess and address situations involving:
  - Domestic violence
  - People with disabilities,
  - People with language barriers (monolingual, deaf, etc.).

QUALITY ASSURANCE
Providers must:
- Have in place a system for client feedback (satisfaction surveys),
- Adhere to ascribed standards,
- Adhere to OraSure protocol,
- Report data, and
- Provide evidence of internal and external quality assurance measures.

EVALUATION
Partner notification sites will be evaluated in the following manner:
1. The NJDHSS/DHAS will conduct annual site visits to assess compliance with guidelines outlined in this protocol and will provide a written report to the site manager within 30 days after completion of the site visit.

2. Partner notification sites will be expected to complete anonymous patient surveys on services. These surveys will be returned to the NJDHSS. Clients should be asked to fill out the survey after completion of the counseling and testing session. Clients who refuse to fill out the survey can check "declined" at the bottom of the survey. After completing the survey or declining, the client should be given a manila envelope in which to place the survey. Surveys should be mailed to the HIV Prevention Program on a quarterly basis.

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permission only. Note: New Jersey Department of Health Public Health Nursing sites are periodically subject to an internal quality assurance process for HIV counseling and testing.

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Minors may receive services at New Jersey HIV counseling and testing sites without knowledge or consent of their parent(s) or guardian(s). These protocols are designed for adolescents and adults and are dependent on the individual's capacity to understand the prevention messages. Youth--age 13 and older--are to be provided services if they are sought freely and without coercion on the part of parents or others. Youth receive their results according to the protocol; results are not shared with parents or guardians.

Other situations, such as language barriers and mental handicaps, may hinder obtaining informed consent. In these instances, please use your best judgment and obtain consent from a translator or guardian, if needed. If special services are needed such as sign language interpretation, or a translator, please contact the WDH HIV/AIDS Program to coordinate these services.

STRATEGIES FOR IDU
Substance abuse treatment -- Why include it?
- Most drug users cannot stop using without treatment
- Treatment prevents/reduces transmission because it helps users reduce drug- and sex-related risk behaviors
- Substance abuse treatment has major positive effects on a user’s life
- Treatment is cost effective
- Providers can reach IDUs with other messages and interventions during treatment
- Society benefits from reduced drug use and associated crime

Community outreach -- Why include it?
- Community outreach reaches IDUs who don't participate in conventional service systems
- It provides services in settings that are familiar to IDUs
- Outreach interventions help create a culture of risk-reduction in the community, which helps to reinforce prevention messages
- Peers, who are often used in community outreach, are likely to be trusted by IDUs
- Community outreach has a relatively low cost

Access to sterile syringes -- Why include it?
- The U.S. Public Health Service and other agencies and institutions recommend consistent, one-time-only use of sterile syringes obtained from a reliable source as a central, risk-reduction strategy for IDUs who cannot, or will not, stop injecting.
- The use of a sterile syringe every time helps ensure that IDUs who continue to inject will not acquire or transmit infection through needle use/sharing.
- Existing laws, regulations and public and pharmacists' attitudes hamper IDUs' ability to obtain and safely dispose of syringes, thereby, promoting multi-person use of syringes.
- Access to sterile syringes does not increase drug use or attract new people to drug use.
- Ensuring access to sterile syringes involves working with pharmacists, addressing existing syringe laws and regulations, and syringe exchange programs.
- Syringe exchange programs give counselors the opportunity to meet with IDUs and suggest other services.
INTERVENTION STANDARDS
STANDARDS FOR COMPREHENSIVE RISK COUNSELING SERVICES (CRCS)

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STANDARDS FOR COMPREHENSIVE RISK COUNSELING SERVICES (CRCS)

1.0 TENETS OF CRCS
• HIV primary prevention - preventing the transmission or acquisition of HIV - is the fundamental goal of CRCS.
• Early identification of HIV infection enables individuals to make informed decisions about their own health.
• Self-determination and self-sufficiency are primary goals when working with clients.
• High standards for CRCS will improve the outcomes for clients.
• CRCS is guided by the same broadly accepted professional standards adhered to by other human service professionals, such as social workers, counselors and clinical psychologists.

1.1 STANDARDS AND GUIDANCE
The standards and guidance in this document describe the core elements essential for success in planning, implementing and evaluating a CRCS program to have Centers for Disease Control and Prevention (CDC) approval.

1.2 GOALS OF CRCS
The goals of a CRCS program are as follows:
• To provide specialized assistance to persons with multiple and complex HIV risk-reduction needs;
• To provide individualized, multiple-session HIV risk-reduction counseling to help initiate and maintain behavior change to prevent the transmission or acquisition of HIV;
• To assess risks of other STIs and ensure appropriate diagnosis and adequate treatment;
• To facilitate referral services for clients' medical and psychosocial needs that affect their health and ability to change HIV-related, risk-taking behaviors; and
• To provide information and referrals for HIV secondary prevention needs of persons living with HIV or Acquired Immunodeficiency Syndrome (AIDS).

2.0 DEFINING CRCS
CRCS is a client-centered, HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs.

CRCS is intended for persons having, or likely to have, difficulty initiating or sustaining practices that reduce or prevent HIV acquisition, transmission or re-infection. As a hybrid of HIV risk-reduction counseling and traditional case management, CRCS provides intensive, ongoing, individualized prevention counseling, support and service brokerage. This HIV prevention activity addresses the relationship between HIV risk and other issues such as substance abuse, STI treatment, mental health, and social and cultural factors.

Priority for CRCS services should be given to HIV seropositive persons having, or likely to have, difficulty initiating or sustaining practices that reduce or prevent HIV transmission and re-infection. For HIV seropositive persons, CRCS involves the coordination of primary and secondary prevention interventions in close collaboration with Ryan White CARE Act case management providers. Further, CRCS ensures the provision of other medical and psychosocial services affecting risk behavior, including STI and substance abuse treatment services.

HIV seronegative persons, or those of unknown HIV serostatus, either (1) engaging in high-risk behavior within communities with moderate to high seroprevalence rates of HIV infection or (2) otherwise at heightened risk of infection may also be appropriate for CRCS.
CRCS includes the following seven essential components:
1. Client recruitment and engagement;
2. Screening and assessment (comprehensive assessment of HIV and STI risks, medical and psychosocial service needs - including STI evaluation and treatment and substance abuse treatment);
3. Development of a client-centered "Prevention Plan;"
4. Multiple-session, HIV risk-reduction counseling;
5. Active coordination of services with follow-up;
6. Monitoring and reassessment of clients’ needs, risks and progress; and
7. Discharge from CRCS upon attainment and maintenance of risk-reduction goals.

2.1 DIFFERENTIATING CRCS FROM OTHER HIV RISK-REDUCTION ACTIVITIES
CRCS is conceptualized as a highly individualized and intensive HIV risk-reduction strategy. CRCS is intended for persons at greatest risk of transmitting or acquiring HIV whose needs are not being effectively served and whose behavior is not influenced by less intensive HIV prevention interventions, such as street outreach, group-level strategies, or HIV counseling and testing. CRCS is considered an individual-level HIV prevention activity and does not typically include group or community-level strategies. Characteristics of CRCS differentiate it from other prevention activities in that:
- The formal enrollment of "clients" into an ongoing service is guided by professional standards.
- The development of a formal relationship characterized by active, cooperative prevention planning, problem solving, counseling, and referral provision occurs between a prevention case manager and a client.
- In-depth, ongoing, risk-reduction counseling addresses specified behavioral objectives, as stated in the risk-reduction plan.

There is a need for professional staff skills to conduct most functions of CRCS, including assessment, prevention planning and risk-reduction counseling.

2.2 DIFFERENTIATING CRCS FROM OTHER FORMS OF CASE MANAGEMENT
Case management is widely acknowledged to be an important psychosocial strategy with potential for addressing a wide range of social ills. The fundamental principles underlying case management services are that case managers facilitate linking clients to the complex delivery system and help to enable clients, through psychosocial interventions, to benefit from appropriate services.

CRCS is specifically focused on HIV-related behavior change.
- CRCS involves the identification of HIV risk behaviors and medical and psychosocial needs that influence HIV risk taking, followed by the development of a client-centered prevention plan with specific behavioral objectives for HIV risk-reduction.
- Through both direct and facilitative service provisions, CRCS provides primary and secondary HIV prevention services and facilitates the provision of other medical and psychosocial services affecting risk behavior, including STI evaluation and treatment and substance abuse treatment. HIV primary prevention aims to reduce the transmission and acquisition of HIV infection, whereas HIV secondary prevention aims to prevent a person living with HIV from becoming ill or dying as a result of HIV-related illness and opportunistic infections.
- The foundation of CRCS involves multiple-session, risk-reduction counseling in which the prevention case manager (to influence HIV risk behavior change) applies a variety of strategies. Like case management, prevention case managers broker needed medical and psychosocial services, specifically those that influence HIV risk-taking, such as STI and substance abuse treatment, thereby providing more efficient coordination of services. For example, an injection drug user may have difficulty benefiting from HIV risk-reduction counseling without receiving substance abuse treatment.
3.0 ORGANIZATIONAL CONTEXT AND CAPACITY
Factors related to organizational context and capacity may influence the potential effectiveness of a CRCS program. These factors include the organization’s:
• Physical setting,
• Staffing capacity and skills,
• Referral tracking capabilities, and
• The availability of, and access to, local referral sources.

CRCS may be implemented from a variety of institutional or community-based settings. CRCS programs that are well integrated within a larger continuum of drug treatment, STI treatment, healthcare, or other social services may be more effective in recruiting and retaining clients. Agencies that provide a spectrum of services and have strong relationships and/or alliances with outside providers in the community may be well positioned to support a CRCS program, whereas "stand-alone" programs - those independent from other preventive, medical or social services - are discouraged from considering a CRCS program.

The skills and capacity of staff are especially important for many of the services CRCS programs provide. Prevention case managers require a broad array of sophisticated skills, including assessment, prevention service planning, and risk-reduction and crisis counseling. CRCS targets those individuals with multiple, complex problems and risk-reduction needs; consequently, sophisticated skills are required of staff for some tasks.

Referral tracking systems, computerized or otherwise, should be implemented to evaluate the effectiveness of a CRCS program's referral system. This implies a level of organizational capacity to establish and confidentially maintain such a data collection system.

The effectiveness of case management, in general, is related to both the availability of referral sources in the community and to supportive structural factors in the agency itself and the larger community system. Therefore, agencies considering a CRCS program should first assess the availability of community services relevant to the target population and then evaluate their ability to develop and implement referral systems.

4.0 CLIENT ELIGIBILITY
CRCS is primarily intended for persons with multiple, complex problems and risk-reduction needs who are having, or likely to have, difficulty initiating or sustaining practices that reduce or prevent HIV acquisition, transmission or re-infection. Priority for CRCS services should be given to HIV seropositive persons. An agency may also serve HIV seronegative persons or those of unknown HIV serostatus if the individual identified for CRCS is (1) a member of a community with moderate to high seroprevalence rates of HIV infection or (2) otherwise, at heightened risk for HIV infection.

The following population groups may be appropriate for CRCS, providing they meet the eligibility criteria just detailed (NOTE: This list is not exclusive or exhaustive):
• Persons recently identified as HIV-infected by counseling and testing sites or partner notification services;
• Partners of HIV-infected persons identified through referral or partner notification services;
• Clients in substance abuse treatment or injection drug users out of treatment who are accessing syringe exchange or harm-reduction programs;
• Men who have sex with men (MSM), including young MSM;
• Adults and teens repeatedly infected with STIs, especially HIV-positive persons identified at health or STI clinics;
• Clients of TB clinics;
• Adults recently released from correctional facilities with a history of substance abuse; and
• Discordant couples with inconsistent condom use.

CRCS program staff should emphasize the benefits of participation to potential clients, including assistance in identifying and addressing barriers to HIV risk-reduction and assistance in accessing health and social
services. Although some persons may present with a variety of acute medical and psychosocial needs, CRCS is a voluntary service that should be reserved for individuals with a willingness to discuss their personal risk for HIV and to participate in HIV risk-reduction counseling on a regular basis. A review of CRCS programs suggests that HIV seropositive persons may have stronger interest in participating in CRCS programs.

**ESSENTIAL COMPONENTS OF A CRCS PROGRAM**

**4.1 RECRUITMENT AND RETENTION**

Each of the seven essential components of a CRCS program is described, in detail, in the following sections.

Protocols for client engagement and related follow-up must be developed, such as requiring a minimum number of follow-up contacts within a specified period.

1. **Client recruitment and engagement** - Each CRCS program must have a comprehensive plan that contains explicit protocols to recruit and engage clients for CRCS. Making a CRCS program well known and visible for those persons the program intends to serve is important. Recruitment strategies might include:
   - Enlisting the assistance of a street outreach program serving a similar target population to identify potential CRCS clients;
   - Recruiting recently identified HIV seropositive persons from a counseling and testing site or partner notification service; or
   - Recruiting clients from other programs such as an STI clinic, a women's health clinic or a drug treatment program. In some cases, programs have used various incentives (for example, bus tokens, hygiene kits, tee shirts, and so on) to enhance recruiting efforts.

Acting quickly and early in the CRCS process is important. Effective outreach and intake efforts are associated with a quick response time and assertive follow-up, a fact that has important implications for successful client recruitment in case management.

**4.2 SCREENING AND ASSESSMENT**

Screening and assessment - To maximize staff resources, potential CRCS clients must be initially screened to ensure their eligibility for the service. Screening may include:

- Assessing risk behavior, intention, or readiness to change risk behavior. A client's willingness and ability to participate in HIV risk-reduction counseling. If a potential client is found ineligible for CRCS services, counseling and referrals relevant to their needs must be provided.
- The need for a thorough assessment of clients' HIV, STI and substance abuse risks, along with their medical and psychosocial needs, is essential for CRCS. Assessment should identify behavioral factors that increase the risk for infection or transmission of HIV and other STDs. Assessment should also include the determination of whether or not the client has been HIV antibody tested and the client's knowledge of his or her HIV serostatus. The case manager should engage the client in a discussion that enables him/her to recognize and accept personal risk for HIV. A client-centered approach to assessment is essential; the approach should be thorough and individualized for each client. Case managers should develop effective interactive methods to involve the client in identifying risk behaviors.
- Assessing one’s health, including access to medical care, current or chronic health conditions, HIV serostatus, date of last HIV antibody test, history of HIV-related opportunistic infections, date of last TB test, TB status, and, for women, date of last gynecological exam, birth control methods and pregnancy history. Case managers must provide clients a copy of a voluntary informed consent document for signature at the time of assessment. This document must assure the client of confidentiality.
- Assessing one’s STD history. The prevention, diagnosis, and treatment of HIV and other STDs are essential components of any CRCS program. The consequences of untreated STDs can be serious; for example, untreated Chlamydia and gonorrhea are two major contributors to
preventable tubal infertility. Furthermore, acute STDs, particularly those involving lesions on the skin or mucous membrane, facilitate the transmission of HIV. Therefore, the clients' history of and treatment for STDs should be assessed, as well as the date of their last STD medical evaluation.

- Assessing substance and alcohol use. A number of factors related to substance and alcohol use should be assessed including the following: history of alcohol use, injecting drugs and other non-injecting drug use; drug(s) of choice; frequency of use; route of administration; length of time using drugs/alcohol; frequency of needle-sharing; treatment history; psychosocial context of drug/alcohol use; and affect of drug/alcohol use on sexual behavior. The potential relationship between substance use and unsafe sexual behaviors highlights the need for a comprehensive assessment of both injecting and non-injecting drugs.

- Assessment of mental health. Several factors related to mental health should be considered, including the following: family and personal mental health history; history of treatment, therapy and hospitalization; adherence to treatment; suicidal ideation and history; and psychotropic medication history.

- Assessment of sexual history. A comprehensive sexual history is necessary to fully assess sexual risk behavior and related factors. Areas for assessment include: number of sex partners; current partners (nature of relationships); HIV serostatus of partners; sexual behaviors practiced and frequency of behaviors; history of sexual abuse; role of alcohol and drugs during sex; involvement in sex in exchange for drugs/money/and so on; risk behaviors of partners; condom use, including barriers and facilitating factors for condom use; and knowledge of safer sex practices.

- Assessment of social and environmental support. Assessing key factors related to social and environmental support will provide a prevention case manager a more comprehensive picture of the context within which a client engages in risk behavior and of external factors potentially influencing risk behavior. Areas for assessment include the following: living situation; economic status; sources of income; employment; in or out of school, if youth; emotional support sources; history of incarceration; significant others; and connections to the community, for example, friends, family, church and service providers.

- Assessing skills level to reduce HIV risk. Prevention case managers should assess the level of client skills in areas such as: use of condoms; sexual assertiveness; use of needle and syringe sterilization methods; use of safer injecting skills; and communication and negotiation skills.

- Assessment of barriers to safer behavior. A careful assessment of clients' perceived barriers to safer behavior is essential. Potential barriers include: knowledge of risk associated with unprotected intercourse and using unclean, shared filters, cookers, and rinse and dilute with water; the availability of, and willingness to use, condoms and sterile syringes and injection equipment; potential for violence; legal concerns; cognitive or perceptual barriers; and personal and/or cultural barriers, e.g., values and norms around sexuality, drug use, or gender roles that affect risk behavior.

- Protective factors, strengths, and competencies. Resources and factors that facilitate the client's ability to stay healthy and practice safer behaviors should be assessed.

- Demographic information. Basic demographic information should be collected, including age, gender, race/ethnicity, sexual orientation and education.
STANDARDS FOR SCREENING AND ASSESSMENT

- CRCS program staff must develop screening procedures to identify persons at highest-risk for acquiring, or transmitting, HIV and who are appropriate for CRCS.

- All persons screened for CRCS, including those who are not considered to be appropriate clients for CRCS, must be offered counseling by the prevention case manager and referrals relevant to their needs.

- Thorough and comprehensive assessment instrument(s) must be obtained or developed to assess HIV, STI, and substance abuse risks, along with related medical and psychosocial needs.

- All CRCS clients must participate in a thorough client-centered assessment of their HIV, STD and substance abuse risks and their medical and psychosocial needs. Case managers must provide clients a copy of a voluntary informed consent document for signature at the time of assessment. This document must assure the client of confidentiality.

- Case managers must provide clients a copy of a voluntary informed consent document for signature at the time of assessment. This document must assure the client of confidentiality.

4.3 DEVELOPMENT OF A CLIENT-CENTERED PREVENTION PLAN

A written, client-centered prevention plan, based on information compiled from the assessment, must be developed. This plan should identify behavioral objectives to reduce the risk of acquiring or transmitting HIV that are time-phased, specific and achievable.

The client should establish both short- and long-term goals with the assistance of the case manager. Client participation is key because many clients are well aware of their goals and what would help them meet those goals.

A client-centered approach will ensure that the prevention plan is responsive to the individual client's needs and circumstances. Therefore, prevention case managers should actively engage the client in setting behavioral objectives and identifying change strategies.

For persons living with HIV and receiving medical treatments, secondary prevention interventions must focus on ensuring adherence to treatment for opportunistic infections and adherence to complex antiretroviral combination therapies.

Secondary prevention interventions should focus on maintaining the health of the client by ensuring the procurement of needed legal and entitlement services, treatment education, information on clinical care, and mental health services.

The client's involvement, if eligible, in Ryan White CARE Act case management services, along with other related programs or services, must be detailed. Further, the prevention plan should document efforts to ensure coordination and/or integration of CRCS and Ryan White CARE Act case management.
The prevention plan must also outline efforts to ensure that a CRCS client is medically evaluated for STDs at regular intervals, regardless of symptom status. This will require that CRCS programs establish a strong relationship and referral mechanism with local STI service providers.

For clients with substance abuse problems, the prevention plan must:
- Address referral to appropriate drug and/or alcohol treatment. This will require that CRCS programs establish strong relationships with local substance abuse providers if these services are not provided in-house.
- Address the relationship between substance use and unsafe sexual behavior highlighting the importance for securing appropriate treatment for those who are in need. Furthermore, a substance-abusing client benefiting from HIV risk-reduction counseling without having received substance abuse treatment is unlikely to be able to sustain behavior changes.
- Maintain files that include individual prevention plans which are to be stored in a locked file cabinet to ensure confidentiality.

### STANDARDS FOR DEVELOPMENT OF A CLIENT-CENTERED PREVENTION PLAN

- For each CRCS client, a written prevention plan must be developed (with client participation) which specifically defines HIV risk-reduction behavioral objectives and strategies for change.
- For persons living with HIV and receiving antiretroviral or other drug therapies, the prevention plan must address issues of adherence.
- The prevention plan must make efforts to ensure that a CRCS client is medically evaluated for STDs at regular intervals, regardless of symptoms.
- For clients with substance abuse problems, the prevention plan must address referral to appropriate drug and/or alcohol treatment.
- Clients must sign-off on the mutually negotiated prevention plan to ensure their participation and commitment.
- Client files that include individual prevention plans must be maintained in a locked cabinet to ensure confidentiality.

### 4.4 CLIENT-CENTERED COUNSELING

Client-centered counseling refers to counseling conducted in an interactive manner responsive to individual client needs (U.S. Department of Health and Human Services, May 1994). With a focus on meeting the identified behavioral objectives specified in the prevention plan, case managers must:

1. Work with the client and apply a variety of strategies over multiple sessions to influence HIV risk behavior change. Depending on a client's readiness to change, case managers should intervene to influence knowledge, perceived risk and vulnerability, intentions to change behavior, self-efficacy, skill levels, environmental barriers, relapse and social support (Prochaska and DiClemente, 1992).
2. Specific interventions for clients, regardless of HIV serostatus, may include skills building, individual counseling, couples counseling, crisis management, resource procurement and preparation for referral of partners.
3. For persons of unknown HIV serostatus, interventions to prepare the client for HIV antibody testing may be appropriate. All clients must receive information regarding the potential benefits of knowing one's HIV serostatus. Counseling should explore barriers to testing faced by the client.
and seek to identify strategies to overcome these barriers. For individuals to make informed decisions about their health, early identification of HIV infection is important.

4. CRCS clients must be provided education about the increased risk of HIV transmission associated with other STDs and about their prevention. This counseling also should address the need for regular medical evaluation for STDs.

5. For seropositive clients, prevention case managers must discuss the notification of sex and needle-sharing partners who have been exposed to HIV. The purpose of notifying partners is to make them aware of their exposure to HIV and assist them in gaining access to counseling, testing, and other prevention and treatment services, including CRCS, earlier in the course of infection.

6. CRCS program staff must develop a protocol for assisting seropositive clients in confidentially notifying partners and referring them to CRCS and/or counseling and testing services. Two major approaches to partner notification have traditionally been applied by STI and HIV programs:
   - When the patient or client notifies and refers his/her own sex and/or needle-sharing partners for testing and provider referral, and
   - When health professionals, usually from the Department of Health and Senior Services, notify the patient’s partners of their exposure.

When the client chooses to notify their own partners, prevention case managers should provide them with needed counseling, support and skills building to ensure the successful, confidential notification and referral of partners for testing. Prevention case managers may invite clients to bring their partners to a CRCS session and appropriate referrals should be provided (e.g., STI testing, medical follow-up, HIV testing).

If the CRCS client is unable or unwilling to notify partners himself/herself, the prevention case manager may facilitate notification by eliciting partner names and locating information. Then, with the client's permission, the CRCS case manager may request health department officials to confidentially notify partners. This approach requires that CRCS programs establish an explicit relationship with health department officials to jointly carry out partner notification services. CRCS program staff should be familiar with the health department's procedures for confidentially notifying partners and explain this process to clients. Finally, CRCS programs may refer the client directly to the health department for assistance. Regardless of the approach used, partners identified may benefit from CRCS services and should be assessed to determine their eligibility for the service.

### Factors That Influence HIV Risk Behavior Change

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
<th>Elements of effective intervention</th>
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<tbody>
<tr>
<td>Knowledge about risk</td>
<td>Accurate understanding of behaviors that confer risk; behavior changes needed to reduce risk; and the rationale underlying risk-reduction changes</td>
<td>Clear identification of behavior practices that create risk; practical advice on behavior changes needed to reduce risk; and taking into account the realities of the client’s lifestyle and relationships</td>
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<tr>
<td>Perceived personal vulnerability</td>
<td>Personalization of risk; believing oneself to be potentially vulnerable for contracting HIV/AIDS</td>
<td>Discussion that accurately communicates the client’s risk level, encourages the client’s self-appraisal of risk, and induces realistic perception of threat</td>
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<tr>
<td>Behavior change intention</td>
<td>Readiness for change and committing oneself to risk-reduction effort</td>
<td>Assessing, together with the client, his or her readiness for change and setting achievable risk-reduction goals through counseling and/or contracting</td>
</tr>
<tr>
<td>Self-efficacy</td>
<td>Believing oneself is capable of successfully</td>
<td>Assigning incremental risk-reduction</td>
</tr>
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</table>
New Jersey Department of Health and Senior Services  
Division of HIV, STD and TB Services  
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| Skill level | Making risk-reduction behavior changes and perceiving that this change will protect against HIV/AIDS | "tasks" that can easily be accomplished to establish a sense of competency and a success record and counseling that challenges a client's sense of fatalism |
| Reinforcement of behavior change efforts | Behavioral competence in areas necessary for change implementation, including condom use or other safer sex practices; sexual assertiveness skills to refuse risk pressures; safer sex negotiation skills; and not sharing needles, use of clean needles, etc. | Skills training and practice; self-management or identification of patterns, habits, or activities that increase vulnerability to risk; and development of alternative plan to address these behavioral "triggers" |
| Environmental barriers | Experience fewer environmental constraints to perform a behavior, rather than not to perform it | Discussion of barriers to performing risk-reduction behaviors; development of strategies to overcome those barriers and to create easier access to the resources required to enact change |


### 4.5 PARTNER COUNSELING

Including the client's partner in risk-reduction counseling sessions is appropriate within the context of CRCS.

