



**California Collaborations in HIV Prevention Research
Dissemination Project**

6
MODULE 6

**HIV/AIDS Prevention Intervention
Among Urban, At-Risk African Americans**

For technical assistance questions, contact:

Tom Stopka, Research Scientist
California Department of Health Services
Office of AIDS, HIV Prevention Research and Evaluation Section
1616 Capitol Avenue
P.O. Box 942732, MS 7700
Sacramento, CA 94234-7320
Phone: (916) 449-5828 Fax: (916) 449-5800
Email: tstopka@dhs.ca.gov

For information about the Dissemination Project, contact:

Judith Fitzpatrick, Project Coordinator
Universitywide AIDS Research Program
University of California
Office of the President
300 Lakeside Drive, 6th Floor
Oakland, CA 94612-3550
Phone: 510-987-9854 Fax: 510-835-4220
Email: Judith.Fitzpatrick@ucop.edu

Materials and information presented in Module 6 (UARP grants CR00-CPEP-124 and CR00-SF-125) are produced by the Universitywide AIDS Research Program, University of California Office of the President, and may be freely used for HIV/AIDS prevention research activities. Appropriate citation is required in publications utilizing this module.



California Collaborations in HIV Prevention Research: Dissemination Project

INTRODUCTION TO THE DISSEMINATION PROJECT

To support community-based research efforts in California, the State Office of AIDS (OA) and the Universitywide AIDS Research Program (UARP) joined forces in 1998 to provide funding for HIV/AIDS community research collaborations. This program is built upon the collaborative research endeavors initiated by UARP in 1995 and community-based research efforts sponsored by OA. The UARP-OA initiative fosters partnerships among researchers, community-based AIDS service organizations, and local health departments. As a coordinated response to a statewide public health need, it:

- Provides support for evidence-based planning, design, delivery, and evaluation of prevention interventions
- Builds community research capacity
- Disseminates information on HIV/AIDS prevention interventions

UARP and OA have jointly funded 26 community collaborative HIV/AIDS prevention intervention projects. The *California Collaborations in HIV Prevention Research: Dissemination Project* is designed to disseminate information on these research projects and other resources developed through a range of UARP-OA initiatives. All of these materials serve as resources to be used by local health departments, community-based organizations, and research organizations in support of their work in HIV/AIDS prevention and evidence-based planning.

The *Dissemination Project* Module series is organized into three sections: Behavioral Risk Research, Intervention Outcome Research, and Translation Research. The Behavioral Risk Research modules describe projects that focus on the context of the delivery of interventions; these modules do not evaluate prevention intervention effectiveness. The Intervention Outcome Research modules provide project findings on the effectiveness of specific interventions (available 2004). The Translation Research modules provide guidelines developed for translation of science-based interventions for use by community service organizations (available 2005).

The *Dissemination Project's* Research Summary series is composed of systematic reviews of HIV/AIDS prevention interventions among peoples of color throughout the United States. The first of these publications, an analysis of HIV/AIDS prevention interventions, focuses on heterosexual African

Americans (available 2004). Additional reviews of Hispanics/Latinos and MSM are forthcoming (2004–2005). These reviews were developed prior to the completion of the UARP-OA-funded community collaborative projects and thus do not include those California prevention interventions.

GUIDANCE FOR INTERVENTION MODULES

This guidance provides general background and direction on use for the UARP-OA intervention modules. The audience for the modules includes program planners and coordinators, policy and resource allocation bodies, and researchers and evaluators working in the field of HIV prevention.

The guidance is divided into the following sections:

- **Overview** of literature on community collaborative research and issues for adapting and using evidence-based interventions and evaluations in community settings
- **Brief descriptions** of the intervention modules, the various methodological approaches used to evaluate research, and the use of findings
- **Guidelines** for using the modules

Collaborative Research and Adaptation of Evidence-based Interventions— Current Challenges

One of the critical issues community-based organizations (CBOs) face is the question of how they can best make use of tested interventions with the populations they serve. While resources are available for implementing interventions that have been shown to be effective with certain populations,¹ little guidance is available on systematic processes for adapting, translating, using, or evaluating these interventions in community settings. Thus, CBOs face challenges in three broad areas when considering the use of an existing intervention: accessing information on interventions, finding an appropriate intervention, and tailoring the intervention to their own needs, organizational setting, and client population.