### 4.6 SECONDARY PREVENTION COUNSELING

Although CRCS always involves primary prevention risk-reduction counseling, counseling related to secondary prevention for persons living with HIV is also appropriate within CRCS. For instance, clients may need counseling support for accessing medical care and treatment. For persons receiving treatment for opportunistic infections and/or antiretroviral therapy(ies), counseling to support adherence to these treatments/therapies must be provided.

### 4.7 SUBSTANCE ABUSE AND MENTAL HEALTH COUNSELING

Although the emphasis of CRCS is on HIV risk-reduction counseling, in some instances, some substance abuse and/or mental health counseling may need to be provided. In fact, counseling about strategies to avoid or modify substance abuse behaviors can be a form of HIV risk-reduction counseling. **Only staff skilled in these areas should provide such counseling.** Referring clients with these counseling needs to agencies with specific expertise in substance abuse and mental health counseling is optimal. However, if such services are unavailable and CRCS staff has the appropriate skills, short-term counseling focused on immediate living problems may be appropriate.

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**STANDARDS FOR HIV RISK-REDUCTION COUNSELING**

- Multiple, individual session HIV risk-reduction counseling aimed at meeting identified behavioral objectives must be provided to all CRCS clients.
- Training and quality assurance for staff must be provided to ensure effective identification of HIV risk behaviors and appropriate application of risk-reduction strategies.
- Clients who are not aware of their HIV antibody status must receive information regarding the potential benefits of knowing their HIV serostatus.
- Clients must be provided education about the increased risk of HIV transmission associated with other STIs.
4.8 COORDINATION OF SERVICES AND ACTIVE FOLLOW-UP

- The CRCS program must establish a procedure for referring persons in a timely, efficient and professional manner to sites providing services that may facilitate a client’s ability to address and reduce his/her HIV risk behavior (for example, medical services, psychological treatment, substance abuse treatment, STI treatment, social services, and other HIV prevention services).
- Collaborative relationships should be established with appropriate representatives of referral sites. CRCS staff should actively assist clients in securing services at referral sites. Such assistance may include accompanying a client to an appointment, providing transportation services or bus/rail tokens, ensuring the provision of childcare services, ensuring translation or interpretation services, and providing the client skills-building to support his/her ability to effectively advocate on behalf of himself/herself with other providers.
- Effective coordination of services necessitates that CRCS programs have current, accurate community provider information on hand. This information should include hours of operation, addresses, phone numbers, accessibility to public transportation, eligibility requirements, and information regarding materials required at application, such as bringing a driver's license, birth certificate and so forth.

<table>
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<tr>
<th>STANDARDS FOR COORDINATION OF SERVICES WITH ACTIVE FOLLOW-UP</th>
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<tr>
<td>- Formal and informal agreements, such as memoranda of understanding (agreement), must be established with relevant service providers to ensure availability and access to key service referrals.</td>
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<tr>
<td>- A standardized, written referral process for the CRCS program must be established.</td>
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<td>- Explicit protocols for structuring relationships and communication between case managers or counselors in different organizations is required to avoid duplication of service, as in the case with transferring or co-managing CRCS clients with Ryan White CARE Act case management.</td>
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<tr>
<td>- Communication about individual clients with others is dependent upon the obtainment of written, informed consent from the client.</td>
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<td>- A referral tracking system must be maintained.</td>
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<td>- Annual assessment of relevant community providers with current referral and access information must be maintained.</td>
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<tr>
<td>- A mechanism to provide clients with emergency psychological or medical services must be established.</td>
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4.9 MONITORING AND REASSESSING CLIENT NEEDS AND PROGRESS

- Regular, structured meetings must be carried out between the prevention case manager and the client to assess the client's changing needs, monitor progress and revise the prevention plan accordingly. In addition, HIV risk-reduction counseling must be provided at all appropriate opportunities. As mentioned previously, case managers should regularly inquire about recent sex and needle-sharing partners of seropositive clients.
- If partners were potentially exposed to HIV, steps should be taken to inform them and encourage their participation in CRCS and/or counseling and testing services. Assessment of progress in meeting the
prevention plan objectives should be communicated to the client for review and discussion. Home visits, if appropriate, may provide a valuable opportunity for prevention case managers to gain a comprehensive impression of the client's social and environmental support. Individual meetings with a client must be reflected in the client's progress notes.

- As individual clients progress in a CRCS program and psychosocial needs are met, needs may become less acute. Assigning individual prevention case managers a balance of new CRCS clients (presumably higher need) and continuing clients (lower need) may also reduce staff burnout. Regardless of the staffing or triage system applied, monitoring ability is enhanced with a manageable caseload and adequate case records.
- Retention of CRCS clients is a concern (CDC 1997), and, as such, program staff must define minimum levels of effort to reach clients for follow-up. For instance, a program should determine how many attempts - telephone calls, field visits, and so on - will be made before a client is made "inactive."

**STANDARDS FOR MONITORING AND REASSESSING CLIENT NEEDS AND PROGRESS**

- Prevention case managers must meet on a regular basis with clients to monitor changing needs and progress in meeting HIV behavioral risk-reduction objectives. Individual meetings with a client must be reflected in confidential progress notes.
- A protocol must be established defining minimum, active efforts to retain clients. That protocol should specify when clients are to be made “inactive.”

**4.10 DISCHARGE FROM CRCS UPON ATTAINMENT AND MAINTENANCE OF RISK-REDUCTION GOALS**

- CRCS is a time-limited, prevention activity intended to meet achievable behavioral objectives - identified by assessment and prevention planning - through counseling, service brokerage and monitoring.
- CRCS is not intended to substitute extended social services or psychological care. Once the client has accomplished the behavioral objectives set forth in the prevention plan, the client and prevention case manager must make a determination that the client is ready for discharge (for example, a client is made "inactive" or "graduates," and CRCS services are terminated).
- At the time of discharge, the prevention case manager, together with the client, should make every effort to ensure that the client is connected to needed resources and services.
- In cases when the client has achieved his or her behavioral objectives but actively experiences relapse to unsafe behaviors and faces ongoing barriers to risk-reduction, continuation of CRCS services may be warranted. For these clients, CRCS services may emphasize continued risk-reduction counseling.

**STANDARD FOR DISCHARGE FROM CRCS UPON ATTAINMENT AND MAINTENANCE OF RISK-REDUCTION GOALS**

- A protocol for client discharge must be established.

**5.0 STAFF QUALIFICATIONS**

In considering staff qualifications, detailing the related CRCS activities, such as assessment, prevention planning, and risk-reduction counseling, and defining appropriate levels of staff training and skills for each may be valuable. Agency managers may choose to have professionally trained staff serve as prevention
case managers and carry out all CRCS activities from recruitment and engagement to discharge. Other agency managers may apply a team approach to CRCS, using both professionals and paraprofessionals.

Paraprofessionals, under the supervision of a case manager, may be effective in assisting with functions such as recruitment, screening and follow-up assistance to ensure coordination of care. Professionals may be more appropriate for performing the functions of CRCS requiring more sophisticated skills, such as assessment, prevention planning and HIV risk-reduction counseling. If a team approach is used, an explicit, structured means for communication among professionals, paraprofessionals and volunteers must exist. Staff qualifications, then, should be based on the skills required to complete the various CRCS functions or activities. All staff must be knowledgeable of confidentiality laws and agency confidentiality policies and procedures.

The essential components of a CRCS program, along with suggested minimum staff qualifications, can be grouped into the following two main categories:

1. **Essential components for client recruitment and engagement, screening and coordination of services.**
   - Suggested minimum staff qualifications - Knowledge of target population; cultural and linguistic competence; knowledge of HIV, AIDS and other STDs; knowledge of available community services; and effective communication skills.

2. **Essential components for assessment, development of a prevention plan, HIV risk-reduction counseling, monitoring and reassessment, ongoing support and relapse prevention, graduation and discharge planning.**
   - Suggested minimum staff qualifications - A bachelor's degree or extensive experience in a human-services-related field, such as social work, psychology, nursing, counseling, or health education; skilled in case management and assessment techniques; skilled in counseling; ability to develop and maintain written documentation (case notes); skilled in crisis intervention; knowledgeable of HIV risk behaviors, human sexuality, substance abuse, STDs, the target population, and HIV behavior change principles and strategies; and must be culturally and linguistically competent.

CRCS supervisors need the academic training and/or experience to adequately develop an overall CRCS program, including CRCS program goals and objectives, CRCS protocols, and quality assurance and evaluation measures.

CRCS supervisors should also have skills and experience in overseeing case management staff. CRCS program managers should provide an orientation to the CRCS program for new workers and ongoing supervision to ensure that the CRCS intervention is clearly understood. Ongoing staff training and development is essential to build staff skills.

### STANDARDS FOR STAFF QUALIFICATIONS

- Staff must be provided with written job descriptions and have opportunities for regular, constructive feedback. In addition, staff must be provided opportunities for regular training and development.

- Organizations must hire case managers with appropriate training and skills to complete the CRCS activities within their job descriptions.

- All staff must be knowledgeable of confidentiality laws and agency confidentiality policies and procedures.

Complexities of individual cases and the lengths of time clients are served. In service areas where fewer resources are available, prevention case managers may be expected to go beyond the HIV risk-reduction counseling and resource-linking roles and become providers of other direct services, if they...
have the appropriate skills. Such circumstances will decrease the number of clients each case manager can effectively serve.

- When case managers deliver many direct services and/or when clients are younger, harder to engage in treatment, or are more vulnerable to negative social forces, such as poverty or homelessness, smaller caseloads are expected (Rubin 1992). Also, with smaller, more intensive caseloads, case managers may develop a more therapeutic relationship with the client. In contrast, if case managers work primarily with low-need clients, the caseload would expectantly be higher.

7.0 COORDINATION OF CRCS WITH RYAN WHITE CARE ACT CASE MANAGEMENT

- The Ryan White CARE Act (RWCA) funds case management services for persons living with HIV or AIDS to ensure coordination and continuity of needed entitlement, medical care and treatment, housing, and other social services. Ryan White planning councils establish eligibility for RWCA case management services at the local level. Because of the obvious potential for service duplication between CRCS and RWCA case management, explicit attention to coordination of these services is essential.
- CRCS is intended as an HIV primary prevention activity (to reduce the transmission and acquisition of HIV infection) and must never duplicate RWCA case management services. However, CRCS services may be integrated into RWCA case management. The integration of these two services will be influenced by the eligibility requirements for RWCA case management in a given community, the extent of primary HIV prevention provided by Ryan White CARE Act case managers, and the range of services provided by both case management services. Together, a Ryan White Care Act case manager and a prevention case manager can determine which services are most appropriate. To ensure effective coordination between these two services, CRCS program staff must establish explicit relationships for coordination and/or integration with RWCA case management providers in their area and be knowledgeable of local RWCA case management eligibility criteria. Effective coordination of Ryan White case management and CRCS services will benefit the client.

8.0 QUALITY ASSURANCE

Quality assurance is essential to make certain that delivery of quality CRCS services is consistent and to ensure that interventions are delivered in accordance with established standards.

For CRCS, clear procedure and protocol manuals are necessary to guarantee effective delivery of services and minimum standards of care. These manuals should address all the standards contained within this document and should be available to all staff. Written quality assurance protocols must be developed by CRCS programs and should be included in procedure and protocol manuals. Client feedback should be routinely used as a factor in assessing the quality assurance of CRCS services provided. Quality assurance mechanisms include:

- **Written protocols;** descriptions of specific communication-related activities, such as protocols for client engagement and follow-up, screening, risk-reduction counseling, partner notification, and so forth.
• **Training for supervisors and staff:** staff are taught appropriate skills to complete the CRCS activities detailed within their job descriptions.

• **Individual supervision:** regular review of each staff member's performance, productivity level and quality of services provided.

• **Chart reviews:** regular review of individual client's CRCS assessment, prevention plan and progress notes by the case management supervisor to ensure clear documentation and appropriate intervention.

• **Case conferences and presentations:** regular presentation of cases, especially those that are complex and difficult, by case managers to peers and supervisors to discuss a client's progress and strategies for intervention.

• **Peer review:** regular review by a convened panel or peer group of performance and quality of services being delivered.

• **Client satisfaction surveys or interviews:** routine feedback from clients about their satisfaction with the service, their concerns and their ideas for improvement.

• **Independent program audits:** reviews and evaluations from panels of professionals from outside the agency on the quality of the program, including assurance that the program is delivering the services it is promoting. Special attention must be given to ensuring the confidentiality of clients when independent program audits are conducted.

### STANDARDS FOR QUALITY ASSURANCE

- Clear procedure and protocol manuals for the CRCS program must be developed to ensure effective delivery of CRCS services and minimum standards of care.

- Written quality assurance protocols must be developed and included in procedure and protocol manuals.

- Client CRCS records must contain a copy of the voluntary informed consent document and the Prevention Plan showing the client’s signature.

### 9.0 PROGRAM EVALUATION

Programs must develop the capacity to conduct outcome evaluation. This involves assessment of the immediate or direct effects of a program on the program participants. For example, this could be defined as the degree to which the program increased knowledge of HIV/AIDS, perceived risk of infection, and/or decreased intent of engaging in risk behaviors related to HIV transmission. Outcome evaluation also assesses the extent to which a program attains its objectives related to intended short- and long-term change for a target population. Agencies interested in conducting outcome evaluation are encouraged to involve program evaluation experts. Formative, process, and outcome evaluation should be implemented and results should be utilized in the updating of service (Continuous Quality Improvement Plans).

### FORMATIVE EVALUATION

Formative evaluation includes methods used in the planning and development of the intervention; how best to access and influence the community (focus groups); program components (e.g., curriculum, format); materials to be used, and pre-testing materials, if necessary.
New Jersey Department of Health and Senior Services  
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Prevention and Education Unit

**FORMATIVE EVALUATION STANDARDS**

- All interventions are expected to utilize formative evaluation methods when developing and revising their interventions.

- Formative evaluation methods used in intervention development and revision should be listed and briefly described in intervention plans and applicable progress reports submitted to DHAS.

**PROCESS EVALUATION**

All CRCS programs should conduct process evaluation. Process evaluation provides a descriptive assessment of a program's actual operation and the level of effort taken to reach desired results (that is, what was done, to whom, how, when, and where). Process evaluation is intended for program improvement. Process evaluation measures may be both quantitative and qualitative in nature. Possible process evaluation measures for a CRCS program include the following:

- Demographic information of clients,
- Risk profiles of clients,
- Health status of clients,
- Service referrals offered and followed through,
- Number and length of CRCS sessions provided,
- Client satisfaction surveys, and
- Review of quality assurance measures.

Data collection includes:

- Agency name
- Reporting period (month/year)
- Type of activity
- Primary and secondary target population
- Target population demographics
- Target population risk behaviors
- Number of intervention sessions
- Number of referrals made by type
- Number of referrals followed-up on

**PROCESS EVALUATION STANDARDS**

- Agencies must collect process evaluation information documenting their activities, as well as demographic information on the clients served.

- Guidelines must be developed to ensure consistent and accurate data collection and reporting.

- Agencies must submit reports as requested by DHAS as well as have records available for inspection.

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INTERVENTION STANDARDS  
REVISED: 1/2011  
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OUTCOME MONITORING AND EVALUATION
- Analysis of pre/post intervention test
- Utilization records
  - Enrollment
  - Participation
  - Retention
- Other, as defined by the program or DHAS

10.0 CULTURAL COMPETENCE
- Organizations must adhere to and demonstrate a philosophy of cultural competency and proficiency as characterized by acceptance of and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and adoption of service models in order to better meet the needs of communities of color.
- Cultural sensitivity is a set of attitudes, practices or polices that respect – rather than merely show – receptivity to cultural differences of people. This includes a thorough knowledge of the target groups values, norms, traditions, customs, history, etc.

CLAS STANDARDS

1. Organizations must make every effort to uphold New Jersey Cultural and Linguistically Appropriate Standards (CLAS) for cultural competence, that is, programs and services provided in a style and format respectful of the cultural norms, values and traditions that are endorsed by community leaders and accepted by the target population. HIV/AIDS service providers should ensure that the services consumers receive from ALL staff is client-centered, understandable, respectful, outcome oriented and compatible with clients’ beliefs, practices and preferred language.

2. HIV/AIDS service providers should implement strategies to recruit, retain and promote diverse staff and leadership at all levels of the organization that are representative of the demographic characteristics of the service area.

3. HIV/AIDS service providers should ensure that staff, at all levels and across all disciplines, receive ongoing education and training in culturally and linguistically appropriate service delivery.

4. HIV/AIDS service providers should render all services in the preferred language of their clients at every point of service delivery, utilizing the services of bilingual staff and interpreters at no cost to the client.

5. HIV/AIDS service providers should make available easily understood written material and signage in the client’s preferred language.

6. HIV/AIDS service providers should ensure that socio-demographic and culturally related data are collected, tracked, and used in strategic planning and program implementation. Data should include race, ethnicity, spoken and written language, sexual orientation, gender identity and substance abuse history.
<table>
<thead>
<tr>
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<th>HIV/AIDS service providers should conduct an initial and ongoing organizational self-assessment of culturally and linguistically appropriate related activities.</th>
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<td>8</td>
<td>HIV/AIDS service providers should maintain the most current demographic and epidemiological profile and needs-assessment to plan for and provide services that respond to the cultural and linguistic characteristics of their clients.</td>
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<tr>
<td>9</td>
<td>HIV/AIDS service providers should develop and implement a written strategic plan that outlines clear goals, policies, operational plans, and management and accountability mechanisms to provide culturally and linguistically appropriate services.</td>
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<tr>
<td>10</td>
<td>HIV/AIDS service providers should ensure that conflict and grievance/complaint processes are culturally and linguistically sensitive and capable of identifying, preventing and addressing cultural differences that might result in conflicts.</td>
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<tr>
<td>11</td>
<td>HIV/AIDS service providers should collaborate with the communities they serve and utilize a variety of mechanisms to facilitate involvement in the design and implementation of culturally competent and linguistically appropriate activities.</td>
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<tr>
<td>12</td>
<td>HIV/AIDS service providers should regularly disseminate to the public, information about the organization’s progress in implementing cultural competency and linguistically appropriate standards.</td>
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STANDARDS FOR OUTREACH

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1.0..........................KNOWLEDGE, SKILLS AND ATTITUDES
2.0..........................RECRUITMENT
3.0..........................CULTURAL COMPETENCE
4.0..........................SAFETY AND AWARENESS OF ENVIRONMENT
5.0..........................EFFECTIVE COMMUNICATION
6.0..........................RISK ASSESSMENT
7.0..........................CONFIDENTIALITY
8.0..........................REFERRALS
9.0..........................EVALUATION
OUTREACH FOR HARD-TO-REACH POPULATIONS
Street and community outreach can be described as an activity conducted outside a more traditional, institutional healthcare setting for the purposes of providing direct health education and risk-reduction services or referral.

Outreach demonstrates an agency’s willingness to go to the community rather than wait for the community to come to the agency.

CHARACTERISTICS OF A QUALITY OUTREACH PROGRAM
- Observation of potential outreach areas to determine the locations, times of day, and the day of the week that are most productive for reaching the population to be serviced
- Regular contact among health educators, outreach specialists, and supervisors
- Has a written and comprehensive field safety protocol that is regularly updated
- Establishment and adherence to a regular and consistent schedule of activities, including times and locations
- A mechanism for measuring the use of referrals services
- Creation and maintenance of a positive relationship between the agency and the local law enforcement authorities
- Identification and development of collaborative relationships with gatekeepers in the community
- Activities for building and earning trust and respect of the community
- Descriptions of skills-building exercises relevant to stated program objectives
- Establishment of mechanisms for maintaining client confidentiality

EFFECTIVE PEER EDUCATORS
- Have a shared identity with the targeted community or group
- Are within the same age range as the targeted community or group
- Speak the same language as the community or group
- Are familiar with the group’s cultural nuances and are able to convey these norms and values to the agency
- Act as an advocate, serving as a liaison between the agency and the targeted community

Peer educators will not replace an agency’s professional health educators, but they can complement the intervention team and enhance intervention efforts. Peer Educators may act as a support group leader or street outreach volunteer that distribute materials to friends. They may be members of the speaker bureau and give workshop presentations.

1.0 SKILLS, ATTITUDES, AND KNOWLEDGE

SKILLS
Outreach staff must have the ability to explain to clients and participants in simple language why it is important to:
- Know how they are at-risk behaviors for HIV;
- Get tested for HIV; and
- Engage in other programs that can assist in behavior change and/or care and treatment.

Outreach staff must also have the ability to:
- Implement outreach protocol, including risk assessment, intervention and follow-up
- Apply theory to outreach work
- Complete required data reporting
- Describe HIV risk factors to participants
- Describe risk-reduction information to clients
• Describe symptoms and basic disease-related information to clients

ATTITUDES OF OUTREACH STAFF
• Non judgmental
• Develop respect for the participants
• Maintain professional objectivity
• Recognize personal and professional limitations
• Build trust in the community
• Appreciate the difference in cultural beliefs and values that may influence health behaviors
• Appreciate the way in which behavioral theory can assist the outreach worker in better conducting his/her work
• Appreciate the complexity inherent in understanding addiction
• Acknowledge that every individual has the potential to change

KNOWLEDGE OF OUTREACH STAFF
• Understand why theories are useful in outreach activities
• Understand several behavioral science theories (e.g., stages of change, health belief)
• Understand the importance of protocols to best serve the client
• Understand basic research terminology, e.g., baseline, follow-up, data, instrument, analysis and intervention
• Have a basic knowledge of addiction and the impact of substance use on HIV risk behaviors
• Knowledge of available services to include drug treatment modalities
• Understand protocol for inpatient care
• Have a knowledge of outpatient methadone care and procedures
• Understand outpatient drug free procedures

2.0 RECRUITMENT
Engagement entails a client and outreach worker participating in an activity that involves a positive interaction, whereby the client is made to feel as comfortable as possible while listening to and speaking with the outreach worker.

Engagement involves identifying and making contact with members of the target group in their natural environments, establishing rapport, enlisting commitment to behavior change, and providing information about risk behaviors and strategies to eliminate or reduce risk.

STRATEGIES
Outreach workers can use innovative methods to gain access to target populations. Meeting participants where they are and at the hours they are available is critical to successful outreach activities.

3.0 CULTURAL COMPETENCY
• Organizations must adhere to and demonstrate a philosophy of cultural competency and proficiency, as characterized by acceptance of and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and adoption of service models in order to better meet the needs of communities of color.
• Cultural sensitivity is a set of attitudes, practices or polices that respect – rather than merely show – receptivity to different cultures. This includes a thorough knowledge of the target group’s values, norms, traditions, customs, history, etc.
• Organizations must make every effort to uphold New Jersey CLAS standards for cultural competence, that is, programs and services are provided in a style and format respectful of the cultural norms, values, and traditions that are endorsed by community leaders and accepted by the target population.
New Jersey Department of Health and Senior Services
Division of HIV, STD and TB Services
Prevention and Education Unit

**CLAS STANDARDS**

1. HIV/AIDS service providers should ensure that the services consumers receive from ALL staff is client-centered, understandable, respectful, outcome oriented and compatible with clients’ beliefs, practices and preferred language.

2. HIV/AIDS service providers should implement strategies to recruit, retain and promote diverse staff and leadership at all levels of the organization that are representative of the demographic characteristics of the services area.

3. HIV/AIDS service providers should ensure that staff, at all levels and across all disciplines, receive ongoing education and training in culturally and linguistically appropriate service delivery.

4. HIV/AIDS service providers should render all services in the preferred language of their clients at every point of service delivery, utilizing the services of bilingual staff and interpreters at no cost to the client.

5. HIV/AIDS service providers should make available easily understood written material and signage in the client’s preferred language.

6. HIV/AIDS service providers should ensure that socio-demographic and culturally related data are collected, tracked, and used in strategic planning and program implementation. Data should include race, ethnicity, spoken and written language, sexual orientation, gender identity and substance abuse history.

7. HIV/AIDS service providers should conduct an initial and ongoing organizational self-assessment of culturally and linguistically appropriate activities.

8. HIV/AIDS service providers should maintain the most current demographic and epidemiological profile and needs-assessment to plan for and provide services that respond to the cultural and linguistic characteristics of their clients.

9. HIV/AIDS service providers should develop and implement a written strategic plan that outlines clear goals, policies, operational plans and management and accountability mechanisms to provide culturally and linguistically appropriate services.

10. HIV/AIDS service providers should ensure that conflict and grievance/complaint processes are culturally and linguistically sensitive and capable of identifying, preventing and addressing cultural differences that might result in conflicts.

11. HIV/AIDS service providers should collaborate with the communities they serve and utilize a variety of mechanisms to facilitate involvement in the design and implementation of culturally competent and linguistically appropriate activities.

12. HIV/AIDS service providers should regularly disseminate to the public, information about the organization’s progress in implementing cultural competency and linguistically appropriate standards.

**4.0 SAFETY AND AWARENESS OF ENVIRONMENT**
Personal and group safety is very important for any action, reaction or movement when performing outreach to any population. Field safety protocol includes:

- Carry picture ID which includes name of organization, name of project, name of the project staff and the purpose of their presence;
- Be aware of weather conditions and prepare for occurrences;
- Work in pairs, always know the location of your partner;
- Design, and adhere to, a schedule for your outreach activities;
- Establish a mechanism to keep your supervisor aware of your schedule, locations and activities daily;
- Establish contact with local police. Leave copies of the ID with appropriate police staff;
- Have contingency plans for worst-case scenarios;
- Avoid controversy and debate with clients and program participants;
- Provide staff with an opportunity to attend support groups to prevent burnout and relapse; and
- Make sure you have contact and permission from a key person in the community prior to entering where the intervention will be completed (e.g. shooting galleries, crack houses, projects, etc.)

5.0 EFFECTIVE COMMUNICATION

The outreach worker staff should reflect the ethnic, gender and cultural diversity of the target population. When appropriate, the outreach staff should include individuals who are bilingual and bicultural.

The outreach worker actively works with the client to reduce the harmful consequences for high-risk behavior and HIV transmission.

6.0 RISK ASSESSMENT

Risk assessment is an ongoing process through which the outreach worker collaborates with the client to determine what that client is doing or has done to put him/herself at risk for HIV, as well as what motivates the risk-taking behavior.

6.1 RISK-REDUCTION

Risk-reduction involves a collaborative process through which the outreach worker and client identify behaviors and develop strategies to achieve health alternatives.

7.0 CONFIDENTIALITY

An outreach worker is obligated to adhere to accepted ethical and behavioral standards of conduct and continuing professional development. The outreach worker must:

- Understand the importance of confidentiality;
- Understand agency, local, state and federal laws regarding outreach in a public environment;
- Understand how to apply appropriate confidentiality regulations;
- Understand the legal ramifications for outreach workers for noncompliance with confidentiality; and
- Understand how to apply confidentiality regulations.

8.0 REFERRALS (Refer to Page 6 through 8)

A mechanism for tracking referrals must be developed by the agency. It is important to establish and maintain relationships with social service organizations to ensure appropriate referrals to help address immediate and unmet needs of the client.

9.0 EVALUATION

Program staff must work on their capacity to conduct outcome evaluation, which is the assessment of the immediate or direct effects of a program on the program participants (for example, the degree to which the program increased knowledge of HIV/AIDS, perceived risk of infection, and/or decreased intent of engaging in risk behaviors related to HIV transmission).

Formative, process, and outcome evaluation should be implemented and results should be utilized in the updating of service (Continuous Quality Improvement Plans).
FORMATIVE EVALUATION
Formative evaluation includes methods used in the planning and development of the intervention; how best to access and influence the community (focus groups); program components, (e.g., curriculum, format); materials to be used; and pre-testing materials, if necessary.

**FORMATIVE EVALUATION STANDARDS**

- All interventions are expected to utilize formative evaluation methods when developing and revising their interventions.
- Formative evaluation methods used in intervention development and revision should be listed and briefly described in intervention plans and applicable progress reports submitted to DHAS.

PROCESS EVALUATION
All outreach programs should conduct process evaluation. Process evaluation provides a descriptive assessment of a program's actual operation and the level of effort taken to reach desired results (that is, what was done, to whom, how, when, and where). Process evaluation is intended for program improvement. Process evaluation measures may be both quantitative and qualitative in nature. Possible process evaluation measures for an outreach program include:

- Demographic information of clients,
- Risk profiles of clients,
- Health status of clients,
- Service referrals offered and followed through,
- Number and length of outreach sessions provided,
- Client satisfaction surveys, and
- Review of quality assurance measures.

Data collection:
- Agency name
- Reporting period (month/year)
- Type of activity
- Primary and secondary target population
- Target population demographics
- Target population risk behaviors
- Number of intervention sessions
- Number of referrals made by type
- Number of referrals followed-up on

**PROCESS EVALUATION STANDARDS**

- Agencies must collect process evaluation information documenting their activities, as well as demographic information on the clients served.
- Guidelines must be developed to ensure consistent and accurate data collection and reporting.
- Agencies must submit reports as requested by DHAS, as well as have records available for inspection.
OUTCOME EVALUATION
Outcome evaluation also assesses the extent to which a program attains its objectives related to intended short- and long-term change for a target population. Agencies interested in conducting outcome evaluation are encouraged to involve program evaluation experts.

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<thead>
<tr>
<th>OUTCOME EVALUATION STANDARDS</th>
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<tbody>
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<td>1. Analysis of pre/post intervention test</td>
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</tr>
<tr>
<td>6. Other, as defined by the program or DHAS</td>
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</table>
INTERVENTIONS DELIVERED TO GROUPS

INDEX

1.0 ........................................CULTURAL COMPETENCE
2.0 ........................................GROUP SIZE
3.0 ........................................LOCATIONS
4.0 ........................................MEETING TIMES
5.0 ........................................DOSAGE
6.0 ........................................CONTENT AND CONFIDENTIALITY
7.0 ........................................QUALITY ASSURANCE
8.0 ........................................EVALUATION
This intervention brings individuals together to learn about HIV/AIDS, discuss safer sex practices and participate in educational activities. Groups meet in community settings for single or multiple sessions. They vary in terms of goals, participants and the characteristics of facilitators. The most important attribute of small group interventions is that they emphasize collective experiences, encouraging members to learn from each other.

GLIs provide single session and small groups of individuals at high risk of acquiring or transmitting HIV infection with:

- Education that promotes and reinforces safer behavior, interpersonal skills training and support in negotiating and maintaining safer sex and needle-sharing behaviors;
- Emphasis on the relationship between substance use and risky behavior;
- Educational materials, and,
- Referrals to appropriate services.

**CORE ELEMENTS FOR HEALTH EDUCATION**

- State realistic, specific, measurable, and attainable program goals and objectives
- Identify methods and activities to achieve specific goals and objectives
- Define staff roles, duties and responsibilities
- Define the populations to be served by geographic locale, risk behavior(s), gender, sexual orientation and race/ethnicity
- Assure that educational materials and messages are relevant, culturally competent, language/age appropriate and approved by the DHAS
- Written procedures are available for the referral and tracking of clients to appropriate services outside the agency
- Provides for collaboration with other local service providers to assure access to services for clients
- Assure confidentiality of persons served

**GOAL OF THE INTERVENTION**

GLI seeks to lower HIV risk behavior through education and skills development.

**1.0 CULTURAL COMPETENCY**

Organizations must adhere to and demonstrate a philosophy of cultural competency and proficiency as characterized by the acceptance of and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and adoption of service models in order to better meet the needs of communities of color. Cultural sensitivity is a set of attitudes, practices or polices that respect – rather than merely show – receptivity to cultural differences. This includes a thorough knowledge of the target group’s values, norms, traditions, customs, history, etc.

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12. HIV/AIDS service providers should regularly disseminate to the public, information about the organization’s progress in implementing cultural competency and linguistically appropriate standards.

2.0 GROUP SIZE
GLI occurs in single session or small groups of five (5) to fifteen (15) individuals depending on the curricula core elements.

2.1 LOCATIONS
Locations for HE/RR must be convenient and accessible to participants. Surroundings (room size) must be comfortable and accepting of the number of individuals in the session. Formative evaluation is critical to determining the best location for the participants.

2.2 MEETING TIMES
Meeting times are scheduled at the convenience of the members.

2.3 DOSAGE
Ideally, groups will consist of multiple sessions. Multiple sessions are generally preferred because this allows for opportunities to develop and discuss topics, such as “real world” experiences between sessions, in more depth and time for reinforcement of skills, without overwhelming the clients.

3.0 CONTENT AND METHODS
All curricula, printed material, videos, etc. must have prior approval from the Division of HIV/AIDS Services (DHAS) Review Board.

Educational interventions include:
• The promotion and reinforcement of safer behavior;
• Interpersonal skills training and support in negotiating and maintaining safer sexual and needle-sharing behaviors;
• Focus on the relationship between substance use and risk behavior;
• Educational materials, and
• Referrals to appropriate services.

Methods should include:
• Role plays
• Skills-building exercises
• Games
• Demonstrations

4.0 STAFF QUALIFICATIONS
• GLI providers must complete the DHAS basic HIV training, Effective Facilitation and the training associated with the specific Effective Behavioral Intervention (EBI) or other DHAS/CDC approved curriculum.
• Educators, whether peers or professionals, must be competent in regard to culture and other diversity and be able to present the materials in an understandable and non-judgmental manner.

5.0 CONSENT AND CONFIDENTIALITY
Programs must ensure confidentiality of participants.

6.0 QUALITY ASSURANCE
All providers will provide a system for client feedback, (e.g., satisfaction survey). Coordinators and project officers should assure quality of the group instruction and facilitations through periodic observations. Site visits should dedicate a portion of time to discuss the successes, problems, barriers, etc. of the EBI.

7.0 EBI PROGRAM EVALUATION
Evaluation is a systematic collection of information about the activities, characteristics and outcomes of programs to make judgments about the program, improve program effectiveness, and/or informed decisions about future programming. Formative, process, and outcome evaluation should be implemented and results
should be utilized in the updating of service (Continuous Quality Improvement Plans).

**EBI EVALUATION ACTIVITIES**
The evaluation plan should follow the curriculum specifications:
- Include process and outcome evaluation
- Have consistent, accurate data collection procedures
- Include staff supervision, observation, and feedback on a regular scheduled basis; and
- Provide findings for program modifications, as appropriate.

**FORMATIVE EVALUATION**
Formative evaluation includes methods used in the planning and development of the intervention; how best to access and influence the community (focus groups); program components, (e.g., curriculum, format); materials to be used; and pre-testing materials, if necessary.

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Division of HIV, STD and TB Services  
Prevention and Education Unit

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**OUTCOME EVALUATION STANDARDS**

- Analysis of pre/post intervention test
- Utilization records
  - Enrollment
  - Participation
  - Retention
- Other, as defined by the program
INTERVENTION ACTIVITIES
CONTACTS
Contacts are usually brief in nature or occur in a group setting, for example:
- Short conversations in the context of street and community outreach or at events, such as health fairs
- One-time presentations to groups
- Hotline calls
- Distribution of brochures and condoms

INTERACTIONS
The CDC describes an HIV prevention intervention as a specific activity (or set of related activities) intended to reduce the risk for HIV transmission in particular target populations using a common strategy for delivering prevention messages.

Activities considered interactions with clients occur on an intensive and usually repeated basis. In an interaction, staff has a conversation with a client, whereby the client may identify his/her risk behaviors for HIV. The staff and client then identify strategies for reducing the client’s risk behaviors.

- Examples:
  - Risk-reduction counseling
  - Comprehensive Risk Counseling Service
  - Ongoing groups that specifically address risk factors

Clarification and distinction between contact and interactions:
- Presentations in correctional settings (or similar settings) should be counted as interactions if the same group of inmates participates in several sessions over time. If a staff person presents to a new group of inmates in a correctional facility each time, these presentations should be counted as contacts.
- Street outreach encounters should be counted as contacts, unless an outreach worker has multiple encounters with the same individual, thereby, developing a relationship that may lead the client to change risk behaviors or seek services.

Defining an intervention includes:
- A clearly defined audience (target population)
- Clearly defined goals and objectives which include:
  - Specific process and intended immediate outcome objectives
  - Specific strategies tailored to the target population
  - An intent to deliver to a specific target populations
- A focus on reducing specific risk behaviors
- A basis of sound behavioral and social science theory
- Opportunities for participants to practice relevant skills

SKILLS-BUILDING COMPONENT
For an intervention to qualify as having a skills-building component, participants must be able to demonstrate attainment of a skill taught through the intervention. For example, a presenter demonstrating how to put a condom on a model is not an example of a skills-building component. If the participants each demonstrate individually how to put a condom on a model, negotiate safer sex or disclose HIV serostatus, the intervention would include a skills-building component. An intervention must include a skills-building component.
<table>
<thead>
<tr>
<th>Intervention Type</th>
<th>Intensity Level</th>
<th>Includes…</th>
<th>Does Not Include…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventions Delivered to Individuals (IDI)</td>
<td>I</td>
<td>Risk-reduction counseling with a skills-building component provided to 1 person at a time</td>
<td>• Outreach (has its own category)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• CRCS (has its own category)</td>
</tr>
<tr>
<td>Interventions Delivered to Groups (IDG)</td>
<td>I</td>
<td>Risk-reduction counseling with a skills-building component provided to more than 1 person at a time, usually multi-session.</td>
<td>• “1-shot” educational presentations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Lectures</td>
</tr>
<tr>
<td>Individual Level Outreach</td>
<td>C</td>
<td>Educational interventions conducted face-to-face in places where clients congregate</td>
<td>• Lectures or group presentations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Outreach solely for counseling and testing</td>
</tr>
<tr>
<td>Comprehensive Risk Counseling Services (CRCS)</td>
<td>I</td>
<td>CRCS combines individual risk-reduction counseling with an individualized case plan developed and implemented by the client and service provider; referrals are included</td>
<td>• One-on-one counseling with skills-building that does not include a written plan for risk-reduction and referrals</td>
</tr>
<tr>
<td>Partner notification and referral (PCRS)</td>
<td>C or I</td>
<td>Systematic notification of sex/needle-sharing partners of HIV + individuals</td>
<td>• Counseling and testing services (has its own category)</td>
</tr>
<tr>
<td>Counseling &amp; testing services (CTS)</td>
<td>C or I</td>
<td>Individualized risk-reduction counseling and testing for HIV antibodies</td>
<td>• PCRS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Treatment for HIV</td>
</tr>
<tr>
<td>Health communication/public information (HC/PI)</td>
<td>C</td>
<td>Use of electronic or print media, educational presentations or lectures, hotlines, or clearinghouses to deliver planned prevention messages, provide information, increase awareness, or build support for safe behavior</td>
<td>Group interventions with skills-building component (GLI)</td>
</tr>
</tbody>
</table>

*C = Contact, I = Interaction*
INDIVIDUAL AND GROUP INTERVENTIONS

<table>
<thead>
<tr>
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<tbody>
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<td><strong>Counselor characteristics</strong></td>
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<td>• Risk behaviors</td>
<td>• Demographics of staff</td>
</tr>
<tr>
<td>• HIV/AIDS-related knowledge, attitudes, beliefs and behaviors</td>
<td></td>
</tr>
<tr>
<td>• Participants’ reaction to sessions</td>
<td></td>
</tr>
<tr>
<td><strong>Description of session</strong></td>
<td><strong>Provider recruitment, training and supervision</strong></td>
</tr>
<tr>
<td>• Site/setting</td>
<td></td>
</tr>
<tr>
<td>• Content</td>
<td></td>
</tr>
<tr>
<td>• Facilitator’s assessment of interaction</td>
<td></td>
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<tr>
<td>• Number of participants per group</td>
<td></td>
</tr>
<tr>
<td><strong>Number of contacts/sessions</strong></td>
<td><strong>Staff turnover during the grant year</strong></td>
</tr>
<tr>
<td><strong>Length of contact/session</strong></td>
<td><strong>Expenditures</strong></td>
</tr>
<tr>
<td><strong>Content</strong></td>
<td><strong>Methods used to promote session participation and recruitment</strong></td>
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<tr>
<td>• As set by curriculum</td>
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<td>• Issues discussed as a result of the group interaction</td>
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<td><strong>Safer sex materials made available</strong> (condoms, bleach kits, etc.)</td>
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<tr>
<td><strong>Success of referrals</strong></td>
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**IDG ACTIVITIES**

IDG activities should include:

- The provision of IDG sessions that promote and reinforce safer behaviors, interpersonal skills, negotiation skills for safer sex and needle-sharing behaviors.
- The provision, recording and tracking of referrals by the number of referrals, type of service, and whether they were successfully completed; and
- Monitoring and reassessment of client’s needs, risks and progress.
- Session activities will include:
  - Promotion and reinforcement of safer behaviors
  - Interpersonal skills training and support in negotiating safer sexual and needle-sharing behaviors
  - Emphasis on the relationship between substance use and risky behaviors
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Division of HIV, STD and TB Services
Prevention and Education Unit

- Appropriate written materials in the language of the target audience
- Appropriate written referrals
- Facilitated referral and follow-up

INDIVIDUAL LEVEL OUTREACH

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  • HIV/AIDS-related knowledge, attitudes, beliefs and behaviors  
  • Participants’ reaction to sessions | • Full /part time, trained staff or consultant  
  • Demographics of staff |
| **Topics discussed and questions answered during the outreach encounter**           | **Outreach worker recruitment, training and supervision**                          |
| **Length of contacts/sessions**                                                  | **Staff turnover during the grant year**                                           |
| **Content**                                                                      | **Expenditures**                                                                  |
| • As set by curriculum  
  • Issues discussed as a result of the interaction |                                                                                   |
| **Safer sex materials made available** (condoms, bleach kits, etc.)**              | **Methods used to promote session participation and recruitment**                  |
| **Informational or educational materials made available**                         | **Number of outreach contacts made**                                              |
| **Types of referrals** – within agency prevention activities or “other” as deemed appropriate by client needs.** | **Schedule of outreach activities**                                              |
| **Success of referrals**                                                         | **Locations where outreach was conducted**                                        |
| Referrals made                                                                   | Referrals made                                                                    |
| Materials and supplies used                                                      |                                                                                   |

INDIVIDUAL LEVEL OUTREACH ACTIVITIES

Outreach activities should:
- Provide health educational/risk reduction skills discussions on sexual risk, needle-sharing behaviors, and the overall relationship between substance use and HIV/STD/hepatitis risk
- Assess client needs.
- Document client demographics and HIV risk behaviors.
- Promote agency services through recruitment for counseling and testing, CRCS, and IDG and other appropriate services.
- Refer to any and all other appropriate services based on client need.
- Include one-on-one contact with distribution of approved materials (brochures, safer sex kits, bleach kits, etc.), which are accurate, up-to-date, culturally appropriate (preferred language of the target population) and non-judgmental.
- Document, track and follow-up on all referrals for appropriateness and success.
• Refer at-risk clients to other HIV services and document and track all services to which they have been referred throughout by the end of the grant period.

COMPREHENSIVE RISK COUNSELING SERVICES

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<tr>
<td><strong>Client characteristics</strong></td>
<td><strong>Provider Characteristics</strong></td>
</tr>
<tr>
<td>• Demographic neighborhood, gender, sexual orientation, race/ethnicity, age and education</td>
<td>• Full/part time, trained staff or consultant</td>
</tr>
<tr>
<td>• Risk behaviors</td>
<td>• Demographics of staff</td>
</tr>
<tr>
<td>• HIV/AIDS-related knowledge, attitudes, beliefs and behaviors</td>
<td></td>
</tr>
<tr>
<td>• Participants’ reaction to sessions</td>
<td></td>
</tr>
<tr>
<td><strong>Number of CRCS counseling sessions per client</strong></td>
<td><strong>Staff recruitment, training and supervision</strong></td>
</tr>
<tr>
<td><strong>Length of each CRCS counseling session</strong></td>
<td><strong>Staff turnover during the grant year</strong></td>
</tr>
<tr>
<td><strong>Number and type of referrals made</strong></td>
<td><strong>Number of clients offered CRCS services</strong></td>
</tr>
<tr>
<td>• Number of HIV risk-reduction counseling sessions provided to each client</td>
<td># HIV positive</td>
</tr>
<tr>
<td>• Extent to which services were coordinated</td>
<td># HIV negative, known to be high-risk</td>
</tr>
<tr>
<td>• Success of referrals</td>
<td># HIV status unknown</td>
</tr>
<tr>
<td><strong>Documentation of monitoring and re-assessment of client’s needs, risks and progress</strong></td>
<td></td>
</tr>
</tbody>
</table>

COMPREHENSIVE RISK COUNSELING SERVICES (CRCS) ACTIVITIES

CRCS activities include:
• Client recruitment and engagement activities wherein protocols for client engagement and related follow-up must be developed, such as requiring a minimum number of follow-up contacts within a specified time period.
• Signed, informed consent.
• Full assessment of each client’s risks and needs (comprehensive history and assessment of HIV, STI and hepatitis A, B and C risks, medical and psychosocial service needs – including STI evaluation and treatment and referral to substance abuse treatment);
• For HIV-infected individuals, programming and/or linkages to assure access to HIV-related medical and related mental health and social services.
• For HIV-infected individuals, programming and/or linkages to assure access to educational and/or counseling interventions focusing on 1) adherence to prescribed HIV-related treatment protocols and medications, and 2) communication skills related to disclosure and communication of one’s HIV status to sexual and injecting drug partners.
• Programming and/or linkages to ensure access to HIV antibody counseling and testing, secondary medical and social services, and community-level interventions.
• Development of a client-centered prevention plan—an individualized HIV risk-reduction and life needs plan that is mutually agreeable to each participating client.
• Recording the number of in-person sessions and successful contacts by phone, mail, home visits, etc.
• Recording the number of referrals, by type of service, and whether they were successfully completed.
• Ongoing monitoring and reassessment of client’s needs, risks and progress.
• Providing CRCS sessions with skills-building components, such as: (1) communication/negotiation (e.g., abstinence); (2) decision-making related to risky sexual and drug use/other behaviors associated with drug and alcohol abuse; (3) self-esteem; (4) relationships; (5) attitudes toward vulnerability (e.g., being immune, indestructible, invincible, immortal); (6) cultural issues; (7) risk/harm reduction strategies (e.g., consistent/correct use of latex condoms, use of clean needles, etc.); (8) direct assistance or referral for major health and social services needs; and (9) other.
• Clients will be screened to identify whether they have other case managers/care coordinators. If other case managers/care coordinators are involved in the client’s care, the grantee must collaborate and coordinate services delivered by each provider. Coordination with Ryan White Care Act case managers is essential to eliminate the duplication of services.
• A discharge from CRCS upon attainment and maintenance of risk-reduction goals.
• Grantees providing non-monetary incentives, as approved by the program management officer, for all clients completing a CRCS session.
• For multi-sessional HE/RR sessions, the use of prevention curricula approved/recommended by the NJDHSS, DHAS. Prior to implementation of changes in a specific curriculum, approval must be obtained from the NJDHSS, DHAS.