1. Centers for Disease Control, “Compendium of HIV Prevention Interventions with Evidence of Effectiveness,” in *HIV/AIDS Prevention Research Synthesis Project*, Atlanta: CDC, March 1999.

Accessing Information on Interventions

How does a CBO wanting to implement a tested intervention begin? How do they access information on interventions?

Easily accessible information and details on tested interventions with related evaluation materials are not always widely available. Thus, in most cases, CBOs rely on information from CBO and public health networks, rather than academic sources.²

An alternative strategy is becoming available. Although the process of translating research-based interventions has yet to be studied systematically, the CDC and a network of researchers participating in the Replicating Effective Programs (REP) project have been involved in disseminating research-based interventions and supporting this dissemination with a technical assistance support system based on a train-the-trainers model.³ This approach⁴ relies on CBOs identifying and adhering to the core elements of interventions that report significant behavior change outcomes, while tailoring key characteristics to fit the unique needs and context of their client population.⁵

Matching the Intervention to the Organization and Population

What are the key issues that organizations consider when deciding on the adoption and/or adaptation of an intervention? A handful of studies identify these points: contextual issues, key characteristics, and features specific to organizations.

Contextual factors that affect the delivery and selection of interventions by CBOs and local health departments include structural or external conditions; cultural norms; client factors; organizational mission, structure, and operations; staffing resources; and the program's relevance, utility, and effectiveness for meeting the needs of populations.

Community organizations base their assessments of the appropriateness of an intervention on a number of key characteristics:⁶

- Degree of compatibility with organizational philosophy about HIV prevention
- Perceived relevance to local culture
- Evidence to support its use
- Feasibility of implementing the intervention
- Ability to fill existing service gaps

Also essential to this decision-making process are organizational commitment and positive attitudes toward the intervention, as well as the availability of technical assistance and other resources to support implementation.

Adapting and Translating Interventions

How does a CBO choose an intervention, and once the choice is made, adapt it? As mentioned above, community organiza-

tions often gravitate to interventions that are accessible and *known* in the local network of providers. However, interventions almost always require some type of tailoring to fit the organization and its constituency. A variety of strategies are employed to enhance cultural appropriateness, including:⁷

- **Peripheral strategies**, such as packaging that focuses on a certain “look” identified as appealing to certain populations
- **Evidential strategies**, use of evidence of the effectiveness of an intervention
- **Linguistic strategies**, translation of the language used in an intervention for a particular population
- **Constituent-involving strategies**, incorporation of the experiences of community members into the intervention
- **Sociocultural strategies**, placement of the intervention within a broad context of health and life issues for a community

Community Collaborative Research— Intervention Outcome Modules

Community collaborative research addresses the issues of replication, adaptation, and use of evidence-based interventions by partnering research scientists and community providers and by ensuring that research, evaluation, and intervention approaches are realistic and grounded in the real world of community organizations working with populations greatly affected by the epidemic.⁸ The field of collaborative research facilitates adaptation, development, implementation, and testing of interventions. Use of related materials specifically tailored for populations is a continuing part of this work.

2. H. Barton-Villagrana et al., “Peer Relationships Among Community-based Organizations (CBOs) Providing HIV Prevention Services,” *Journal of Primary Prevention* (forthcoming).

3. M. Neumann and E. Sogolow, “Replicating Effective Programs: HIV/AIDS Prevention Technology Transfer,” *AIDS Education and Prevention* 12, supp. A (2000): 35–48.

4. See E. M. Roger, *Diffusion of Innovations*, 4th ed., New York: Free Press, 1995.

5. J. Kelly et al., “Transfer of Research-based HIV Prevention Interventions to Community Service Providers: Fidelity and Adaptation,” *AIDS Education and Prevention* 12, supp. A (2000): 87–98.

6. R. Miller, “Innovation in HIV Prevention: Organizational and Intervention Characteristics Affecting Program Adoption,” *American Journal of Community Psychology* 29, no. 4 (2001): 621–47.

7. M. W. Kreuter et al., “Achieving Cultural Appropriateness in Health Promotion Programs: Targeted and Tailored Approaches,” *Health Education & Behavior* 30, no. 2 (2003): 133–46.