HOT LINE

<table>
<thead>
<tr>
<th>CLIENT-LEVEL DATA</th>
<th>PROGRAM-LEVEL DATA</th>
</tr>
</thead>
</table>

**Client characteristics**

- Demographic gender, geographical area of the caller and behavioral risks.
- Document client referral(s)
- Document reason for call
## MATERIALS DISTRIBUTION

<table>
<thead>
<tr>
<th>CLIENT-LEVEL DATA</th>
<th>PROGRAM-LEVEL DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client characteristics</strong></td>
<td><strong>Outreach worker characteristics</strong></td>
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<tr>
<td>• Demographic neighborhood, gender, sexual orientation, race/ethnicity, age and education</td>
<td>• Full /part time, trained staff or consultant</td>
</tr>
<tr>
<td>• Risk behaviors</td>
<td>• Demographics of staff</td>
</tr>
<tr>
<td>• HIV/AIDS-related knowledge, attitudes, beliefs and behaviors</td>
<td></td>
</tr>
<tr>
<td>• Participants’ reaction to sessions</td>
<td></td>
</tr>
<tr>
<td><strong>Safer sex materials made available</strong> (condoms, bleach kits, etc.)</td>
<td><strong>Staff recruitment, training and supervision</strong></td>
</tr>
<tr>
<td><strong>Informational or education materials made available</strong></td>
<td><strong>Staff turnover</strong></td>
</tr>
<tr>
<td><strong>Types of referrals made</strong>—within agency prevention activities or “other” as deemed appropriate by client needs.</td>
<td><strong>Expenditures</strong></td>
</tr>
<tr>
<td><strong>Success of referrals</strong></td>
<td><strong>Locations where distribution occurred</strong></td>
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<tr>
<td><strong>Expenditures</strong></td>
<td><strong>Materials and supplies distributed</strong></td>
</tr>
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</table>

## MASS MEDIA

<table>
<thead>
<tr>
<th>PROGRAM-LEVEL DATA</th>
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</thead>
<tbody>
<tr>
<td>• Number of ads that were developed</td>
</tr>
<tr>
<td>• Ways in which ads were distributed to media outlets</td>
</tr>
<tr>
<td>• Number of times ads ran</td>
</tr>
<tr>
<td>• If broadcast:</td>
</tr>
<tr>
<td>o Times ads ran</td>
</tr>
<tr>
<td>o Size and demographics of the audience based on station data</td>
</tr>
</tbody>
</table>
APPENDIX A

EFFECTIVE BEHAVIORAL INTERVENTIONS (EBIs)

Fact Sheets and Procedural Guides
HEALTHY RELATIONSHIPS

DESCRIPTION

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

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

Goals

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

- Discussing HIV status with family and friends
- Discussing HIV status with sex partners and needle-sharing partners
- Building healthier and safer relationships

How It Works

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

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

Theory behind the Intervention

Healthy Relationships is based on social cognitive theory. It focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills.
Research Findings
Compared with participants in a health maintenance control group, participants in the Healthy Relationships intervention group reported
- greater self-efficacy for suggesting condom use with new sex partners
- greater self-efficacy for being able to satisfy sex partners and themselves even when practicing safer sex
- intentions to consider the pros and cons of disclosing HIV status to partners
- intentions to engage in safer sex with partners of unknown HIV status

At 3-month and 6-month follow-up contacts, participants in the intervention group were significantly more likely than participants in the control group
- to have followed through on their earlier intentions
- to have considered the pros and cons of disclosing HIV status to sex partners
- to report less sexual intercourse
- to report less unprotected intercourse with partners who were not HIV infected

At the 6-month follow-up (but not the 3-month) contact, participants in the intervention group
- were significantly more likely to have refused to engage in unsafe sex (which was not true at the 3-month follow-up)
- reported
  - less unprotected intercourse
  - more protected intercourse
  - fewer sexual contacts

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

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

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

Healthy Relationships has the following 5 core elements:
- Define stress and reinforce coping skills with HIV-infected people across 3 life areas.
  - Disclosing HIV status to family and friends
  - Disclosing HIV status to sex partners and needle-sharing partners
  - Building healthier and safer relationships
- Use modeling, role-playing, and feedback to teach and practice skills for coping with stress.
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Prevention and Education Unit

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

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

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

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

Procedures for Healthy Relationships are as follows:

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

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

**Conducting Exercises**

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

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

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

**Showing Videos**

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

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

**Describing Scenarios**

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

---

**ADAPTING**

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

People

Healthy Relationships needs

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

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

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

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

Space

Healthy Relationships needs space that is

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

Supplies

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

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

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

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

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

POLICIES AND STANDARDS

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

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

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

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

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

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

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

QUALITY ASSURANCE

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

Facilitators
Training
Facilitators should
- complete a training workshop, including review of the intervention theory and materials
- participate in practice sessions
- observe cofacilitation of groups, including practicing mock intervention sessions
Session Review
CBOs should have in place a mechanism to ensure that all session protocols are followed as written. Quality assurance activities can include observation and review of sessions by key staff and supervisors involved with the activity. This review should focus on
- adherence to session content
- use of appropriate videotapes with adequate facilitation of discussions
- accessibility and responsiveness to expressed client needs
- important process elements (e.g., time allocation, clarity)

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

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

MONITORING AND EVALUATION

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

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

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

KEY ARTICLES AND RESOURCES


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

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

**REFERENCES**

SISTA Project Overview

The SISTA Project—Sisters Informing Sisters about Topics on AIDS—is a social-skills training intervention aimed at reducing HIV sexual risk behavior among African American women at highest risk. It consists of five 2-hour sessions delivered by peer facilitators in a community-based setting. The sessions are gender specific and culturally relevant and include behavioral skills practice, group discussions, lectures, role-playing, prevention video viewing, and take-home exercises. The five sessions that generate these discussions and activities are Ethnic/Gender Pride, HIV/AIDS Education, Self-Assertiveness Skills Training, Behavioral Skills Management, and Coping.

SISTA applies two theories: the social cognitive theory and the theory of gender and power. According to the social cognitive theory, people need information about HIV risk; people need social and behavioral skills to apply risk-reduction strategies; and a change in behavior is dependent upon self-efficacy, self-confidence, and outcome expectations.

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

The study was originally conducted with 128 heterosexual women. Results indicated that social-skills training delivered in a community setting can positively affect condom use. Specifically, women in the experimental group, reported more condom use than did women in the control group.¹

The SISTA intervention should be facilitated by two peer health educators, at least one of whom is a full-time employee. Peers should be of the same race/ethnicity and gender as the target population. The staff should be well versed on HIV transmission and methods for preventing HIV transmission and should have a nonjudgmental attitude toward people living with HIV/AIDS. Partnering agencies, if any, and a location to conduct five group sessions with 10 to 12 women should be identified.

Agencies implementing SISTA should choose a location that is easily accessible by public transportation. The intervention sessions must be conducted in a secure location such that confidentiality of participants is maintained. It is important that sessions are not interrupted by distractions such as people entering and leaving the room or by outside noise levels. The location should accommodate 10 to 12 persons comfortably and privately. In addition, the agency should take into consideration the intervention activities, including role-playing and role demonstration.

SISTA Core Elements

- **Conduct** small-group sessions to discuss the session objectives, model skills development, role-play women's skills acquisition, and address the challenges and joys of being an African American woman.

- **Use** skilled facilitators to implement SISTA group sessions.

- **Use** materials that are gender-specific and culturally appropriate to acknowledge pride and enhance self-worth in being an African American woman (e.g., use poetry, artwork by African American women).

- **Train** women in sexual assertion skills so that they can demonstrate care for partners and negotiate safe behaviors.

- **Teach** women proper condom use; SISTA is designed to foster positive attitudes and norms toward consistent condom use and to provide women the appropriate instruction for placing condoms on their partner.

- **Discuss** cultural and gender triggers that may make it challenging for women to negotiate safer sex.

- **Emphasize** the importance of partner involvement in safer sex; the homework activities are designed to involve the male partner.
SISTA Sessions

The SISTA Project consists of five weekly 2-hour sessions. The goals and activities of the sessions are as follows:

Session 1: Ethnic/Gender Pride
Goal: Generate a discussion about being African American and female, having pride in oneself, and valuing oneself.

Session 1 Activities
- Reading of opening poem
- Greetings and introduction
- Ground rules and expectations
- Facilitation of gender/ethnic pride discussion
- Homework
- Evaluation of Session 1
- Reading of closing poem and recitation of SISTA motto

Session 2: HIV/AIDS Education
Goal: Provide factual and statistical information on HIV/AIDS and other sexually transmitted diseases, correct misconceptions about HIV/AIDS, and discuss the importance of protecting oneself.

Session 2 Activities
- Reading of opening poem
- Review of ground rules and expectations
- Review of Session 1 key concepts
- Distribution of HIV/AIDS informational materials and initiation of discussion
- HIV/AIDS educational activity
- Video presentation and discussion
- Homework
- Evaluation of Session 2
- Reading of closing poem and recitation of SISTA motto

Session 3: Assertiveness Skills Training
Goal: Teach the distinction among assertive, aggressive, and nonassertive behaviors; and teach skills to initiate assertiveness.

Session 3 Activities
- Reading of opening poem
- Review of Session 2 key concepts and review of homework
- Facilitation of discussion on assertion and aggression
- Review of situational vignettes and discussion of steps in decision making
- Homework
- Evaluation of Session 3
- Reading of closing poem and recitation of SISTA motto
Session 4: Behavioral Self-Management
Goal: Decrease participants’ anxiety about condom use, demonstrate and role-play how to use condoms, and discuss reasons that women do not insist on using condoms.

Session 4 Activities
- Reading of opening poem
- Review of Session 3 key concepts
- Discussion on using condoms and overcoming barriers to their use
- Distribution of condom packets and lubricant
- Demonstration of condom use and assessment of participants’ knowledge
- Role-playing of negotiation exercises
- Homework
- Evaluation of Session 4
- Reading of closing poem and recitation of SISTA motto

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

Session 5 Activities
- Reading of opening poem
- Review of Session 4 key concepts and homework
- Review of Session handouts
- Discussion of coping skills and their relationship to alcohol consumption
- Distribution of coping handout
- Purpose of booster sessions
- Final evaluation
- Reading of closing poem and recitation of SISTA motto

For more information on the SISTA project, please visit our website at www.effectiveinterventions.org, email interventions@aed.org, or call (800) 462-9521.
STREET SMART

DESCRIPTION

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

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

Goal

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

How It Works

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

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

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

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

**Key Characteristics**

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

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

**Procedures**

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

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

**Getting the Language of HIV and Other Sexually Transmitted Diseases**

The main point of this session is to convey that knowing the facts about HIV/AIDS is essential because this knowledge allows people to protect themselves and others. Furthermore, understanding HIV/AIDS allows people to monitor their own effectiveness at implementing HIV prevention strategies. In this session, clients will use an educational game and role-playing to:
- become familiar with the key characteristics of the intervention (e.g., use of tokens, “feeling thermometer”)
- learn basic information about HIV and other sexually transmitted diseases and how these diseases are transmitted
- learn their personal risk factors

**Assessing Personalized Risk**

The main point of this session is to use role-playing and group brainstorming to help clients figure out which of their behaviors put them at risk and which triggers lead to unsafe behaviors. In this session, clients will
- increase familiarity with key characteristics of the intervention
- understand safer sex
- recognize personal risk behaviors
- learn which triggers increase their personal risk
- learn to set personal limits

**Learning How to Use Condoms**

The main point of this session is for clients to become less anxious and more comfortable talking about and using condoms. Clients will
The sessions take place in small groups to provide a supportive environment for behavior change. A private session with a counselor enables each client to personally identify risk for HIV transmission and find ways to overcome his or her own barriers to safer sex. Additionally, clients can access medical care, mental health care, and referrals for individual health concerns, if needed.

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

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

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

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**CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES**

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

Street Smart has the following 6 core elements:
- Increase clients’ knowledge about
  - HIV and its transmission
  - Benefits of HIV testing and knowing one’s HIV status
  - The role of stigma
  - The changing epidemiology of the epidemic
- Have clients identify peers’ and partners’ social norms and expectations, to increase self-efficacy.
- Have clients recognize and control feelings and emotional responses.
- Have clients identify their risk, and teach personal use of HIV/AIDS risk hierarchy.
- Use peer support to identify personal triggers to unsafe behavior.
• increase familiarity with key characteristics of the intervention
• learn and practice the correct use of male and female condoms
• increase their comfort level with condoms

**Learning about the Effects of Drugs and Alcohol**
The main point of this session is to use role-playing and confronting beliefs so clients can identify how drugs and alcohol affect their thinking and choices. Clients will learn
  • how alcohol and drugs affect the ability to practice safer sex
  • the pros and cons of substance use
  • how drugs and alcohol can affect a person
  • about addiction and triggers for substance use
  • skills for breaking the cycle of addiction

**Recognizing and Coping with Feelings**
The main point of this session is to use role-playing and the “feeling thermometer” to help clients identify different coping styles for tough situations and to solve problems. Clients will
  • learn skills for coping with stressful feelings
  • become familiar with the SMART method for coping and problem-solving. SMART stands for
    o State the problem
    o Make a goal
    o Actions you can take
    o Reach a decision
    o Try and review it
  • learn relaxation techniques

**Negotiating Effectively**
In this session, clients will
  • review key characteristics of the intervention
  • learn how to stand up for their personal values
  • use interpersonal problem-solving and role-playing to
    o explore personal sexual values
    o learn to deal with peer pressure
    o develop problem-solving skills
    o learn to communicate effectively using “I” statements

**Doing Self-Talk**
In this session, clients engage in educational games and exercises to learn how to use their thoughts and self-talk to help them make safer decisions. Clients will
  • review key characteristics of the intervention
  • learn how to think through positive and negative events to facilitate protective actions
  • learn to break the cycle of negative thoughts
  • practice thinking positive thoughts about themselves
  • learn helpful self-talk to keep themselves safe
Practicing Safer Sex
In this session, clients engage in a small-group discussion and create a media message (music video, soap opera, commercial) to figure out why they engage in risky behaviors and to learn how to argue against their rationalizations. Clients will

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

ADAPTING

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

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

RESOURCE REQUIREMENTS

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

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

Facilitators

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

Facilitators should understand

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

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

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

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

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

The CBO should also have
• attractive and easily understood promotional materials
• enough supplies (e.g., nametags, tissues, paper, pens and pencils, handouts) for all clients
• clear, correct, and understandable visual aids
• a suggestion box
• strong relationships with different social service agencies at both the leadership and staff levels
- access to at-risk youth (CBOs implementing Street Smart must serve at-risk youth or have established relationships with organizations serving at-risk youth [e.g., juvenile detention centers, homeless shelters, drop-in youth centers, youth outreach centers]). CDC does not endorse Street Smart for in-school programs.
- access to community resources for youth
- CBO commitment to
  - have adult facilitators complete Street Smart intervention training (3 full days)
  - implement the entire program
  - adapt program with fidelity to core elements
- adequate funds or creative community resources to provide incentives for clients (e.g., food or small prizes for the activities and games)
- system to refer clients to additional services (e.g., counseling) if required

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**RECRUITMENT**

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

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

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

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**POLICIES AND STANDARDS**

Before a CBO attempts to implement Street Smart, the following policies and standards should be in place to protect clients and the CBO:
Confidentiality
A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client or his or her legal guardian must be obtained.

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

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

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

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

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

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

QUALITY ASSURANCE

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

CBOs

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

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

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

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

MONITORING AND EVALUATION

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

General monitoring and evaluation reporting requirements for the programs listed in the Procedural Guidance will include the collection of standardized process and outcome measures as described in the Program Evaluation and Monitoring System (PEMS). PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-
VOICES/VOCES

DESCRIPTION

VOICES/VOCES (Video Opportunities for Innovative Condom Education and Safer Sex) is a single-session, video-based program for the prevention of HIV and other sexually transmitted diseases. VOICES/VOCES was designed to encourage condom use and improve condom negotiation skills among heterosexual African American and Latino men and women, aged 18 years and older, who are at very high risk for HIV and other sexually transmitted diseases.

The original research was conducted in sexually transmitted disease clinics; however, many clients who are at very high risk for getting or transmitting HIV and other sexually transmitted diseases but are not being treated in sexually transmitted disease clinics might benefit greatly from VOICES/VOCES. The intervention has also been conducted in family planning centers, community health centers, drug rehabilitation clinics, correctional facilities, and other settings.

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

Goals
VOICES/VOCES is designed to encourage condom use and improve condom negotiation skills by African American and Latino men and women.

How It Works
This brief intervention, in English and Spanish, is a workshop that can be easily integrated into the flow of services provided by busy CBOs. It fits effective prevention education into the time frame of a clinic visit or other brief opportunity to reach clients during a “teachable moment.” For example, having to visit a sexually transmitted disease clinic may motivate a person to change behavior.

To implement VOICES/VOCES, health educators convene groups of 4 to 8 clients for a single, 45-minute session. Whenever possible, groups are gender- and ethnic-specific so that clients can develop prevention strategies appropriate for their culture. Information on HIV risk behaviors and condom use is delivered using videos, facilitated group discussion, and a poster board showing features of various condom brands in English and Spanish. Two culturally specific videos are used: 1 for African American clients and 1 (bilingual) for Latino clients. Skills in condom use and negotiation are modeled in the videos, then role-played, practiced, and discussed. At the end of the session, clients are given samples of the types of condoms they have identified as best meeting their needs.
Theory behind the Intervention
VOICES/VOCES is based on the theory of reasoned action, which explains how people’s behaviors are guided by their attitudes, beliefs, and experiences as well as by how they believe others think they should act in a given circumstance (i.e., the social and cultural norms of their community).

Research Findings
VOICES/VOCES is also based on extensive research exploring cultural and gender-based reasons why people engage in unsafe sex practices and how they can be encouraged to change their behavior. VOICES/VOCES produced significant results in field trials, demonstrating both biological markers and self-reported behavior change. Participants in VOICES/VOCES had a significantly lower rate of infection with new sexually transmitted diseases than did control participants. In addition, participants had increased knowledge about the transmission of HIV and other sexually transmitted diseases as well as increased intentions to use condoms regularly. They were also more likely to go get more condoms at a neighborhood store in the weeks after their clinic visit.

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

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

VOICES/VOCES has the following 4 core elements:
- Show culturally specific videos portraying condom negotiation.
- Convene small-group skill-building sessions to work on overcoming barriers to condom use.
- Educate clients about different types of condoms and their features.
- Distribute samples of condoms identified by clients as best meeting their needs.

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

VOICES/VOCES has the following key characteristics:
- Introduce VOICES/VOCES as a routine part of clinic or CBO services.
- Convene groups of 4 to 8 persons of the same gender and race and ethnicity, to allow for open discussion of sensitive issues among persons holding similar cultural values.
- Conduct the intervention session in a private space.
- Deliver the intervention in a single session (40–60 minutes).
- Begin the session by showing a culturally specific video (15–20 minutes).
- Show a video that
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Division of HIV, STD and TB Services
Prevention and Education Unit

- reflects up-to-date information about HIV and other sexually transmitted diseases
- uses male and female actors whose race and ethnicity is similar to that of the clients
- depicts real-life situations involving characters like the clients themselves
- shows condom negotiation as a shared responsibility between sex partners
- models communication skills and prevention attitudes and behaviors with regard to HIV and other sexually transmitted diseases
- includes subject matter that is explicit but appropriate for viewing at the site

- Use the characters and situations depicted in the video to launch group discussions.
- Address barriers to condom use and safer sex by
  - increasing awareness of personal risk for infection with HIV and other sexually transmitted diseases
  - providing information on safer sex to prevent infection
  - correcting misinformation about condom use
  - presenting the features of different types of condoms
- Give clients a minimum of 3 condoms each of the type they identified as best meeting their needs.

Procedures

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

Procedures for VOICES/VOCES are as follows:

Showing Culturally Specific Videos

Videos quickly transmit information and model attitudes and behaviors regarding safer sex appropriate for members of particular cultures. In VOICES/VOCES, videos provide a nonthreatening starting point for groups of strangers, brought together for 1 brief session, to discuss intimate topics and behaviors. Videos also provide a safe context for discussing culturally sensitive issues. This context is especially important when group facilitators differ from clients in race and ethnicity or other characteristics, as is often the case with community health agencies providing services to diverse client populations.

Two videos have been developed for the VOICES/VOCES intervention: _Porque Sí_, in Spanish and English, for Latino men and women, and _Love Exchange_, for African Americans. The VOICES/VOCES videos were specifically designed for heterosexual African American and Latino adult men and women and may not be appropriate for all target populations. Other videos may be substituted or added, as long as they meet the criteria outlined in the VOICES/VOCES intervention package (see “Selecting Videos to Use in Delivering VOICES/VOCES,” VOICES/VOCES implementation manual, page 17). If an alternative video is selected, it should be screened for appropriateness by CBO staff as well as consumers and community members (e.g., community advisory board, consumer focus groups, materials review panels). When an alternative video is used for VOICES/VOCES, staff facilitators should update the video activity sheets (see VOICES/VOCES implementation manual, pages 37–39) to identify specific “trigger points” that will be used during the small-group sessions.

Conducting Small-Group Skill-Building Sessions
The interactive sessions are held after clients watch the video; the sessions are the heart of the VOICES/VOCES intervention. They help clients develop and practice the skills they need to negotiate condom use. They also provide an opportunity for clients to discuss problems that they have encountered in trying to adopt safer-sex behaviors and, with peers, develop and practice strategies for overcoming these problems.

Facilitators lead groups of 4 to 8 clients, using a standardized protocol. Facilitators begin by asking specific questions about the characters and events depicted in the video, then encourage clients to relate these situations to their own lives. Sessions address barriers to condom use and safer sex by providing information, correcting misinformation, discussing condom options, and having clients practice condom-negotiation techniques. Sessions follow a consistent format, but the content is adapted to address the concerns and experiences of each group. If possible, groups should comprise members of the same gender; that is, they should be men only or women only, to allow open discussion of sensitive issues surrounding sexual behaviors and attitudes.

Educating Clients about Condoms
The condom education component of the intervention supplements the skill-building session by providing clients with detailed information about condoms and how to choose a condom that they and their partner will feel most comfortable using. This component offers aids to familiarize clients with condoms and their features, making it easier for them to obtain and correctly use condoms. The Condom Features poster board, in English and Spanish, available in the VOICES/VOCES intervention kit, is used for this activity. In accordance with CDC’s Statement on Nonoxylnol-9 Spermicide (May 10, 2002, which is available at www.cdc.gov/mmwr/preview/mmwrhtml/mm5118a1.htm), condoms lubricated with nonoxynol-9 have been removed from the Condom Features poster board, and use of nonoxynol-9 spermicide is not encouraged in the VOICES/VOCES intervention.

Distributing Condom Samples
At the end of the VOICES/VOCES session, clients are given samples of the types of condoms they have identified as best meeting their needs.

ADAPTING

VOICES/VOCES was specifically designed for heterosexual African American and Latino adult men and women who are at very high risk for acquiring HIV. CBOs may adapt VOICES/VOCES for other populations who are at very high risk. However, before doing so, CBOs should conduct formative research to assess whether VOICES/VOCES, its theory of behavior change, and intervention activities are appropriate for the influencing factors, HIV risk behaviors, and cultural norms of the target population. For example, if discussion or use of condoms is largely prohibited in a particular cultural group, VOICES/VOCES may not be a good fit for that cultural group.
When using VOICES/VOCES for other populations at very high risk for acquiring HIV, CBOs should use an appropriate culturally specific video that represents members of the target population and their primary language.

CBOs may adapt VOICES/VOCES for settings other than sexually transmitted disease clinics. VOICES/VOCES has been implemented successfully in settings such as a neighborhood health center, prison, CBO, and school-based clinic. CBOs implementing VOICES/VOCES in settings other than clinics are encouraged to develop recruitment and other processes that accommodate the flow of client services at a particular agency. Although the core elements of VOICES/VOCES may not be altered or omitted, CBOs may modify the key characteristics of the intervention to better meet the needs of the target population.

RESOURCE REQUIREMENTS

People
VOICES/VOCES needs 1 to 2 facilitators and a program coordinator/manager.

Facilitators
- recruit clients
- show the video
- run the small-group skill-building sessions

Existing CBO staff members make good facilitators as long as they know how to do the above. Having more than 1 facilitator helps ensure continuity and consistency of the program in instances of absences or turnover. Facilitators also can support one another and help troubleshoot any issues that arise. Staff facilitators should possess some group facilitation skills or attend group facilitation training to develop these skills. Staff facilitators are strongly encouraged to attend a VOICES/VOCES training of facilitators to learn how to plan and implement the intervention. Staff facilitators, who will facilitate the VOICES/VOCES sessions, are strongly encouraged to attend the 2-day VOICES/VOCES training of facilitators.

Regarding materials costs, CBOs should budget for the distribution of a minimum of 3 condoms per person in the intervention. Because clients select which types of condoms best meet their needs, CBOs should budget for a diverse supply of condoms.

Program Coordinators/Managers
- oversee the intervention and supervise the staff facilitators
- should attend the VOICES/VOCES training of facilitators
- oversee maintenance, quality control, and documentation
- introduce the intervention and support it through implementation
- ensure that the intervention becomes a regular part of services
- help secure resources
- work in partnership with local and state public health agencies
- identify and address potential problems and answer questions
• serve as advocates for improved prevention services

Program Coordinators/Managers and those interested in learning more about the intervention are encouraged to read the VOICES/VOCES preview/administrator’s guide, which can be found at www.effectiveinterventions.org as well as in the VOICES/VOCES intervention package. Half-day orientation trainings are not being offered.

Space
VOICES/VOCES can use existing clinic and CBO space. New users should examine their own clinic and CBO settings and develop strategies for delivering the intervention so the greatest number of clients will benefit. The main requirement is a private, quiet room for having confidential discussions and watching videos. Recommended sites include
• sexually transmitted disease clinics
• family planning clinics
• community health centers
• CBOs
• drug treatment centers
• prisons and jails

Supplies
VOICES/VOCES needs
• a TV and VCR
• money for
  • personnel costs
  • rented space, if needed
  • video equipment
  • staff training
  • materials such as condoms (CBOs should budget for the distribution of at least 3 condoms per person in the intervention. Because clients select which types of condoms best meet their needs, CBOs should budget for a diverse supply of condoms, including the types shown on the Condom Features poster board.)
  • ongoing technical assistance

Because VOICES/VOCES is primarily intended to fit into the opportunity provided by a client’s routine visit to a sexually transmitted disease clinic or similar health service or community agency, additional costs incurred by clients are often negligible, since little additional travel or time investment is required.²

RECRUITMENT

The population recruited for VOICES/VOCES is persons who are at very high risk for HIV and other sexually transmitted diseases. VOICES/VOCES should be a part of routine services and offered on a regular basis to as many clients as possible every week. Successful recruitment involves determining where VOICES/VOCES fits into the flow of CBO services. CBO staff can recruit and enroll clients by presenting the intervention as part of the client’s regular clinic visit.
General recruitment into the VOICES/VOCES sessions can include word of mouth, peer-to-peer recruitment strategies, and other marketing strategies (e.g., flyers, newsletters, and special events).

POLICIES AND STANDARDS

Before a CBO attempts to implement VOICES/VOCES, the following policies and standards should be in place to protect clients and the CBO:

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

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

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

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

Legal and Ethical Policies
CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners; CBOs are obligated to inform clients of the organization’s responsibilities if a client receives a positive HIV test result and the organization’s potential duty to warn. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.
Referrals
CBOs must be prepared to refer clients as needed. For clients who need additional assistance in decreasing risk behavior, providers must know about referral sources for prevention interventions and counseling, such as partner counseling and referral services and other health department and CBO prevention programs.

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

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing VOICES/VOCES:

CBOs
Leadership and Guidance
The CBO manager must provide hands-on leadership and guidance for the intervention—from preparation through institutionalization. The orientation session enables the CBO manager (and facilitators) to provide this guidance.

Implementation Manual
The VOICES/VOCES implementation manual provides procedures for quality assurance, process monitoring, and process evaluation and describes the experiences of others who have used the intervention. The manual also guides staff on how to incorporate feedback and findings from quality assurance and process evaluations into VOICES/VOCES programming.

Fidelity to Core Elements
Throughout implementation of VOICES/VOCES, it is necessary to determine whether staff members are delivering the intervention with fidelity to the 4 core elements. It is also necessary to ensure that the intervention is meeting the needs of CBO clients and staff. Staff will use the quality assurance checklist contained in the implementation manual to identify, discuss, and solve problems in successfully implementing the intervention.

Clients
Clients' satisfaction with the services and their comfort should be assessed periodically. Staff will use the client satisfaction survey contained in the implementation manual or their own satisfaction survey to collect feedback from clients. The results of the survey will be used to strengthen the intervention.
MONITORING AND EVALUATION

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

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

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

KEY ARTICLES AND RESOURCES


REFERENCES


MANY MEN, MANY VOICES

DESCRIPTION

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

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

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

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

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

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

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

3MV has the following 9 core elements:
- Enhance self-esteem related to racial identity and sexual behavior.
- Educate clients about HIV risk and sensitize to personal risk.
- Educate clients about interactions between HIV and other sexually transmitted diseases and sensitize to personal risk.
- Develop risk-reduction strategies.
- Build a menu of behavioral options for HIV and other sexually transmitted diseases risk reduction, including those that one can act on individually and those that require partner involvement.
- Train in risk-reduction behavioral skills.
- Enhance self-efficacy related to behavioral skills.
- Train in partner communication and negotiation.
- Provide social support and relapse prevention.

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

3MV has the following key characteristics:
- Foster positive identity development and self-esteem for black MSM by
  - exploring the dual identity culture of black MSM
  - addressing social influences and family, religious, and cultural norms within the black community
  - exploring the concept of internalized racism and homophobia
- Discuss sexual relationship roles and risks, addressing knowledge of interactions between HIV and other sexually transmitted diseases and transmission risk, and exploring beliefs about those risks.
- Address perceived personal risk and personal susceptibility for infection with HIV and other sexually transmitted diseases as well as perceived barriers to remaining HIV negative.
- Increase skills, self-efficacy, and intentions with regard to protective behaviors.
- Explore the dynamics of sexual relationships, including the dynamics of power and the concept of “tops” and “bottoms” for black MSM.
- Address the importance of peer support and social influence on maintaining healthy behaviors.
Procedures
Procedures are detailed descriptions of some of the above-listed elements and characteristics.

Procedures for 3MV are as follows:

**Holding the Sessions**
The 7 sessions address specific influencing factors in a purposeful sequence.

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

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

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

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**ADAPTING**

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

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

Space
3MV needs meeting space, which can usually be found at the CBO. It must be
- large enough for 6 to 14 people
- safe, with comfortable seating
- easy to get to using public transportation and near where black MSM live, work, and socialize
- private and secure, so that confidentiality can be maintained
- quiet and without interruptions (such as people entering and exiting the room or outside noise)

Supplies
3MV needs
- VCR, TV, overhead projector
- markers, easels and paper, masking tape, poster boards, clothespins
- Outreach materials (poster, flyers)

RECRUITMENT

The population recruited for 3MV is black men who are gay, bisexual, or same-gender-loving and black men who may not identify themselves as gay or bisexual but who do have sexual or emotional attraction to other men (men on the down-low). 3MV is not appropriate for other MSM such as inmates who have "situational sex," those who have sex for money or drugs who do not have sexual or emotional attraction for other men, or heterosexual men.
Note: In relation to 3MV, black refers to black race, including African American, African, Caribbean/West Indian, and black Latino or Hispanic.

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

**POLICIES AND STANDARDS**

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

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

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

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

**Informed Consent**
CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO's responsibility and the clients' rights. Individual state laws apply to consent procedures for minors; but at a minimum, consent should be obtained from each client and, if appropriate, a legal guardian if the client is a minor or unable to give legal consent. Participation must always be voluntary, and documentation of this informed consent must be maintained in the client's record.
Legal and Ethical Policies
CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners; CBOs are obligated to inform clients of the organization’s responsibilities if a client receives a positive HIV test result and the organization’s potential duty to warn. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

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

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

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

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

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

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

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing 3MV:
Facilitators
Training for facilitators should address
- completion of a training workshop, including review of the intervention theory and materials
- participation in practice sessions
- observed cofacilitation of groups, including practice of mock intervention sessions

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

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

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

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

MONITORING AND EVALUATION

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

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

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

HOLISTIC HEALTH RECOVERY PROGRAM

DESCRIPTION

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

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

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

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

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

Research Findings
Clients in both an Enhanced Methadone Maintenance Program (which includes a 6-session HIV risk-reduction component) and HHRP exhibited significant improvements on measures of addiction severity, harm-reduction behaviors, harm-reduction knowledge, motivation, behavioral skills, and quality of life. HHRP clients had significantly greater improvement in behavioral skills and showed continued decreases in addiction severity and risk behavior after 3 months;
members of the control group did not maintain improvements. In later stages of the project, the HHRP manual for HIV-negative persons was developed as a variation of the HHRP manual for HIV-infected persons to generalize the intervention beyond HIV-infected drug users. It was tested and found to be efficacious in a randomized clinical trial among injection drug users who were either HIV negative or whose status was unknown.

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

**CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES**

**Core Elements**

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

HHRP has the following 8 core elements:

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

**Key Characteristics**

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

HHRP has the following key characteristics:

- **Group sessions.** Hold group sessions at the same time and place each week, and follow the same structured format.
- **Group size.** Have 3 to 15 clients in each group.
- **Facilitators**
• Have the groups cofacilitated by 2 substance abuse counselors who have experience working with HIV-infected substance abusers and who are comfortable with the concepts of harm reduction in this population.
• Include 1 male counselor and 1 female counselor, if possible, on the facilitation team.
• Ensure that at least 1 of the counselors cofacilitating the interventions has a master’s degree in a counseling discipline.

• **Group gender or sexual orientation.** Select groups to accommodate the CBO’s clientele (e.g., all male, mixed-gender, all gay or lesbian, mixed sexual orientation). During the adaptation process, HHRP may be modified to accommodate all relevant groups for group makeup.

• **Group Structure and Duration.** Schedule HHRP in 1 of several ways.
  - 1 weekly 2-hour session for 12 weeks (e.g., 9:30-11:30 every Wednesday)
  - 2 weekly 1-hour sessions for 12 weeks (e.g., 9:30-10:30 every Tuesday and Thursday)
  - One session (2 hours) alternating with discussion groups weekly for 24 weeks (e.g., Week 1=Group 1, Wednesday, 9:30-11:30; Week 2=Group 1 Discussion Wednesday, 9:30-11:30)

• **Enrollment.** Choose from 2 enrollment options, each of which has pros and cons. Each organization will decide which enrollment option best meets their requirements.
  - **Open enrollment.** New clients start in any week (this option can be used only if HHRP is offered on an ongoing basis).
  - **Cohort enrollment:** Clients start together and proceed through all 12 groups as a group. If using the cohort recruitment method, to allow for attrition it is recommended that you start with at least 12 clients.

• **Threshold for Discontinuation.** Membership in HHRP requires clients to make a commitment. HHRP members are to attend all group and individual sessions without exception. Members are to be discontinued if they miss 6 sessions. They may start over if the CB is offering other sessions and if they indicate that they want to participate.

• **Eligibility requirements.** Ensure that clients
  - are of the appropriate HIV status for their HHRP intervention (e.g., HIV infected and HIV negative or unknown HIV status)
  - have recently (within the last 30 days) used or are actively using drugs
  - are either enrolled in a drug treatment program or have expressed a desire to enroll

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

### Procedures

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

Procedures for HHRP are as follows:
Conducting Sessions
The HHRP manual describes 12 group sessions, each 2 hours long, which can be presented in 1 of the following formats:

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

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

Providing Content

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

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

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

- **Consistency** in meeting times and places, provision of an agenda, and following of the same structured format

- **Assessment and feedback** of knowledge and skills gained
  - This allows members to evaluate the different teaching strategies.
  - This also provides a chance for additional practice of new skills.

- **Generalizability** of information to the life situations of group members
  - **Memory book system** to improve memory for session material and for organizing and remembering activities required for living a healthy lifestyle
  - **Learning by doing** through activities that are appropriate to the group topic and aid in skills acquisition, retention, and self-confidence
  - **Providing immediate feedback** during games, to reinforce appropriate behaviors, discourage less helpful behaviors, and increase self-esteem and self-confidence

- **Managing stress**
  - Use visualization strategies focused on relaxation and health promotion.
  - Stress can impair concentration, increase cognitive dysfunction (such as memory difficulties or impulsivity), and potentially lead to relapse.

- **Group treatment**
  - Enable clients to practice and strengthen generalizable social behaviors.
  - Use group treatment to reduce feelings of isolation and provide a sense of interpersonal support from persons with similar life circumstances.

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

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

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

RESOURCE REQUIREMENTS

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

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

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

The HHRP counselor manual was designed to be highly user-friendly and contains relevant background and theoretical material. This manual minimizes the need for extensive prior training. The manual includes all the other materials needed to run the program, such as
- detailed scripts for each group session
- all necessary visual aids (slides or PowerPoint format)
- learning activities
- quizzes

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

Other
For the program to be effectively and safely implemented, CBOs must
- maintain 2 group facilitators
• maintain a program manager/director
• maintain an administrative manager/interviewer
• provide individual sessions (Orientation and Closing)
• provide and adhere to all 12 of the manual-guided group sessions of HHRP
• have preexisting counseling and referral capabilities

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RECRUITMENT

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

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

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POLICIES AND STANDARDS

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

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

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

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

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

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

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

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

Facilitators
Training
The HHRP manual is comprehensive and contains detailed scripts for each session. Additional training required for facilitators will depend upon the facilitator’s level of expertise but could include
- completion of a training workshop, including review of the intervention theory and materials
- participation in practice sessions
- observed cofacilitation of groups, including practice with mock intervention sessions
Session Review
CBOs should have in place a mechanism to ensure that all session protocols are followed as written. Quality assurance activities can include observation and review of sessions by key staff and supervisors involved with the activity. This review should focus on

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

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

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

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

MONITORING AND EVALUATION

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

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

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


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

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

DESCRIPTION

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

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

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

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

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

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

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

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

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

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

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

Safety Counts has the following 5 core elements:

- Conduct 2 group sessions to have clients
  - identify their HIV risks and current stage of change
  - hear risk-reduction success stories
  - set a personal goal
  - identify a first step to reduce HIV risk
- Conduct 1 (or more) individual counseling session to
  - discuss and refine the client’s risk-reduction goal
  - assess the client’s needs and refer, if needed, to HIV counseling and testing services and to medical and social services
- Hold 2 (or more) group social events to have clients
  - share a meal and socialize
  - participate in planned HIV-related risk-reduction activities
  - receive reinforcement for personal risk reduction
- Conduct 2 (or more) follow-up contacts to
  - review the client’s progress in achieving risk-reduction goal
  - discuss barriers encountered
  - identify a next step and possible barriers and solutions
  - refer clients, if needed, to HIV counseling and testing services and to medical and social services
- Conduct or refer to counseling and testing for HIV and hepatitis C.
Each core element of Safety Counts must be implemented as prescribed in the Safety Counts program manual to ensure fidelity to the original intervention. The sessions are to be provided in the order and manner indicated in the program manual, in accordance with the 4-month timeline of the intervention. This required sequence of events is the most efficient way to conduct the Safety Counts intervention. Any deviation from the order outlined in the program manual may result in clients' failure to achieve or adhere to their chosen risk-reduction goal and may ultimately compromise the effectiveness of the Safety Counts intervention.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Follow-up Contacts**

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

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

**HIV and Hepatitis C Counseling and Testing**

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

**Key Characteristics**

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

Safety Counts has the following key characteristics:

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

**Procedures**

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

Procedures for Safety Counts are as follows:

**Counseling and Testing**

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

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

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

**Recruiting and Conducting Outreach**

In this important component of Safety Counts, clients recruit their peers into the group sessions. A peer who enrolls in the Safety Counts program is encouraged to seek counseling and testing for HIV, hepatitis C, and other infectious diseases as soon as possible, preferably on site. Staff also refer clients to prevention and treatment services; drug treatment services; shelter; and other social, medical, and support services.
Conducting the Intervention (general)
- Provide a meeting space that is comfortable and inviting.
- Plan interventions at the same time and place, which should be convenient and should not conflict with clients' other responsibilities or needs.
- Plan intervention sessions (especially socials) that are lively and developed with plenty of input from clients.
- Create an environment of trust and respect.
- Maintain strict confidentiality.
- Include the capacity to refer clients to other services (domestic abuse agencies, rape counseling, and mental health).

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

Individual counseling. The individual counseling session, which is conducted after the group sessions, focuses on behavior. It gives clients an opportunity to reflect on their personal risk-reduction goals and barriers to achieving those goals.
- If the goals were unrealistic or too difficult, clients work with counselors to revise them and come up with smaller, more achievable steps toward risk reduction.
- If the goals were easily achievable, clients and counselors set more challenging goals.

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

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

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

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**RESOURCE REQUIREMENTS**

**People**

At the minimum, Safety Counts requires the following:

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

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

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

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

**Space**

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

**Space for group meetings must**

- be available when needed
- be large enough for groups (group sessions of 8–10 people, social events of up to 30 people)
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- have comfortable seating arrangements for small- and large-group activities

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

**Other**

- **Money.** The cost of Safety Counts will vary according to regional and local differences; however, cost can be significantly reduced if supplies, services, and incentives are donated rather than purchased. When implementing Safety Counts, it is best to start with your budget first. Look at the amount of money you have, and then think about how many clients you would like to serve. The Safety Counts program manual suggests 8 to 10 clients per group, which means 8 to 10 per 4-month intervention cycle. Some agencies have implemented Safety Counts using 6 to 8 clients per group. You can consider having ten 4-month Safety Counts interventions a year, recruiting and starting a new 4-month intervention cycle approximately each month, or you can have three 4-month interventions a year. It all depends on your budget. The following example can be used as a general guide. If you have 10 clients per Safety Counts intervention, you need to consider cash or other incentives for all 10 and transportation assistance for all 10, then multiply that by 7 for each intervention activity (core element). That is just transportation assistance and incentives. For refreshments, calculate the cost for food and drink for all 10 at group sessions 1 and 2, and for the social events for the 10 and their guests. Once that is done, take your total (for transportation assistance, incentives, and food) and multiply that by the number of Safety Counts interventions you will conduct a year. That is the total cost to fund just the intervention.

- **Transportation** for clients and outreach workers, depending on where Safety Counts is implemented. In metropolitan areas, subway or bus tokens should be made available to clients, both as an incentive and as insurance that they will attend the intervention activities. In rural areas, consideration should be given to providing funds or vouchers for gasoline. CBOs may also consider asking clients to share rides to Safety Counts events.

- **Supplies** (TV, easels with paper and markers, safer-sex and needle-hygiene kits, photocopier, audiotape recorder/player, VCR, and video camera [optional])

- **Partnerships** with other organizations, if needed

- **Incentives.** Clients should receive an incentive for each and every core element that they successfully complete. Some CBOs will have budgeted for these incentives; some will not have. It is recommended that if cash or cash equivalents (gift coupons to grocery stores or department stores) cannot be distributed, alternatives be found to this type of incentive. It is recommended that members of the target population be asked (either individually or in a focus group) as to what type of incentives they would appreciate for Safety Counts participation. In addition, those CBOs that have no funds for incentives should seek donations from local merchants in order to provide the requested incentives.

- **Referral network** (for needs the CBO cannot meet, especially HIV counseling and testing)
RECRUITMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Volunteers**

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

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**QUALITY ASSURANCE**

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

**CBOs**

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

**Implementation Plan**

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

**Leadership and Guidance**

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

**Fidelity to Core Elements**

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

**Clients and Staff**

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

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

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

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

KEY ARTICLES AND RESOURCES


MPOWERMENT

DESCRIPTION

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

Mpowerment has been packaged by CDC’s Diffusion of Effective Behavioral Interventions project; information on obtaining the intervention training and materials is available at [www_effectiveinterventions.org](http://www_effectiveinterventions.org).

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

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

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

M-groups
At these peer-led, 1-time, 3-hour meetings, groups of 8 to 10 young gay and bisexual men discuss factors contributing to unsafe sex (e.g., misconceptions about safer sex, poor sexual communication skills). Through skill-building exercises and role-playing, the men practice safer-sex negotiation and correct condom use. The men receive free condoms and lubricant. They are trained and motivated to conduct informal outreach.

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

- adopting safer-sex behaviors
- knowing one’s HIV status
- seeking HIV testing
- disclosing HIV status to sex partners
- seeking medical care if HIV infected
Ongoing Publicity Campaign
The campaign attracts men to the project by word of mouth and through articles and advertisements in newspapers (gay, alternative, university).

Theories behind the Intervention
Mpowerment embodies many principles of community psychology, including the following:
- social diffusion theory
- social motivations for behavior
- importance of a community-level approach and multiple levels of approach
- community building and support
- peer influence
- empowerment philosophy

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

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

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

Mpowerment has the following 9 core elements:
- Recruit and maintain a core group of 12 to 20 young gay and bisexual men to design and carry out project activities.
- Recruit volunteers to help deliver services and to make important decisions about the program.
- Use project coordinators to oversee project activities.
- Establish a dedicated project space where many of the project activities can be held.
- Conduct formal outreach, including educational activities and social events.
- Conduct informal outreach to influence behavior change.
- Convene peer-led, 1-time discussion groups (M-groups).
- Convene a publicity campaign about the project within the community.
- Convene a Community Advisory Board.

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

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

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

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

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

- **Conduct Informal Outreach that**
  - spreads a norm of safer sex and HIV antibody testing
  - uses peer influence to change behavior
is achieved through nonjudgmental and supportive peer interactions
is reinforced through other project activities

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

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

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

**Guiding Principles**

- **Social focus.** Address young gay or bisexual men's social needs; link HIV prevention to
  fulfillment of these needs; infuse HIV prevention into all activities.

- **Empowerment philosophy.** Empower young gay or bisexual men. Behavior change is
  most lasting when persons are actively involved in creating and implementing solutions
  to their own problems; young gay or bisexual men are the decision makers of the project;
  it is their own project.

- **Peer-based.** Mobilize peers to act as agents of change within their social networks; peer
  influence is very powerful.

- **Multilevel and multicomponent.** Address multiple predictors of risk, and operate at
  many levels. Young gay or bisexual men engage in high-risk sex for a variety of reasons:
  individual factors (e.g., perception that safer sex is dull), interpersonal factors (e.g.,
  inability to negotiate safer sex with partner), and environmental factors (e.g., risky
  venues, no targeted programs for young gay or bisexual men).

- **Gay positive and sex positive.** Enrich and strengthen young gay or bisexual men's
  sexual identity and pride in being gay or bisexual; make safer sex methods more
attractive (not just focused on condoms); use images that reflect diversity of the community.

- **Community building.** Create healthy community; promote supportive friendship networks; disseminate a norm of safer sex throughout the community.

- **Diffusion of innovations.** Have young gay or bisexual men talk and encourage their friends to be safe; they spread this message throughout the community, and a norm of safer sex is established and reinforced.

**Procedures**

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

Procedures for Mpowerment are as follows:

**Locating Coordinators**

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

**Assessing the Community**

Next, CBOs conduct a community assessment to identify

- the different groups of young gay and bisexual men throughout the community (including what social settings exist and where the different groups congregate)

- resources (e.g., spaces in which to hold outreach events, especially those that attract young gay and bisexual men)

- people in the community who are relevant to the project (e.g., potential members of the Community Advisory Board, organizations that might support the project, places to advertise and recruit young gay and bisexual men)

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

**Assembling the Core Group**

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

**Recruiting Volunteers**

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

**Conducting Formal Outreach**

Formal outreach includes outreach teams and outreach events.

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

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

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

**Conducting Informal Outreach**

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

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

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

**Conducting a Publicity Campaign**

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

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**ADAPTING**

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

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**RESOURCE REQUIREMENTS**

**People**
Mpowerment needs the following people:

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

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

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

**Supplies**
Mpowerment needs

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

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

- formal outreach
- informal outreach
- publicity campaign

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

POLICIES AND STANDARDS

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

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

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

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

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

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

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

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

QUALITY ASSURANCE

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

Coordinators
Training
Coordinators should complete a training workshop that includes
- review of the intervention theory and materials
- participation in practice sessions.
- observation while cofacilitating groups, including practice of mock core groups and M-groups

Supervisors of coordinators should also (but are not required to) attend a training workshop that includes review of the intervention theory and materials.
Protocol Review
CBOs should have in place a mechanism to assure that all session protocols are followed as written. For quality assurance, key staff can review the sessions (by direct observation or videotape). They should look for
- adherence to session content
- use of appropriate videotapes and adequate facilitation of discussions
- accessibility and responsiveness to expressed client needs
- important process elements (e.g., time allocation, clarity)

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

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

MONITORING AND EVALUATION

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

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

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

KEY ARTICLES AND RESOURCES

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

REFERENCES


TOGETHER LEARNING CHOICES

DESCRIPTION

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

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

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

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

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

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

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

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

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

**Research Findings**

**Module 1**

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

**Module 2**

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

**Module 3**

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

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

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

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

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

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

- elimination of redundant concepts and activities
- addition of updated information on prevention technology, medical management of HIV, and “club drugs”
• integration of a perspective that treats HIV as a chronic disease, greater emphasis on nonscripted role plays.

Second, TLC now focuses on HIV-infected adolescents and young adults 13–29 years old who are receiving HIV-related services in medical clinics or social service agencies. It can be easily be adapted for other settings such as mental health centers.

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

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

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**CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES**

**Core Elements**

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

TLC has the following 5 core elements:

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

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

TLC has the following key characteristics:

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

Procedures for TLC are as follows:

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

Determining Session Format
HIV-infected young people meet regularly in small groups to provide social support, learn and practice new skills, and socialize. Every session in each of the 3 TLC modules establishes a routine to help clients confront a specific attitude or belief, address thoughts and feelings, and change a specific behavior. CBOs that implement TLC must include the following core components in each session:
- Clients review previous goal.
- Facilitator provides engaging activities focused on skill development, problem-solving, attitude formulation, and knowledge acquisition.
- Facilitators help clients reframe negative behavior patterns. A series of fun activities is used. Clients may videotape themselves meeting a new friend, disclosing their HIV status, or brainstorming on how to get angry with a doctor without then receiving poor medical care.
- Facilitators reinforce desired behavior through use of incentives.
- Clients set a new goal.
- Clients are complimented and compliment each other for trying to change their lives.

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

The steps of problem solving are as follows:
1. Determine what you want.
2. Identify ways to get what you want.
3. Evaluate the best way to get what you want.
4. Practice how to get what you want.
5. Try to get what you want.
6. Review how successful you were in reaching your goal.

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

ADAPTING

TLC was field tested in 9 clinical care sites in 4 AIDS epicenters (Los Angeles, New York, San Francisco and Miami). Most participants were black and Latino youth. TLC could be adapted for use in other venues and among other racial or ethnic groups.

RESOURCE REQUIREMENTS

Resource needs depend on the number of people living with HIV who are served by the CBO.

People

Program supervisor (at least 1)
- Program supervisors spend 50% of time training, supervising, and coordinating implementation during the first year.
- Program supervisors will need experience in behavioral theories of change and in conducting interventions with persons in small groups.
- Program supervisors need to spend 8 days in training (2 training courses, 4 days each, 1–2 months apart). This training can be spread out over 4 to 8 months. Trained program supervisors may be asked to train all CBO staff.

2 trained facilitators
1 program assistant

Space
TLC can be done anywhere that confidentiality of clients can be assured (for example, a private room) and where a group of young people living with HIV can meet.

Supplies
TLC uses
- special intervention tokens
- a “feeling thermometer”
- condoms
- models for practicing condom use
- standardized program workbooks
RECRUITMENT

The population recruited for TLC is young people living with HIV. They may be recruited from a variety of sites (community venues, AIDS service organizations, medical clinics) using a variety of techniques (word of mouth, print advertisements, flyers).

The Acting Safe module of TLC was designed to reduce sexual risk and substance use behaviors that contribute to increased risk for transmitting HIV. Perinatally infected youth who are not sexually active may not be ideal targets for this component of the intervention. Before implementing TLC organizations should consider screening youth to ascertain extent of risk behaviors and should assign those who are not sexually active into groups with similar ages, backgrounds, and experiences.

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

POLICIES AND STANDARDS

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

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

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

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

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

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

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

QUALITY ASSURANCE

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

Facilitators
Training for facilitators should address the following 3 areas:
- Completion of a training workshop, including review of the intervention theory and materials
- Participation in practice sessions
- Observed cofacilitation of groups, including practice of mock intervention sessions

A review mechanism should be in place to assure that all session protocols are followed as written. For quality assurance, key staff and supervisors can review the sessions. They should look for
- adherence to session content
• use of key cognitive behavioral skills techniques
• accessibility and responsiveness to expressed client needs
• important process elements (e.g., time allocation, clarity, use of social rewards)

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

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

MONITORING AND EVALUATION

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

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

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

KEY ARTICLES AND RESOURCES


A complete copy of the TLC intervention is available at:
http://chipts.ucla.edu/interventions/manuals/.

CDC would like to acknowledge and thank the faculty and staff of the Center for HIV Identification, Prevention, and Treatment Services (CHIPTS) in the UCLA Center for Community Health for their assistance in compiling this Procedural Guidance for Implementation of TLC.

REFERENCES


REAL AIDS PREVENTION PROJECT

DESCRIPTION

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

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

Goals
The objectives of RAPP are to

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

How It Works
The program has 3 phases: community assessment, mobilization, and maintenance.

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

Theories behind the Intervention
RAPP is based on 3 theories.

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

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

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

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

RAPP has the following 5 core elements:

- **Peer Network.** Recruit people from the community to become part of the peer network to talk to women and men about HIV prevention and related issues, distribute role model stories and educational materials, and provide referrals.
  - Depending on resources and target populations being served, a CBO can have more than 1 peer network. For example, if the target population is both African American and Latina women, a CBO can have 2 peer networks to meet the needs of these 2 target populations.
  - Additionally, male and youth networks can be established. It is important for CBOs to obtain information during their community assessment about how many networks should be established. The peer networks serve not only as a mechanism to increase HIV/AIDS awareness in a community but may serve also as support mechanism for the members (via ongoing trainings, social events, informal gatherings, etc.).

- **Staged-based Encounters.** To find out the person’s stage of change, conduct encounters that are 1-on-1 conversations led by trained outreach specialists and peer volunteers who ask questions about attitudes and condom use. Then, on the basis of the response, the outreach specialists or peer volunteers give women a message aimed at encouraging them to begin or continue condom use.
  - Staged-based encounters occur over time and are not necessarily conducted during the first encounter with a community member. It may be important for outreach specialists and trained peer volunteers to first establish a rapport with their community prior to conducting staged-based encounters.
  - Only trained staff should conduct this type of outreach as it requires a certain set of skills and an in-depth understanding of the stages of change model.

- **Role Model Stories.** Develop and distribute printed role model stories that are based on interviews with community members about their decisions to change their behavior.
  - The role model stories are based on real-life experiences of people in the community. In each role model story, a certain risk behavior is highlighted along with the role model’s stage of readiness to change the behavior and the influencing factors that will facilitate those changes.
The stories should capture only movement from 1 stage to another. However, CBOs can develop a set of role model stories based on 1 character that illustrates behavioral change through all 5 stages along with their appropriate influencing factors.

- **Community Network.** Recruit local businesses, organizations, and agencies to become part of the community network to support the project's goals. Ask them to display and distribute role model stories and other educational materials and to sponsor activities.
  - For recruitment and retention purposes, it is important for CBOs to conduct meetings for their community network members. These meetings provide an opportunity for network members to learn about RAPP, provide input, and volunteer resources to the project.
  - CBOs are strongly encouraged to conduct a yearly gathering to show appreciation for their community network members. This provides an opportunity for the community network members to renew their commitment to the project and provide recommendations for future RAPP activities.

- **Small-Group Activities.** Conduct small-group activities to promote safer sex, and host HIV/AIDS presentations. Recruitment for participation in the small-group activities is central to the outreach activities of RAPP.
  - The safer-sex gathering is a 1-session skills-building activity that allows women to learn to use male and female condoms correctly and teaches them how to negotiate safe-sex practices with their partners. However, depending on the needs of their target population, agencies can choose to have more than 1 session or gathering.
  - “Basic HIV 101” is provided during this session to increase women’s knowledge about HIV transmission and associated risk behaviors.
  - Culturally based role-playing activities and condom practice are emphasized during this session to empower women to use condoms correctly and consistently with their partners. Additional sessions can emphasize self-esteem building and issues like domestic violence.
  - This type of gathering also allows for women to learn of other programs or services being delivered in their community. Referrals are made to HIV testing and counseling centers as well as to other social service providers.
  - Participants in the safer-sex gatherings should be of the same sex and age group. Men-only gatherings can be conducted. Additionally, couple gatherings can be conducted, if requested by the women.
  - The HIV/AIDS presentations are delivered in various settings to increase awareness of how HIV affects the community and to increase HIV testing and counseling among community members. These presentations are delivered in places such as schools, churches, recreation centers, businesses, and health clinics.

**Key Characteristics**

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

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

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

Procedures for RAPP are as follows:

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

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

The purpose of community mobilization is to
- use existing networks to support behavior change
- draw attention to the role model stories and media message
- create opportunities for community involvement
- create project name and logo
- use the power of the community to initiate and maintain behavior change
Preimplementation activities usually take 9 to 12 months and include
- doing the community needs assessment
- recruiting persons for focus groups and key participant interviews
- finding volunteers for the peer network and community network
- arranging for materials to hand out

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

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

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

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

To get the widest range of opinions, the focus groups should be conducted with the following people:
- community leaders and other influential people who can “make or break” the project
- adult women who can share issues specific to women
- adult men who can provide insights from the male perspective
- teenagers

**Key participant interviews** are 1-on-1 interviews conducted with people who know about the community and about the people who will be affected by the project’s activities. Recognized community leaders, residents of the community, and people with alternative lifestyles (e.g., sex workers) should be interviewed. They should be asked about attitudes, beliefs, and perceptions related to HIV prevention.
Running the Project (Implementation)
This phase involves
- doing outreach
- scheduling and tracking peer network activities
- training volunteers, getting feedback from them, and adjusting according to the feedback
- writing new role model stories
- doing community networking
- leading safer-sex presentations
- keeping records

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

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

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

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

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

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

CBOs should use the following strategies for maintaining their peer network:
- Identify responsibilities early.
- Provide incentives such as gift certificates.
- Give volunteers a special bag for carrying materials.
- Present certificates for completed trainings.
- Provide ongoing support.

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

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

Stage-based outreach involves 5 things.
- Making contacts where people in the community live, work, and play
- Asking a few simple questions to find out whether the person is using condoms
- Determining the person's stage of change
- Responding in a way that gives information, encouragement, and positive feedback specific to the person's stage of change
- Handing out role model stories and condoms

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

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

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

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

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

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

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

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

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

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

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

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

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

Examples of adapting RAPP include

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

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

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

AHP Strategy 2. Implement new models for diagnosing HIV infections outside medical settings.
All activities described above can also be used to promote and provide information on programs or sites that offer special programs or opportunities for testing. CBOs that implement RAPP can offer testing, including rapid testing, or refer people to organizations or programs that can provide testing. In forming the community network, CBOs that implement RAPP can pay special attention to including AIDS service organizations and other agencies offering programs for diagnosing HIV infections outside of medical settings.
AHP Strategy 3. Prevent new infections by working with persons diagnosed with HIV and their partners.
Consistent condom use—the initial RAPP behavior change objective—will help prevent new infections. In addition, staff and volunteers from the CBOs conducting RAPP can refer, to case management or other services, any persons living with HIV that they encounter. They can provide information about the importance of partner notification. With the exception of information that may be provided in the course of a stage-based encounter, it is unlikely that RAPP personnel will know whether they are talking to someone who has a diagnosis of HIV. However, other RAPP activities can be used to provide sources for additional referrals or referral information. Use of a well-developed referral network is critical.

AHP Strategy 4. Further decrease mother-to-child HIV transmission
Pregnant women encountered in any of the activities conducted by RAPP staff and volunteers can be given information about the importance of prenatal care as well as testing and can be given referrals. (Voluntary testing is an integral part of standard prenatal care.) Encouragement provided through stage-based encounters, role model stories, or peer street outreach may be influential in a pregnant woman’s decision to be tested.

RESOURCES REQUIREMENTS

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

Space
RAPP needs a place to hold trainings and staff meetings. It should
- have comfortable seating for 6 to 12 people
- be near public transportation
- be near where the target population lives, works, and congregates

Supplies
RAPP needs
- a TV and VCR
- a computer and printer
- condoms
- incentives
RECRUITMENT

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

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

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

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

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

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

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

POLICIES AND STANDARDS

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

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

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

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

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

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

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

**Volunteers**

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

### QUALITY ASSURANCE

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

**RAPP Outreach Specialists**

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

**Peer Network Training (1 day)**

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

**Role Model Stories Training**

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

**Staged-Based Encounters Training (2 days)**

This 2-day training should be conducted by the outreach specialist or CBO staff. Participants in this training should have attended the 1-day peer network training. The first day of this training should focus on identifying stages of change, and the second day should concentrate on identifying and using influencing factors. The 2 sessions should not be held more than 1 week apart. The training should be conducted with small groups of 6 to 8 trainees. Frequent review and periodic retraining sessions with peer volunteers may be necessary. This training should be conducted by a trainer who is familiar with the application of stages of change theory.
All RAPP Training
Quality assurance activities can include direct observation and review of training conducted by the outreach specialist. The review could focus on the quality (or adherence to the fidelity) of the training delivered and responsiveness and openness of the volunteers to the outreach facilitator. Outreach specialists should collect all evaluation forms after the training and ensure confidentiality of the peer volunteers. In addition, outreach specialists should ensure that all clients are actively involved in the training activities. Monthly meetings with supervisors to discuss progress and opportunities for change are encouraged.

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

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

MONITORING AND EVALUATION

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

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

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

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

REFERENCES


CLEAR

DESCRIPTION

CLEAR (Choosing Life: Empowerment, Action, Results!) is an evidence-based HIV prevention and health promotion intervention for youth and adults (ages 16 or older) living with HIV/AIDS or at high risk for HIV. This individual-level intervention uses cognitive-behavioral techniques within a client-centered model to motivate people to change behavior. CLEAR can be implemented as a stand-alone intervention or integrated into Comprehensive Risk Counseling and Services programs. Because of the way CLEAR is designed (i.e., 5 required core skill sessions, 21 menu sessions, and a wrap-up session), counselors can tailor the intervention to fit each client’s unique circumstances.

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

Goals
CLEAR aims to help clients maintain health, reduce transmission of HIV and other sexually transmitted diseases, and improve their quality of life.

How It Works
CLEAR is unique in that it not only focuses on HIV prevention but provides clients with the skills to make healthy choices in all areas of their lives. In other words, it addresses the client’s overall life context. Life goals often are at the forefront of clients’ minds and help motivate clients to avoid making decisions that might harm their health or prevent them from reaching their dreams. Therefore, CLEAR is structured to focus first on clients’ life goals and then on HIV prevention goals.

The intervention starts off with 5 required core skill sessions, during which the counselor introduces the core elements and the client learns the essential cognitive-behavioral techniques (e.g., reframing, positive self-talk, relaxation) of CLEAR. By the end of the 5 core skill sessions, the client (with the help of the counselor) identifies both a life goal and 1 or more prevention goals on which to focus during the remainder of the program. The client’s prevention goals drive the selection of the menu sessions.

Using the individual prevention plan developed in core skill session 5, the counselor selects sessions from a menu of 6 domains to assist the client in achieving his or her prevention goals. Each client does not have to complete sessions in each of the 6 domains; the counselor should only implement the domains that are germane to the client’s prevention goals. Moreover, the counselor must select the menu domains based on the order of the prevention goals prioritized by the client. The 6 domains address sexual risk, substance use risk, health care and self-care, medication adherence, disclosure, and HIV stigma. Each domain consists of 2 to 6 sessions that help clients
practice the cognitive-behavioral techniques that were introduced in the core skill sessions. After the menu sessions are complete, a final wrap-up session addresses the maintenance of behavioral changes made in the program.

**Theory Behind the Intervention**

The CLEAR intervention is based on Social Action Theory, which asserts that a person’s ability to change behaviors that endanger his or her health is influenced by the individual’s self-change process (i.e., cognitive capability, information, self-efficacy, outcome expectancies, social skills, self-regulating skills, rewards) and contextual factors (i.e., environmental factors and social interactions) that encourage or discourage the change process.

CLEAR was designed to address the self-change process of the model by building clients’ problem-solving and negotiation skills and increasing clients’ self-efficacy to change behaviors.1

**Research Findings**

The original CLEAR intervention was evaluated with 175 HIV-positive people living in Los Angeles, San Francisco, and New York.2 Participants were ages 16-29, 26% were black, 42% were Latino, and 69% were gay men. They were assigned to a 3-module intervention that consisted of 18 sessions, delivered by telephone, in person, or a delayed-intervention condition. After the intervention, the proportion of protected sexual acts increased for all partners (and especially HIV-negative partners) among participants who received the in-person intervention. In addition, participants who received the in-person intervention had a larger decrease in the number of HIV-negative partners than did those in the control group. During preparation for its use in the field, CLEAR was modified to make implementation easier. For example, the number of intervention sessions was reduced from 18 sessions to 5 core skill sessions and additional menu sessions. This change in the number of sessions did not change the content of the curriculum. Further, all of the core elements responsible for CLEAR’s effectiveness were maintained.

**CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES**

**Core Elements**

Core elements are critical components of an intervention’s conceptualization and design that are believed to be responsible for the intervention’s effectiveness. These core elements are derived from the behavioral theories on which the intervention or strategy is based. **Core elements are essential and cannot be ignored, added to, or changed, in order to maintain intervention fidelity and intent.**

CLEAR has the following 5 core elements:

- Development of emotional awareness through use of a “feeling thermometer” and identification of the link between feelings, thoughts, and actions (Feel-Think-Do framework).
Identification of one’s ideal self to help motivate and personalize behavior change.
Teaching, modeling, and practicing short- and long-term goal setting.
Teaching, modeling, and practicing SMART (Self-Management and Recovery Training) problem solving.
Teaching, modeling, and practicing assertive behavior and communication.

**Key Characteristics**

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the community-based organization or target population. CLEAR has the following 6 key characteristics:

- Use incentives to encourage clients to return to sessions.
- Complete each session in 60 to 75 minutes.
- Conduct sessions once per week to allow clients time to practice new skills before the next session.
- Use experienced counselors or mental health professionals who have received formal clinical training.
- Deliver the intervention with a client-centered approach.
- Hold sessions in a room that ensures privacy and confidentiality and is free from interruptions.

**Procedures**

Procedures are detailed descriptions of some of the elements and characteristics listed above. Some of the procedures for CLEAR are as follows:

**Pre-assessment to establish eligibility**

Before implementing CLEAR, agencies should determine eligibility criteria and communicate this information to potential referral sources. When potential clients have been identified, agencies should conduct a brief pre-assessment to ensure that clients are eligible to participate in the program. At a minimum, clients should have at least a moderate level of motivation to make changes in high-risk behaviors related to any of the 6 menu domains: 1) substance use risk, 2) sexual risk, 3) health care and self-care, 4) medication adherence, 5) disclosure, and 6) HIV-related stigma. Level of motivation can be gleaned from a client’s history of keeping commitments to goals and tasks, expressed desire to seek support for general life or HIV-related stressors, or past attempts to seek support or participate in therapy or intervention programs.

**Ongoing assessment**

In CLEAR, counselors do not conduct client assessments just at the beginning of the intervention. Rather, the counselor gathers information from the client in an informal manner throughout his or her relationship with the client. Through this process, the counselor and the client work together to identify the client’s life goals and develop an individualized prevention plan. The life goals and prevention plan inform the menu selections.
Conducting CLEAR sessions
CLEAR sessions should occur on a weekly basis and be delivered by using a client-centered approach. Using this approach, the counselor lets the client dictate the priority of various goals and does not attempt to push an HIV-prevention agenda on the client. This is not to say that HIV prevention is not a focus of CLEAR; a skilled counselor will be able to create concern in clients about high-risk behaviors by tying these in with the client’s general life concerns.

Core skill sessions
There are 5 core skill sessions. Each of the sessions should be implemented sequentially, starting with core skill session 1 and ending with core skill session 5:
1. Getting to Know Each Other
2. Creating a Vision for the Future
3. Stressors and SMART Problem Solving
4. Exploring Different Types of Communication
5. Putting It All Together

Menu sessions
There are 21 menu sessions that fall under 6 domains. Like the core skill sessions, the menu sessions in each domain must be implemented sequentially. However, the counselor should begin with whatever domain was prioritized on the basis of the prevention goal the client chose to focus on first.

Domain 1: Sexual Risk (6 sessions)
1. Understanding Why I Have Unsafe Sex
2. How to Use Condoms (Correctly)
3. Can I Influence My Partner to Use Condoms?
4. Can I Influence My Partner to Engage in Safer Sex?
5. How Do I Refuse Unsafe Sex?
6. Should I Disclose My Status to My Sexual Partner(s)?

Domain 2: Substance Use Risk (5 sessions)
1. Setting a Foundation for Change
2. What Are My External Drug and Alcohol Triggers?
3. What Are My Internal Drug and Alcohol Triggers?
4. What Will Help Me Achieve My Goal Related to Injection Drug Use?

Domain 3: Health Care and Self-Care (3 sessions)
1. Motivation for Change: Wanting to Stay Healthy
2. Attending Health Care Appointments
3. Partnering in My Care and Treatment

Domain 4: Adherence (3 sessions)
1. Understanding My Medications and Adherence
2. What Affects the Way I Take My Medications?
1. How Can I Discuss Medications with My Health Care Provider?

Domain 5: Disclosure (2 sessions)
1. Should I Disclose My Status?
2. When and How Should I Disclose My HIV Status?

Domain 6: Stigma (2 sessions)
1. How Can I Cope with Internal Stigma?
2. How Can I Cope with External Stigma?

Termination
After addressing each of the client’s prevention goals, the counselor conducts a wrap-up session to bring closure to the client’s experience with CLEAR. This final session is designed to help the client develop maintenance strategies for sustaining new behaviors, provide an opportunity for the client to reflect on his or her experiences in CLEAR, and give the client his or her workbook, which can be used as a future resource.

ADAPTING

CLEAR can be used in a variety of settings where people are living with HIV/AIDS or have behaviors that put them at high risk for HIV. Because CLEAR is designed to address the unique needs of each client through the menu sessions, it is easily adaptable. In addition, CLEAR can be used as a structured approach to conducting comprehensive risk counseling and services.

RESOURCE REQUIREMENTS

Counselors
CLEAR requires trained counselors or mental health professionals. In the original intervention study, CLEAR was delivered by people who either held a master’s degree or were enrolled in a doctoral program in psychology, social work, or public health. Counselors with the following combination of skills and experience will be most successful in delivering CLEAR:

☐ Knowledge of HIV/AIDS.
☐ Knowledge of the target population.
☐ Past direct experience with the target population (children and adults living with HIV/AIDS or at high risk for HIV).
☐ Previous clinical training.
☐ Understanding of and experience working from a cognitive-behavioral theoretical orientation.
☐ Previous experience in delivering structured interventions.
☐ Bachelor’s or graduate degree in psychology, social work, or related field.
☐ Cultural sensitivity.
Clinical Supervisors
Counselors should participate in weekly group or individual clinical supervision in order to debrief about existing clients. Clinical supervision should be facilitated by a licensed clinician (e.g., clinical psychologist, marriage and family therapist, social worker) who has a strong background in cognitive-behavioral therapy. Clinical supervision typically addresses the following areas:

- Counselors’ personal feelings that may have surfaced during the session with the client.
- Clinical issues (e.g., family of origin concerns, history of trauma) that arose during the session.
- Delivery of the session from a clinical perspective.
- Delivery of the session from a client-centered perspective.
- Adherence to the intervention’s curriculum and integration of core elements.

Confidential Space
CLEAR sessions should be conducted in a comfortable space that is free from interruptions. Clients will be able to best learn new skills, share their life experiences, and develop trust in themselves and the counselors if sessions are held in a friendly, informal atmosphere where confidentiality is ensured. This space should include a table for taking notes and reviewing various handouts.

Materials
The CLEAR intervention package includes several helpful worksheets, handouts, and templates:

- Feeling thermometer.
- F-T-D grid.
- Weekly goal cards.
- Guidelines for good goals.
- SMART problem-solving steps.
- Individual prevention plan worksheet.
- Life goals worksheet.

RECRUITMENT
Agencies should have a recruitment plan in place that details how clients will be recruited, including recruitment venues, recruitment and marketing tools, and number to be recruited. An agency’s community advisory group should be able to help to develop this plan. Agencies implementing CLEAR may be most successful at recruiting and retaining clients from partner agencies that offer related services (e.g., Ryan White case management, substance abuse treatment, mental health services, counseling and testing). In addition, clients can be recruited via street outreach by using flyers or brochures, or via word-of-mouth from previous clients.
POLICIES AND STANDARDS

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

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

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

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

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

Legal and Ethical Policies
If agencies offer HIV testing with CLEAR, clients will learn their HIV status when they return for their test results. CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners. CBOs are obligated to inform clients of the organization’s responsibilities if a client receives a positive HIV test result and the organization’s potential duty to warn. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.
Referrals
CBOs must be prepared to refer clients as needed. For clients who need additional assistance in decreasing risk behavior, providers must know about referral sources for prevention interventions and counseling, such as comprehensive risk counseling and services, partner counseling and referral services, and other health department and CBO prevention programs.

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

QUALITY ASSURANCE

Quality assurance is an ongoing process that ensures that counselors maintain fidelity to the core elements of the intervention. The following quality assurance activities should be in place when implementing CLEAR.

Counselors and Supervisors

Training
Both counselors and clinical supervisors should participate in training and continuing education to ensure that they have the requisite skills to implement CLEAR successfully. Program managers, executive directors and key stakeholders should participate in the overview webinar to ensure they are aware of CLEAR program planning, implementation, and evaluation issues.

Session observation
The clinical supervisor should observe the counseling sessions periodically to ensure that counselors are consistently adhering to the CLEAR protocol and are providing high-quality counseling. These observations may be done in person, or the counselor might videotape or audiotape the session for later review by the supervisor or peer-review groups. Before the clinical supervisor observes the session, the counselor must obtain the consent of the client.

Record review
Records should be reviewed regularly to ensure that counseling sessions are documented consistently and correctly, consent forms (signed either by the client, if older than 18 or emancipated, or by a legal guardian) are on file, and that notes are of sufficient detail to document that clients are participating actively.

Case conferences
Case conferences are an ideal opportunity for counselors and supervisors to obtain support from and provide constructive feedback to other staff in the agency. During case conferences, the counselors and supervisors can present challenging sessions, practice
using the CLEAR intervention materials, and discuss strategies for better serving their clients. Peer role-playing can be a useful strategy during these meetings.

**Clients**
CLEAR staff should administer client satisfaction surveys to clients at the end of the 5 core skill sessions and then every 3 to 4 sessions thereafter. These anonymous surveys can be used to assess clients’ satisfaction with the overall counseling experience, session components (e.g., development of the individual prevention plan), and counselor characteristics (e.g., display of empathy). Clients also should be given the opportunity to offer suggestions on how to improve the sessions.

**MONITORING AND EVALUATION**

Specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the procedural guidance will include the collection of standardized process and outcome measures. Specific data reporting requirements will be provided to agencies after notification of award. For their convenience, grantees may utilize PEMS software for data management and reporting. PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management. CDC will also provide data collection and evaluation guidance and training and PEMS implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC by using PEMS or other software that transmits data to CDC according to data requirements. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies designed to assess the effect of HIV prevention activities on at-risk populations.

**KEY ARTICLES AND RESOURCES**


REFERENCES


RESPECT

An Effective, Individual, Client-focused HIV Prevention Intervention

FACT SHEET

Program Overview
RESPECT is an individual-level, client-focused, HIV prevention intervention, consisting of two brief interactive counseling sessions. The intervention is based on the Theory of Reasoned Action and Social Cognitive Theory. The provider follows a structured protocol to guide delivery of the intervention, using or creating a "reachable moment" to enhance a client's perception of their risk and level of concern for HIV infection. Teachable moments can be used to increase a person's motivation to change behaviors (i.e., being diagnosed with a new STD, or having a recent STD/HIV exposure). By discussing recent risk incidents, the provider helps the client identify triggers, circumstances, and patterns of risk-taking behavior, to increase perception of susceptibility. The provider works with the client to develop a risk reduction (RR) plan including referrals which support risk reduction.

This intervention can be easily incorporated into an HIV counseling/testing program, with HIV antibody testing offered to the client at the end of the first session. In this context, the provider provides the result of the HIV test during the second session, in which he helps the client understand the implications of the result, and provides additional support for risk reduction plans and partner counseling and referral.

If implemented in settings where testing is not offered, the same format is followed. However, in these settings it is recommended that RESPECT be embedded into an individual-level, multiple-session program, such as prevention-case management, or other behavioral counseling programs. This facilitates completion of the 2-session model, and discussion of reviewing the negotiated step toward risk reduction.

Core Elements of RESPECT:
- Conduct one-on-one counseling, using the RESPECT protocol prompts
- Utilize a “teachable moment” to motivate clients to change risk-taking behaviors
- Explore circumstances and context of a recent risk behavior to increase perception of susceptibility
- Negotiate an achievable step which supports the larger risk reduction goal
- Implement and maintain quality assurance procedures

Target Population
RESPECT can be implemented for any population at increased risk for HIV/STD. This intervention was originally studied in heterosexual persons, 14 years and older, who were accessing services from an STD clinic.

Program Materials
- The RESPECT manual
- RESPECT training video demonstrating the intervention counseling model
- Return appointment/RR plan cards
- A quality assurance protocol

Research Results
Compared to those in a comparison group (who received a brief educational message), men and women receiving the counseling intervention:
- Reported significantly greater condom use and reduction of risk behaviors
- Were diagnosed with fewer new sexually-transmitted infections

Significant changes were observed up to 12 months after the intervention.

Impressive Behavior Changes in Adolescents
In subgroup analysis, not only were the differences for the adolescent groups (counseling vs. education) highly significant, there were equally impressive risk reductions as well, including a 50% reduction in new STDs in adolescents (compared with 30% overall).

For more information on RESPECT...
To obtain additional information about how to receive training and/or technical assistance, please visit our website at: www.effectiveinterventions.org

APPENDIX B

EBI Matrices
CLEAR – Choosing Life: Empowerment, Action, Results!
New Jersey Department of Health and Senior Services  
Division of HIV, STD and TB Services  
Prevention and Education Unit

**CLEAR - Core Elements**  
*(cannot be changed)*

1. Development of emotional awareness through use of a Feeling Thermometer and identification of the link between feelings, thoughts and actions (F-T-D Framework).

2. Identification of one’s Ideal Self to help motivate and personalize behavior change.

3. Teaching, modeling, and practicing Short-and Long-Term Goal Setting.

4. Teaching, modeling, and practicing SMART Problem-Solving.

5. Teaching, modeling, and practicing Assertive Behavior and Communication.

<table>
<thead>
<tr>
<th>Key Characteristics (can be modified if needed)</th>
<th>State Requirements (cannot be changed)</th>
<th>Best Practices (suggested for best outcome)</th>
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<tbody>
<tr>
<td>☐ Use of incentives – to encourage clients to return to subsequent sessions and keep them engaged, incentive strategy should be purposeful and developed by or with feedback from your community advisory group.</td>
<td>☐ A policy and procedure guide must be developed for the implementation and facilitation of CLEAR at each agency.</td>
<td>☐ Case conferencing should be integrated into staff meetings to discuss issues and receive feedback about the delivery of the CLEAR intervention.</td>
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<td>☐ Time – sessions will be about 60-75 minutes in length and should be kept to the time allotted.</td>
<td>☐ An IDI must be conducted prior to enrolling in CLEAR to: complete screening to determine eligibility and appropriateness, be introduced to CLEAR, complete any needed forms, and discuss HIV testing to learn about status before starting intervention, and complete the stages of change assessment.</td>
<td>☐ HIV testing must be <em>offered</em> before beginning the Core sessions. Knowing a client’s HIV status will help both counselor and client focus in on a specific perspective about HIV risk and will help develop an individualized plan incorporating the appropriate domains from the menu of 21 other sessions.</td>
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<td></td>
<td>☐ After initial IDI and first 5 core sessions are completed, one of the six domains will be selected by counselor and client based on client need. Additional domains may be selected per client’s identified need.</td>
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<td>Intervals between sessions – once a week, biweekly may work but once a month is not recommended. Note: it is not recommended that an agency conduct all core or menu sessions in one day or a weekend.</td>
<td>Wrap-Up session must be conducted after the last domain is completed. This session will include additional referrals and the Stages of Change assessment.</td>
<td>If using CLEAR for a PWP program, additional training may be needed (e.g., medical HIV updates, conferences, etc.)</td>
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<td>Location – conducted in a setting that can maintain confidentiality and privacy.</td>
<td>Sessions must be held weekly. If client misses a scheduled session, counselor must attempt to reschedule with client within a week. Counselor must document missed session, his or her follow-up efforts and when client has been rescheduled. If two or more sessions are missed consecutively, counselor must notify supervisor to discuss alternatives to client retention and engagement. If a client is inactive for 1 month, he or she will be discharged.</td>
<td>Additional training to help develop or strengthen counseling skills should be incorporated when available as part of professional development for those prevention workers who may be new to or need to enhance counseling skills (i.e. Motivational Interviewing).</td>
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<td>A client will be eligible for re-enrollment into CLEAR 60 days after discharge or successful completion.</td>
<td>New counselors should be observed once a week by their supervisor.</td>
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<td>Client is considered to have successfully completed CLEAR after 1) initial IDI for screening and eligibility, 2) first 5 core session, 3) at least 1 domain, and 4) the Wrap-Up Session (see algorithm for details). All sessions within each domain must be conducted to in order to be considered a successful completion of that domain.</td>
<td>Use varied recruitment strategies.</td>
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<td>CLEAR should be used to compliment other prevention strategies such as EBI group interventions, HC/PI, support group and HIV/STD testing.</td>
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</table>
Client Files must be kept in a locked cabinet and behind a locked door to ensure confidentiality.

Information must be included about Hep/STD (including written materials) and referrals to testing and treatment when appropriate.

Supervisors must observe a CLEAR session with each counselor once a quarter using the Counselor Observation Form.

Chart reviews must be conducted on a quarterly basis to ensure quality and consistency of services. Each counselor conducting CLEAR must attend the HIV Series offered by DHAS and the CLEAR Training of Facilitators.

Supervisors must attend the HIV Series offered by DHAS, the CLEAR Training of Facilitators and the CLEAR Supervisor’s Training.

Sessions must take place in a private and secure area to ensure confidentiality.

HIV counseling and testing referral resources must be provided to the client if he or she has not already agreed to HIV testing.

Use only DHAS approved teaching materials (including pamphlets, videos, etc.).

Linkage with a mental health counselor should be secured to assure timely referrals.

Agencies that provide one time only or brief interventions (like Voices, RESPECT, or unstructured IDI’s). should utilize CLEAR to enhance services to their funded target population.

Enroll one-third more clients to ensure that the Attachment C goal numbers are met.
3MV – Many Men, Many Voices
### 3MV - Core Elements

*cannot be changed*

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

### 3MV - Enrollment

<table>
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<tr>
<th>Key Characteristics (can be modified if needed)</th>
<th>State Requirements (cannot be changed)</th>
<th>Best Practices (suggested for best outcome)</th>
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<tbody>
<tr>
<td>☐ Groups must consist of at least six but no more than 12 participants (for retreats, 30-40)</td>
<td>☐ If a group membership drops to three or less, the cycle must be re-started. DHAS will not count a group of three or less as a completed cycle</td>
<td>☐ To ensure a full group, enroll at least 1/3 more clients</td>
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| ☐ If a group membership drops to three or less, the cycle must be re-started. DHAS will not count a group of three or less as a completed cycle | ☐ There are three choices of group composition:  
- seven three-hour sessions  
- twelve 75-minute sessions  
- a weekend retreat | ☐ Unless otherwise assessed by facilitator, a score of “Pre-contemplative” on the Stages of Change assessment indicates the client is not ready for a group intervention |
### 3MV - Enrollment (continued)

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<tr>
<td>If conducting sessions offsite, an MOA is needed with the outside agency where the intervention will be conducted</td>
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<td>Groups are closed. If a participant misses a session, he/she must wait for the next intervention cycle</td>
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### 3MV - Staff Composition

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<tr>
<td>This EBI should be co-facilitated by two or more facilitators who are MSM of color</td>
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<tr>
<td>Facilitators, Supervisors, and any other staff or volunteers that wish to co-facilitate must attend the HIV Series trainings as well as EFS, and the 3MV Training of Facilitators.</td>
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<td>Program Coordinator must attend one-day Supervisors’ Training.</td>
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<td>One facilitator should be of the same ethnicity or race of the majority of the group</td>
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### 3MV - Staff Composition (continued)

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<tr>
<td>□ Program Coordinator must observe one session per cycle (female supervisors will request a consultant who must match target population to observe) and meet with facilitator to evaluate quality assurance and fidelity to the intervention model</td>
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### 3MV - Target Population

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<tr>
<td>□ Participants must be at least 18 years of age</td>
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<td>□ This intervention is for MSM of color who self-identify as either gay or MSM. It may also target men on the “down low” who may not be open to communicating and may be antagonistic self-identifying gay men or MSM but caution should be exercised in enrolling men on the down low</td>
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<tr>
<td>□ The group must be sexually homogenous (all MSMs) to allow for open discussion pertaining to sexual practice.</td>
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### 3MV - Program Implementation

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<th>Best Practices (suggested for best outcome)</th>
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</thead>
<tbody>
<tr>
<td>☐ Explore sexual relationship dynamics</td>
<td>☐ Prescreening process is required for each participant, including the Stages of Change assessment</td>
<td>☐ Ensure HIV counseling and testing access by inviting a tester to be present before or after at least one group session</td>
</tr>
<tr>
<td>☐ Foster positive identity development for gay men of color by:</td>
<td>☐ Each potential participant must have at least 2 IDIs before entering the program</td>
<td>☐ A session added to cover Hep/STD should be done in a group or as IDIs at the end of the cycle (refer to Attachment C)</td>
</tr>
<tr>
<td>1. exploring the dual identity culture</td>
<td>☐ Free condoms (both male and female) must be made available to participants</td>
<td>☐ Each participant in the 3MV EBI should receive follow-up risk reduction counseling in the form of single or multi-session IDIs to provide opportunities for follow-up discussion and risk-reduction counseling</td>
</tr>
<tr>
<td>2. addressing social and culture norms within racial/ethnic communities</td>
<td>☐ HIV counseling and testing referral resources must be provided to the group</td>
<td>☐ Any</td>
</tr>
<tr>
<td>3. exploring positive and negative peer influences, setting self-standards and clarifying values</td>
<td>☐ Information must be included about Hep/STD including written materials and referrals</td>
<td></td>
</tr>
</tbody>
</table>
Healthy Relationships
### Healthy Relationships - Core Elements (cannot be changed)

1. Defining stress and reinforcing coping skills with people living with HIV/AIDS across three life areas:
   - disclosing to family and friends
   - disclosing to sexual partners
   - building healthier and safer relationships
2. Using modeling, role-play, and feedback to teach and practice skills related to coping with stress
3. Teaching decision-making skills about disclosure of HIV status
4. Providing participants with Personal Feedback Reports, based on the Initial Assessment Survey, to motivate change of risky behaviors and continuance of protective behaviors
5. Using movie-quality clips to set up scenarios about disclosure and risk reduction to stimulate discussions and role-plays

### Healthy Relationships - Enrollment

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<tbody>
<tr>
<td>☐ Groups must consist of at least six but no more than 12 participants</td>
<td>☐ To ensure a full group, enroll at least 1/3 more clients</td>
<td></td>
</tr>
<tr>
<td>☐ If a group membership drops to three or less, the cycle must be re-started. DHAS will not count a group of three or less as a completed cycle</td>
<td>☐ Unless otherwise assessed by facilitator, a score of “Pre-contemplative” on the Stages of Change assessment indicates the client is not ready for a group intervention</td>
<td></td>
</tr>
<tr>
<td>☐ If conducting sessions offsite, an MOA is needed with the outside agency where the intervention will be conducted</td>
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Healthy Relationships - Staff Composition

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</thead>
<tbody>
<tr>
<td>☐ One facilitator is male and the other female</td>
<td>☐ Facilitators, Supervisors, and any other staff or volunteers that wish to co-facilitate must attend the HIV Series trainings as well as EFS, and the Healthy Relationships Training of Facilitators</td>
<td>☐ One facilitator should be of the same ethnicity or race as the majority of the group</td>
</tr>
<tr>
<td>☐ At least one facilitator matches the ethnicity of the majority of group members</td>
<td>☐ Program Coordinator must attend the Healthy Relationships Training of Facilitators training</td>
<td></td>
</tr>
<tr>
<td>☐ At least one group facilitator is an experienced and skilled counselor, and preferably, a mental health professional. This facilitator may or may not be living with HIV/AIDS</td>
<td>☐ Program Coordinators must attend a one-day Supervisor’s Training</td>
<td></td>
</tr>
<tr>
<td>☐ One facilitator is a peer counselor who is living with HIV/AIDS</td>
<td>☐ Program Coordinator must observe one session per cycle and meet with facilitator to evaluate quality assurance and fidelity to the intervention model</td>
<td></td>
</tr>
<tr>
<td>☐ Both facilitators have the personal characteristics and group skills of effective facilitators</td>
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<td></td>
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</tbody>
</table>
### Healthy Relationships - Target Population

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<thead>
<tr>
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</tr>
</thead>
</table>
| ☐ Groups are divided by gender and sexual orientation of the members | ☐ Participants must be HIV+  
☐ Participants must be at least 18 years of age  
☐ This intervention is for heterosexual men, heterosexual women, or homosexual men only  
☐ The group must be sexually homogenous (all heterosexual men, all heterosexual women, or all homosexual men) to allow for open discussion pertaining to sexual practice  
☐ Persons that are in a relationship can not attend the same group | |

### Healthy Relationships - Program Implementation

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</table>
| ☐ Participants meet in small groups, similar in style to support groups. The groups are "closed", which means that new members cannot join once the series of sessions has begun  
☐ Participants sit in a circle, face-to-face | ☐ Groups are closed. If a participant misses a session, he/she must wait for the next intervention cycle  
☐ There must be at least 1 week between each session  
☐ Free condoms (both male and female) must be made available to participant. | ☐ Ensure HIV counseling and testing access for partners by inviting a tester to be present before or after at least one group session  
☐ A session added to cover Hep/STD should be done in a group or as IDIs at the end of the cycle (refer to Attachment C) |
<table>
<thead>
<tr>
<th>Healthy Relationships - Program Implementation (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key Characteristics</strong> (can be modified if needed)</td>
</tr>
</tbody>
</table>
| ☐ Groups meet for at least five 120-minute sessions (note: the amount of time spent can be increased but not decreased) | ☐ HIV counseling and testing referral resources must be provided to the group  
☐ Information must be included about Hep/STD including written materials and referrals  
☐ Use only DHAS approved teaching materials (including pamphlets, videos, etc.) | ☐ Linkage with a mental health counselor should be secured to assure timely referrals |
HHRP – Holistic Health Recovery Plan
**HHRP - Core Elements**
(can not be changed)

1. Teaches skills to reduce harm of injection drug use and unprotected sexual activities
2. Teaches negotiation skills to reduce unsafe sexual behaviors with sexual partners and teaches skills to heal social relationships
3. Teaches decision making and problem solving skills using cognitive remediation strategies
4. Teaches goal setting skills including developing action plans to achieve goals
5. Teaches skills to manage stress, including relaxation exercises and understanding what aspects of the stressful situation can, and cannot, be controlled
6. Teaches skills to improve health, health care participation, and adherence to medical treatments
7. Teaches skills to increase clients’ access to their own self-defined spiritual beliefs, in order to increase motivation to engage in harm reduction behaviors
8. Teaches skills to increase awareness of how different senses of self can affect self-efficacy and hopelessness

**HHRP - Enrollment**

<table>
<thead>
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<th>Best Practices (suggested for best outcome)</th>
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</thead>
<tbody>
<tr>
<td>☐ HHRP is delivered only in a group modality. Group size three to 15</td>
<td>☐ Groups must consist of at least six but no more than 15 participants</td>
<td>☐ To ensure a full group, enroll at least 1/3 more clients</td>
</tr>
</tbody>
</table>
| ☐ There are two enrollment options available to agencies:  
  1. Cohort enrollment- clients start together and proceed through all 12 groups as a group  
  2. Open enrollment- new clients start any week (this option can be used only if HHRP program is offered on an ongoing basis) | ☐ If a group membership drops to three or less, the cycle must be re-started. DHAS will not count a group of three or less as a completed cycle  
  ☐ If conducting sessions offsite, an MOA is needed with the outside agency where the intervention will be conducted  
  ☐ Either cohort enrollment (closed group) or open enrollment is | ☐ Unless otherwise assessed by facilitator, a score of “Pre-contemplative” on the Stages of Change assessment indicates the client is not ready for a group intervention |
New Jersey Department of Health and Senior Services  
Division of HIV, STD and TB Services  
Prevention and Education Unit

<table>
<thead>
<tr>
<th>HHRP - Staff Composition</th>
<th>permissible</th>
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<tr>
<td><strong>Key Characteristics (can be modified if needed)</strong></td>
<td><strong>State Requirements (cannot be changed)</strong></td>
</tr>
<tr>
<td>☐ HHRP groups are co-facilitated by 2 substance abuse counselors, at least one of whom should be a masters' level clinician with experience. ☐ A male/female team is recommended.</td>
<td>☐ Facilitators, Supervisors, and any other staff or volunteers that wish to co-facilitate must attend the HIV Series trainings as well as EFS, and the HHRP Training of Facilitators ☐ Program Coordinator must attend one-day Supervisors' Training ☐ Program Coordinator must observe one session per cycle and meet with facilitator to evaluate quality assurance and fidelity to the intervention model</td>
</tr>
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<table>
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<tr>
<th>HHRP - Target Population</th>
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<td><strong>Key Characteristics (can be modified if needed)</strong></td>
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</table>
| ☐ The standard eligibility criteria are as follows:  
  • have recently used (within the last 30 days) or are actively using drugs | ☐ Participants must be at least 18 years of age  
  ☐ The intervention is for HIV negative persons. However, an HIV+ person may participate if he/she has been counseled to understand that the focus of the group will include HIV prevention | |
**HHRP - Target Population (continued)**

<table>
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<tr>
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<th>Best Practices (suggested for best outcome)</th>
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</thead>
<tbody>
<tr>
<td>either in drug treatment or have expressed a desire to enter drug treatment (However, eligibility requirements may be adapted or tailored to be made more appropriate for other populations, such as HIV+ drug users or users of unknown serostatus)</td>
<td>The intervention is for persons currently in drug treatment or has expressed a desire to enter treatment</td>
<td>Participants must have used drugs with the last year</td>
</tr>
</tbody>
</table>

**HHRP - Program Implementation**

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</table>
| There are several ways that HHRP can be implemented.  
1. One two-hour session for 12 weeks  
2. Two weekly one-hour sessions for 12 weeks  
3. One two-hour session alternating with discussion groups weekly for 24 weeks | Cycle composition must be one two-hour session for 12 weeks | Ensure HIV counseling and testing access by inviting a tester to be present before or after at least one group session |
| Membership in HHRP takes commitment. HHRP members are to attend all group and | There must be at least 1 week between each session | A session added to cover Hep/STD should be done in a group or as IDIs at the end of the cycle (refer to Attachment C) |
| | For the sake of PEMS reporting, a participant is considered successfully completing the program if he/she attends 9 out of the 12 sessions | Linkage with a mental health counselor should be secured to assure timely referrals |
New Jersey Department of Health and Senior Services  
Division of HIV, STD and TB Services  
Prevention and Education Unit

<table>
<thead>
<tr>
<th>HHRP - Program Implementation (continued)</th>
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</thead>
<tbody>
<tr>
<td>- Members are to be discontinued (and are to start over, if they indicate that they want to participate) if 6 sessions are missed</td>
<td>- If a client misses 6 total sessions, an IDI must occur to address barriers of participation before client can re-enter the cycle. This does not mean the client must take the cycle again, but re-enter whatever session is next in the cycle</td>
<td>- Free condoms (both male and female) must be made available to participants</td>
<td>-</td>
</tr>
<tr>
<td>- The presentation of information through HHRP video segments are meant to teach skills and enhance the learning process.</td>
<td>- HIV counseling and testing referral resources must be provided to the group</td>
<td>- Information must be included about Hep/STD including written materials and referrals</td>
<td>-</td>
</tr>
<tr>
<td>- Experiential activities provide a non-threatening context in which members of HHRP can practice skills</td>
<td>- Use only DHAS approved teaching materials (including pamphlets, videos, etc.)</td>
<td>-</td>
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<tr>
<td>- Immediate feedback during games, role plays, and exercises can reinforce appropriate behavior and increase self-esteem and self-confidence.</td>
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<tr>
<td>- HHRP slides are meant to be 1. visually engaging 2. gender neutral, and 3. race/ethnic neutral</td>
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</tbody>
</table>

individual sessions without fail.
RESPECT
RESPECT - Core Elements *(cannot be changed)*

<table>
<thead>
<tr>
<th>Key Characteristics <em>(can be modified if needed)</em></th>
<th>State Requirements <em>(cannot be changed)</em></th>
<th>Best Practices <em>(suggested for best outcome)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Allow the client to identify an achievable risk reduction step.</td>
<td>☐ A policy and procedure guide must be developed for the implementation and facilitation of RESPECT at each agency.</td>
<td>☐ Case conferencing (including role plays) should be integrated into staff meetings to discuss issues and receive feedback about the delivery of the RESPECT intervention.</td>
</tr>
<tr>
<td>☐ Engage in role-plays with the client to increase the client’s self-efficacy to engage in risk-reduction behaviors.</td>
<td>☐ If conducting sessions offsite, an MOA is needed with the outside agency where the intervention will be conducted</td>
<td>☐ Use varied recruitment strategies.</td>
</tr>
<tr>
<td>☐ Provide referrals based on the client’s self-identified needs.</td>
<td>☐ Use only DHAS approved teaching materials (including pamphlets, videos, etc.)</td>
<td>☐ This structured IDI intervention should be used to compliment other prevention strategies (to create or strengthen prevention goals and risk reduction efforts) such as EBI group interventions HC/PI, support group and</td>
</tr>
<tr>
<td>☐ Modify the time needed to complete all of the protocol components. Taking cues from client needs</td>
<td>☐ Risk Assessment must be done during Session 1 to determine risk behaviors.</td>
<td></td>
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<tr>
<td></td>
<td>☐ Documentation of a strategy to reduce HIV risk identified during assessment must be completed using the risk reduction step form</td>
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<tr>
<td></td>
<td>☐ Counselor must guide the flow of the sessions using the structured protocol provided in curriculum or by</td>
<td></td>
</tr>
</tbody>
</table>
New Jersey Department of Health and Senior Services  
Division of HIV, STD and TB Services  
Prevention and Education Unit

<table>
<thead>
<tr>
<th>and agency requirements.</th>
<th>DHAS (Respect Session # 1 and #2 or Respect Modified Session #1 and #2).</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Provide testing onsite</td>
<td>□ For conducting Rapid HIV Testing in conjunction with RESPECT, use the Respect Modified Session #1 and #2 protocols</td>
</tr>
<tr>
<td>□ Conduct sessions using open-ended questions, prompting the client to engage actively in the discussion.</td>
<td>□ Sessions must take place in a private and secure area to ensure confidentiality</td>
</tr>
<tr>
<td></td>
<td>□ Client files must include: Progress notes, Risk Reduction Step form, appropriate referrals forms and other forms as needed (i.e. records releases, incentive tracking forms)</td>
</tr>
<tr>
<td></td>
<td>□ Client Files must be kept in a locked cabinet and behind a locked door to ensure confidentiality.</td>
</tr>
<tr>
<td></td>
<td>□ HIV testing referrals must be offered if 1) client has not tested onsite during this session or 2) testing is not available onsite.</td>
</tr>
<tr>
<td></td>
<td>□ Information must be included about Hep/STD (including written materials) and referrals to testing and treatment if appropriate.</td>
</tr>
<tr>
<td></td>
<td>□ Supervisors must observe a RESPECT session with each counselor once a quarter using the Counselor Observation Form.</td>
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<tr>
<td></td>
<td>□ Chart reviews must be conducted on a quarterly basis to ensure quality and consistency of services</td>
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<tr>
<td></td>
<td>□ Enroll one-third more clients to ensure that the Attachment C goal numbers are met.</td>
</tr>
<tr>
<td></td>
<td>□ Linkage with a mental health counselor should be secured to assure timely referrals.</td>
</tr>
<tr>
<td></td>
<td>□ When planning Attachment C objectives, Respect should be first choice in short-term one-on-one individual level prevention services. Unstructured IDI’s should be reserved for recruitment and engagement efforts as well as a great tool for follow-up with previously enrolled and/or completed interventions.</td>
</tr>
</tbody>
</table>
Each counselor utilizing the RESPECT intervention must attend the HIV Series offered by DHAS and the RESPECT Training of Facilitators

☐ Supervisors must attend the HIV Series offered by DHAS, the RESPECT Training of Facilitators and the RESPECT Supervisor's Training.
Safety Counts
Safety Counts - Core Elements (cannot be changed)

1. Group Session One and Group Session Two (identify client’s HIV risks and current stage of change, hear risk-reduction success stories, set personal goal, identify first step to reduce HIV risk, and make referrals to C&T and medical/social services).

2. One (or more) Individual Counseling Session (discuss/refine risk-reduction goal, assess client’s needs, and provide needed referrals to C&T and medical/social services).

3. Two (or more) Social Events (share meal and socialize, participate in a planned HIV-related risk-reduction activity, and receive reinforcement for personal risk reduction.)

4. Two (or more) Follow-up Contacts (review client’s progress in achieving risk-reduction goal, discuss barriers encountered, identify concrete next step and discuss possible barriers/solution, and make referrals to C&T and medical/social services).

5. HIV Counseling and Testing (offer the client this service either through referrals or at the implementing agency).

Safety Counts - Enrollment

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<tr>
<td>☐ Groups must consist of at least six but no more than 12 participants</td>
<td>☐ To ensure a full group, enroll at least 1/3 more clients</td>
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<tr>
<td>☐ If a group membership drops to three or less, the cycle must be re-started. DHAS will not count a group of three or less as a completed cycle</td>
<td>☐ Unless otherwise assessed by facilitator, a score of “Pre-contemplative” on the Stages of Change assessment indicates the client is not ready for a group intervention</td>
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</tr>
<tr>
<td>☐ Groups are open enrollment (i.e. after Program Enrollment, clients can enter the group at whatever session the cycle is in)</td>
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</table>
## Safety Counts - Enrollment (continued)

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<td>☐ If conducting sessions offsite, an MOA is needed with the outside agency where the intervention will be conducted</td>
<td>☐ Program Coordinator must observe one session per cycle and meet with facilitator to evaluate quality assurance and fidelity to the intervention model</td>
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## Safety Counts - Staff Composition

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<tbody>
<tr>
<td>☐ Facilitators, Supervisors, and any other staff or volunteers that wish to co-facilitate must attend the HIV Series trainings as well as EFS, and the Safety Counts Training of Facilitators</td>
<td>☐ Program Coordinator must attend one-day Supervisors’ Training</td>
<td>☐ One facilitator should be of the same ethnicity or race of the majority of the group</td>
</tr>
<tr>
<td>☐ Program Coordinators must observe one session per cycle and meet with facilitator to evaluate the quality assurance and fidelity to the intervention model</td>
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</tbody>
</table>
### Safety Counts - Target Population

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<tbody>
<tr>
<td>☑ Participants must be at least 18 years of age</td>
<td>☑ This intervention is for persons currently using drugs and are not in treatment only</td>
<td>☐ Ensure HIV counseling and testing access by inviting a tester to be present before or after at least one group session</td>
</tr>
</tbody>
</table>

### Safety Counts - Program Implementation

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<tr>
<td>☑ Use different media (e.g., videotapes) for risk-reduction success stories of local drug users who have reduced their risk for HIV and hepatitis</td>
<td>☑ Intervention cannot be conducted at any drug treatment center</td>
<td>☐ Ensure HIV counseling and testing access by inviting a tester to be present before or after at least one group session</td>
</tr>
<tr>
<td>☑ Help the client identify and access sources of social support for accomplishing a personal risk-reduction goal</td>
<td>☑ There must be at least one week between each session</td>
<td>☐ A session added to cover Hep/STD should be done in a group or as IDIs at the end of the cycle (refer to Attachment C)</td>
</tr>
<tr>
<td>☑ Provide ongoing guidance and reinforcement for each client's step-by-step progress in achieving the risk-reduction goal</td>
<td>☑ Sequence &amp; Timing of Sessions: Program Enrollment – on going • Week One - Group One • Week Two - Social Event • Week Three - Group Two • Week Four - Individual Counseling Session • Within one month after Individual Counseling Session conduct Social Event Two • Within one month after Social Event Two conduct Follow-up Contact One</td>
<td>☐ Social Events should be on-going and occur once a month</td>
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<tr>
<td></td>
<td></td>
<td>☐ Linkage with a mental health counselor should be secured to assure timely referrals</td>
</tr>
</tbody>
</table>
## Safety Counts - Program Implementation (continued)

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<th>Key Characteristics (can be modified if needed)</th>
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<tbody>
<tr>
<td>• Within one month after Follow-up contact conduct Follow-up Contact Two</td>
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<tr>
<td>• Follow-Ups must be conducted face to face in the field</td>
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</tr>
<tr>
<td>• Free condoms (both male and female must be available to participants</td>
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</tr>
<tr>
<td>• HIV counseling and testing referral resources must be provided to the group</td>
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<td>• Information must be included about Hep/STD including written materials and referrals</td>
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<tr>
<td>• Use only DHAS approved teaching materials (including pamphlets, videos, etc.)</td>
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SISTA
**SISTA - Core Elements** (cannot be changed)

1. Convene small-group sessions to discuss the session objectives, model skills development, role-play women's skills acquisition, and address the challenges and joys of being an African American woman.

2. Use skilled African American facilitators to implement SISTA group sessions.

3. Use cultural and gender appropriate materials to acknowledge pride and enhance self-worth in being African-American (i.e., artwork, poetry and music by African-American women).

4. Teach women to communicate both verbally and nonverbally to show that she cares for self and her partner and needs to protect self (i.e., negotiation skills, assertive communication skills).

5. Instruct women on how to effectively and consistently use condoms (i.e., condom use skills).

6. Discuss culture- and gender-related barriers that may make it challenging for women to negotiate safer sex.

7. Discuss culture- and gender-related barriers that may make it challenging for women to negotiate safer sex.

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**SISTA - Enrollment**

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<tr>
<td>☐ Groups must consist of at least six but no more than 12 participants</td>
<td>☐ If a group membership drops to three or less, the cycle must be re-started. DHAS will not count a group of three or less as a completed cycle</td>
<td>☐ To ensure a full group, enroll at least 1/3 more clients</td>
</tr>
<tr>
<td>☐ If a group membership drops to three or less, the cycle must be re-started. DHAS will not count a group of three or less as a completed cycle</td>
<td>☐ Groups are closed. If a participant misses a session, she must wait for the next intervention cycle</td>
<td>☐ Unless otherwise assessed by facilitator, a score of “Pre-contemplative” on the Stages of Change assessment indicates the client is not ready for a group intervention.</td>
</tr>
<tr>
<td>☐ Groups are closed. If a participant misses a session, she must wait for the next intervention cycle</td>
<td>☐ If conducting sessions offsite, an MOA is needed with the outside agency where the intervention will be conducted.</td>
<td></td>
</tr>
<tr>
<td>SISTA - Staff Composition</td>
<td>State Requirements</td>
<td>Best Practices</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Key Characteristics</strong></td>
<td><strong>State Requirements</strong></td>
<td><strong>Best Practices</strong></td>
</tr>
<tr>
<td>(can be modified if needed)</td>
<td>(cannot be changed)</td>
<td>(suggested for best outcome)</td>
</tr>
</tbody>
</table>
| - Passionate facilitators committed to delivering this intervention with conviction and purpose will only enhance project success | - Facilitators, Supervisors, and any other staff or volunteers that wish to co-facilitate must attend the HIV Series trainings as well as EFS, and the SISTA Training of Facilitators  
- There must be 2 facilitators (lead facilitator and co-facilitator)  
- Lead facilitator must be of the same ethnicity or race of the group  
- Co-facilitator may be a woman of any ethnicity or race  
- Program Coordinator must attend one-day Supervisors’ Training  
- Program Coordinator must observe one session per cycle (male supervisors will request a consultant to observe) and meet with facilitator to evaluate quality assurance and fidelity to the intervention model |  

New Jersey Department of Health and Senior Services  
Division of HIV, STD and TB Services  
Prevention and Education Unit  

INTERVENTION STANDARDS

REVISED: 1/2011
### SISTA - Target Population

<table>
<thead>
<tr>
<th>Key Characteristics (can be modified if needed)</th>
<th>State Requirements (cannot be changed)</th>
<th>Best Practices (suggested for best outcome)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] This intervention was designed by and for African-American women. Using this intervention to target other populations may reduce its effectiveness</td>
<td>[ ] This intervention is for African American and Latina women between the ages of 18-29</td>
<td>[ ] The group must be racially and culturally homogenous (all African American or all Latina)</td>
</tr>
</tbody>
</table>

### SISTA - Program Implementation

<table>
<thead>
<tr>
<th>Key Characteristics (can be modified if needed)</th>
<th>State Requirements (cannot be changed)</th>
<th>Best Practices (suggested for best outcome)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] The inclusion of a broad range of discussions on relationships, dating, and sexual health only enhances intervention effectiveness</td>
<td>[ ] Groups meet for at least five consecutive weekly 120 minute sessions</td>
<td>[ ] Conduct IDIs and/or an IDG between Booster Session One and Booster Session Two</td>
</tr>
<tr>
<td>[ ] Flexibility is needed in tailoring this intervention for different populations of African-American women (e.g., women in substance abuse treatment facilities, incarcerated women, women in shelters, sex workers)</td>
<td>[ ] There must be at least one week between each session</td>
<td>[ ] Ensure HIV counseling and testing access by inviting a tester to be present before or after at least one group session</td>
</tr>
<tr>
<td></td>
<td>[ ] Conduct Stages of Change Assessment as an IDI after focus group before Session One</td>
<td>[ ] A session added to cover Hep/STD should be done in a group or as IDIs at the end of the cycle (refer to Attachment C)</td>
</tr>
<tr>
<td></td>
<td>[ ] Conduct Stages of Change Assessment as an IDI after Session Five before Booster One</td>
<td>[ ] Linkage with a mental health counselor should be secured to assure timely referrals</td>
</tr>
<tr>
<td></td>
<td>[ ] Booster Session One must be done at four weeks after Session Five</td>
<td></td>
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<tr>
<td></td>
<td>[ ] Booster Session Two must be done within three months after Session Five</td>
<td></td>
</tr>
<tr>
<td>Key Characteristics (can be modified if needed)</td>
<td>State Requirements (cannot be changed)</td>
<td>Best Practices (suggested for best outcome)</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
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</tr>
<tr>
<td>☐</td>
<td>☐ There must be at least one month between Booster Session One and Booster Session Two ☐ Free condoms (both male and female) must be made available to participants ☐ HIV counseling and testing referral resources must be provided to the group ☐ Information must be included about Hep/STD including written materials and referrals during Session Two ☐ Use only DHAS approved teaching materials (including pamphlets, videos, etc.)</td>
<td>☐</td>
</tr>
</tbody>
</table>
VOICES/VOCES
**VOICES/VOCES - Core Elements**
(cannot be changed)

12. Conducting small group skill-building sessions to work on overcoming barriers to condom use.
13. Educating program participants about different types of condoms and their features.
14. Distributing samples of condoms identified by participants as best meeting their needs.

**VOICES/VOCES - Enrollment**

<table>
<thead>
<tr>
<th>Key Characteristics (can be modified if needed)</th>
<th>State Requirements (cannot be changed)</th>
<th>Best Practices (suggested for best outcome)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Groups must consist of at least six but no more than 12 participants. If a group membership drops to three or less, the cycle must be re-started. DHAS will not count a group of three or less as a completed cycle</td>
<td>☐ To ensure a full group, enroll at least 1/3 more clients</td>
<td></td>
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<tr>
<td>☐ If conducting sessions offsite, an MOA is needed with the outside agency where the intervention will be conducted</td>
<td></td>
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</tr>
</tbody>
</table>

**VOICES/VOCES - Staff Composition**

<table>
<thead>
<tr>
<th>Key Characteristics (can be modified if needed)</th>
<th>State Requirements (cannot be changed)</th>
<th>Best Practices (suggested for best outcome)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Convene groups of four to eight persons of the same gender and race and ethnicity, to allow for open discussion of sensitive issues among persons holding similar cultural values</td>
<td>☐ Facilitators, Supervisors, and any other staff or volunteers that wish to co-facilitate must attend the HIV Series trainings as well as EFS, and the Voices/VOCES Training of Facilitators</td>
<td></td>
</tr>
</tbody>
</table>
### VOICES/VOCES - Staff Composition (continued)

<table>
<thead>
<tr>
<th>Key Characteristics (can be modified if needed)</th>
<th>State Requirements (cannot be changed)</th>
<th>Best Practices (suggested for best outcome)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Conduct the intervention session in a private space</td>
<td>☐ Facilitator’s ethnicity does not need to match the target population’s ethnicity. However, he/she must be culturally competent</td>
<td>☐ Program Coordinator must attend one-day Supervisors’ Training</td>
</tr>
<tr>
<td>☐ Use the characters and situations depicted in the video to launch group discussions</td>
<td>☐ Program Coordinator must observe one session per quarter and meet with facilitator to evaluate quality assurance and fidelity to the intervention model</td>
<td></td>
</tr>
</tbody>
</table>

### VOICES/VOCES - Target Population

<table>
<thead>
<tr>
<th>Key Characteristics (can be modified if needed)</th>
<th>State Requirements (cannot be changed)</th>
<th>Best Practices (suggested for best outcome)</th>
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</thead>
<tbody>
<tr>
<td>☐ Address barriers to condom use and safer sex by: 1. increasing awareness of personal risk for infection with HIV and other sexually transmitted diseases 2. providing information on safer sex to prevent infection 3. correcting misinformation about condom use 4. presenting the features of different types of condoms</td>
<td>☐ This intervention is for African American or Latinos  ☐ Participants must be at least 18 years of age  ☐ The group must be culturally homogenous (all African American or all Latino) to allow for open discussion pertaining to sexual practice</td>
<td></td>
</tr>
</tbody>
</table>
### VOICES/VOCES - Program Implementation

<table>
<thead>
<tr>
<th>Key Characteristics (can be modified if needed)</th>
<th>State Requirements (cannot be changed)</th>
<th>Best Practices (suggested for best outcome)</th>
</tr>
</thead>
</table>
| ☐ Deliver the intervention in a single 40-60 minutes session  
☐ Introduce VOICES/VOCES as a routine part of clinic or CBO services  
☐ Begin the session by showing a culturally specific video (15-20 minutes)  
☐ Show a video that: 1. reflects up-to-date information  
2. about HIV and other sexually transmitted diseases  
3. uses male and female actors  
4. whose race and ethnicity are similar to that of the client  
5. depicts real-life situations involving characters like the clients themselves  
6. shows condom negotiation as a shared responsibility between sex partners  
7. models communication skills and prevention attitudes and behaviors with regard to HIV and other sexually transmitted diseases | ☐ Deliver the intervention in a single 40-60 minutes session  
☐ Begin the session by showing a culturally specific video (15-20 minutes)  
☐ Utilize role-play or other activity to reinforce video message  
☐ Use Condom Poster for demonstration and education  
☐ Free condoms (both male and female) must be made available to participants  
☐ HIV counseling and testing referral resources must be provided to the group  
☐ Information must be included about Hep/STD including written materials and referrals  
☐ Use only DHAS approved teaching materials (including pamphlets, videos, etc.) | ☐ Linkage with a mental health counselor should be secured to assure timely referrals |
### VOICES/VOCES - Program Implementation (continued)

<table>
<thead>
<tr>
<th>Key Characteristics (can be modified if needed)</th>
<th>State Requirements (cannot be changed)</th>
<th>Best Practices (suggested for best outcome)</th>
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</thead>
<tbody>
<tr>
<td>8. includes subject matter that is explicit but appropriate for viewing</td>
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<tr>
<td>□ Give clients a minimum of 3 condoms each of the type they identified as best meeting their needs</td>
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</tbody>
</table>
NJ SYRINGE ACCESS PROGRAM
HOTLINE FACT SHEET
CAMDEN SAP—LIFEWOR克斯

SAP DELIVERY MODEL
Mobile Access

MOBILE SITE LOCATION
Broadway and Fairview
Camden, NJ

MAIN FACILITY
Camden AHEC
514 Cooper St
Camden, NJ, 08102

Contact: Ellen Marshall
Marshall_ellicamden-ahec.org
Work Hours 856-963-2432 Ext. 216

EMERGENCY CONTACT
Not Available

SAP HOURS OF OPERATION
Tuesday 10:00am to 1:00pm
Thursday 8:00am—12:00pm

The Camden SAP teams up with the Camden AHEC mobile health van offering a combination of services including:
- On-site Advanced Nurse Practitioner
- HIV testing
- STD screenings
- Blood pressure
- Diabetes screening
- Wound care
- Information about and referrals to drug treatment, supportive housing and other social services.

The holder of this card is a participant in the State of New Jersey Syringe Access Program (SAP). The SAP is a public health program established under the New Jersey Blood Borne Disease Harm Reduction Act (P.L. 2006, c.99) and under the Camden City Ordinance #MC-3962. Possession of a hypodermic syringe or needle by a consumer who participates in a SAP established pursuant to the Act shall not constitute an offense pursuant to the New Jersey Drug Paraphernalia Act (N.J.S.2C:36-1 et seq).
NJ SYRINGE ACCESS PROGRAM
HOTLINE FACT SHEET

SOUTH JERSEY AIDS ALLIANCE

SAP DELIVERY MODEL
Drop-in Center

SITE LOCATION
32 S. Tennessee Ave
Atlantic City, NJ, 08401

Contact: Therese Wilkerson
609-572-1929

EMERGENCY CONTACT
(Emergency will define emergency)
Georgetta Watson
gwatson@sjaid.org
Emergency: 609-364-9827

HOURS OF OPERATION

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>10:00am to 5:30pm</td>
</tr>
<tr>
<td>Tuesday</td>
<td>10:00am to 5:30pm</td>
</tr>
<tr>
<td>Wednesday</td>
<td>10:00pm to 5:30pm</td>
</tr>
<tr>
<td>Thursday</td>
<td>10:00am to 5:30pm</td>
</tr>
<tr>
<td>Friday</td>
<td>10:00am to 5:30pm</td>
</tr>
</tbody>
</table>

Full range of drop-in center services in a welcoming, comfortable, non judgmental environment delivered by a staff who accept and believe in harm reduction.
- On-Site Registered Nurse
- HIV testing
- Health screening
- Referrals to include drug treatment, medical, dental, mental health, housing, food, clothing.
- Medical case management
- Access to showers and laundry,
- Support groups.

The holder of this card is a participant in the State of New Jersey Syringe Access Program (SAP). The SAP is a public health program established under the New Jersey Blood Borne Disease Harm Reduction Act (P.L. 2006, c.99) and under the Atlantic City Ordinance #85-2007. Possession of a hypodermic syringe or needle by a consumer who participates in a SAP established pursuant to the Act shall not constitute an offense pursuant to the New Jersey Drug Paraphernalia Act (N.J.S.2C:36-1 et seq).
Access to Reproductive Care and HIV Services (ARCH) Program (ARCH)

Each of the five Syringe Access Programs (SAPs) (Atlantic City, Camden, Jersey City, Newark and Paterson) have an ARCH nurse on site who provides a range of services free-of-charge. The ARCH nurse is available to anyone accessing the service.

The ARCH program is a comprehensive program that provides the following services for injection drug users, their sexual partners, pregnant drug users, and women on methadone:

- HIV counseling & education
- Preconception and reproductive health education
- Pregnancy testing & referrals for prenatal care
- Hepatitis testing & treatment referral
- Vaccination against hepatitis
- Sexual transmitted disease (STD) testing & referral
- Sexual risk-reduction counseling
- Drug treatment assessment & referral
- Education on overdose prevention & safer injection practices
- Overdose prevention using naloxone
- Wound care assessment & referral
- Adult immunizations—Tdap, influenza, pneumococcal, meningococcal, human papilloma virus, and hepatitis A&B
JERSEY CITY SYRINGE ACCESS PROGRAM

SAP DELIVERY MODEL
Drop-in Center
Fixed Site

SITE LOCATION
Drop-in Center—118 Summit Ave., Jersey City, NJ
Fixed site—Hudson Pride 32 Jones St. Jersey City, NJ

Contact: Alicia Parker
732-801-4935

EMERGENCY CONTACT
(Emergency will be defined by the SAP)
Alicia Parker
aparker@hyacinth.org
Emergency: 732-801-4935

HOURS OF OPERATION

Drop-in Center
Monday-Thursday and Friday 10:00am-6:00pm
Tuesday and Wednesday 12:00pm –8:00pm

Full range of drop-in center services in a welcoming, comfortable, non judgmental environment delivered by a staff who accept and believe in harm reduction.

- On-site Registered Nurse
- HIV testing
- Health screening (blood pressure, wound care, pregnancy tests, etc.
- A full range of referrals to include: drug treatment, medical, dental, mental health, housing, food, clothing
- Education on HIV, STD, harm reduction

The holder of this card is a participant in the State of New Jersey Syringe Access Program (SAP). The SAP is a public health program established under the New Jersey Blood Borne Disease Harm Reduction Act (P.L. 2006, c.99) and under the Jersey City Ordinance #07-129. Possession of a hypodermic syringe or needle by a consumer who participates in a SAP established pursuant to the Act shall not constitute an offense pursuant to the New Jersey Drug Paraphernalia Act (N.J.S.2C:36-1 et seq).
NEWARK SYRINGE ACCESS PROGRAM—"PROJECT ACCESS"

SAP DELIVERY MODEL
Fixed Site
393 Central Avenue
Newark, NJ, 07103
973-483-3444

Mobile Site
Newark Community Health Center Parking Lot
101 Ludlow Ave., Newark, NJ

Contact: Bob Baxter, Director
973-483-3444 Ext. 132
b.baxter@njcri.org

EMERGENCY CONTACT
(Emergency will be defined by the SAP)
BOB BAXTER
Emergency #: 973-296-7914

HOURS OF OPERATION
Fixed site:
Monday 9:30am to 4:00pm
Tuesday 1:00pm to 4:00pm
Wednesday 9:30am to 2:00pm
Thursday 9:30am to 2:00pm
Friday 9:30am to 2:00pm
Mobile site:
Tuesday 9:30am - 11:30am
Wednesday 2:15pm - 4:15pm

The fixed site is a multiservice center addressing the concerns and disparities of access to health care faced by high risk populations. Services include:
- On-site registered nurse
- HIV prevention
- Street Outreach
- HIV/STD testing
- HIV Care services
- Chronic illness management education
- Substance abuse treatment and referral
- A full range of referrals (mental health, housing, entitlements, etc.)
- Transportation
- Food pantry

The holder of this card is a participant in the State of New Jersey Syringe Access Program (SAP). The SAP is a public health program established under the New Jersey Blood Borne Disease Harm Reduction Act (P.L. 2006, c.99) and under the Newark Ordinance #6FF050207. Possession of a hypodermic syringe or needle by a consumer who participates in a SAP established pursuant to the Act shall not constitute an offense pursuant to the New Jersey Drug Paraphernalia Act (N.J.S.2C:36-1 et seq).
NJ SYRINGE ACCESS PROGRAM
HOTLINE FACT SHEET

PATERSON SAP—Point of Hope

SAP DELIVERY MODEL
Drop-in Center

SITE LOCATION
Well of Hope Community Development Corporation, Inc.
“Point of Hope”
207 Broadway
Paterson, NJ 07501
973-523-0700

Syringe Access Program
(973) 523-0700

EMERGENCY CONTACT
(Emergency will be defined by the SAP)
Karen Walker
Cell: 973-868-7294

HOURS OF OPERATION
Monday  8:30am to 4:00pm
Tuesday 8:30am to 4:00pm
Wednesday 8:30am to 4:00pm
Thursday 12:00pm—6:00pm
Friday  8:30am— 4:pm

Full range of drop-in center services in a welcoming, comfortable, non-judgmental environment delivered by a staff who accept and believe in harm reduction.
- On-site registered nurse
- HIV testing
- Health screening
- Referrals to include drug treatment, medical, dental, mental health, housing, food, clothing
- Medical case management
- Access to showers and laundry
- Support groups
- Services for HIV+ through a minority initiative (MAI)

The holder of the ID card is a participant in the State of New Jersey Syringe Access Program (SAP). The SAP is a public health program established under the New Jersey Bloodborne Disease Harm Reduction Act (P.L. 2006, c.99) and under the Paterson City Ordinance #07-036. Possession of a hypodermic syringe or needle by a consumer who participates in a SAP established pursuant to the Act shall not constitute an offense pursuant to the New Jersey Drug Paraphernalia Act (N.J.S. 2C:36-1 et seq).
REFERENCES

REFERENCES AND RESOURCES


Fact Sheets of Effective HIV Prevention Interventions, Health Education Training Centers Alliance of Texas, University of Texas Southwestern Medical Center, Texas Department of Health - Available Online, http://www3.utsouthwestern.edu/preventiontoolbox/interven/final%20document.pdf

HIV COMPREHENSIVE RISK COUNSELING SERVICES – Guidance, CDC, Division of HIV/AIDS Prevention - Available Online http://www.cdc.gov/hiv/pubs/CRCSg/CRCSg-toc.htm


Outreach-Based HIV Prevention for Injecting Drug Users: A Review of Published Outcome Data, Susan L. Coyle, PhD, Richard H. Needle, PhD, Jacques Norman, PhD, Public Health Reports, June 1998, Vol. 113 Supplement I.

The Change Book, A Blueprint for Technology Transfer, Addiction Technology Transfer Centers (ATTC) – Available Online http://www.nattc.org/resPubs/cbResources.html