8. See K. H. Stanstad et al. (eds.), “Collaborative Community Research: Partnerships Between Research and Practice,” *Health Education & Behavior* 26, no. 2 (1999).

How UARP-OA Collaborative Projects and Intervention Modules Address Current Challenges

UARP-OA collaborative projects are designed to ensure that equal partnerships between academics and community organizations drive the testing and implementation of interventions in community settings. One of the key goals of the *Dissemination Project* is to make materials from evaluation research available to a range of stakeholders: community-based organizations, researchers, and public health providers. The projects presented in the modules represent investigators' work, often in pilot phase, in evaluation and intervention outcome research.

In these modules, projects include outcome research on interventions serving people of color, IDU, youth, women, MSM, and people with HIV. As in previously distributed modules, details are provided on the research project, including key findings and collaborative research strategies. The instruments, resource tools, and other sample materials developed to support delivery of the interventions are also included.

The studies presented in these modules are important not simply because of their findings in terms of behavior change or increased knowledge about HIV prevention, but also because of their strategies for placing evaluation and intervention in the context of real community settings (e.g., CBOs providing services) and tailoring them to the actual lives they serve. These collaborative strategies inform the evaluation findings, and in many ways they offer a deeper and more complex perspective on service delivery and evaluation than any one set of outcome findings could provide.

Organizations will need to make their own determinations about the appropriateness of the interventions, using the considerations outlined in the preceding section. Applicability will vary depending on the methodological approach and findings from the intervention.

How the Interventions Included in the Modules Have Been Tested—And What This Tells Us

Evaluation research can be charted along a continuum—from initial research on populations to short-term and long-term outcomes of the intervention. Due to their differing purposes and contexts, the UARP-OA evaluation projects include a range of approaches that spans this continuum. The following paragraphs provide an overview of evaluation approaches represented in specific modules and identify how data from various evaluation approaches can be used by stakeholders for intervention design and delivery.

Formative evaluation (behavioral risk and context assessment) is used to collect data on consumer populations to ensure that an intervention is targeted to specific behaviors and specific psychological, social, and cultural contexts. Formative data may be used to improve implementation, solve unanticipated problems, and make sure participants are progressing toward desired outcomes. *See:*

- Module 1: *HIV/AIDS Behavioral Risk Research on African American Gay, Bisexual, and MSM*
- Module 2: *The Los Angeles Transgender Health Study*
- Module 3: *Youth Drug Injectors, Needle Exchange Use, and HIV Risk in San Francisco and Santa Cruz*
- Module 5: *HIV Prevention Outreach Programs in Santa Barbara*
- Module 6: *HIV/AIDS Prevention Intervention Among Urban, At-Risk African Americans*
- Module 8: *Asian/Pacific Islander MSM HIV Prevention Evaluation Study*

Process evaluation (intervention implementation) is used to measure the implementation of an intervention in terms of fidelity to core elements, appropriate targeting, and implementation procedures. It describes the components of the intervention, who it is reaching, and how it is implemented. Process data are often used to make sure the intervention is being implemented as planned and is reaching intended populations successfully. *All the modules report on process data.*

Outcome monitoring (pre- and post-intervention measurement, no control) is used to measure short-term outcomes when control groups are not available or ethical. It is limited in its ability to attribute changes to an intervention, but that can be mitigated somewhat through time-series data collection. Outcome monitoring can be a useful early test for an intervention being implemented at a new site or within a new population. Depending on the number of study participants, this approach can reveal that short-term changes may have taken place, although not necessarily that they are due to the intervention. *See:*

- Upcoming modules focusing on outcome evaluation: Interventions with IDU women and with MSM and people of color, and a study to help understand HIV testing among young adults

Outcome evaluation (quasi-experimental design, nonrandomized control groups) is used to measure short-term outcomes and attribute outcomes to an intervention, in cases where randomization is not feasible. Depending on the number of study participants, this approach can reveal that short-term changes are likely to have occurred as a result of the intervention. *See:*

- Module 6: *HIV/AIDS Prevention Intervention Among Urban, At-Risk African Americans*
- Module 7: *Teen Parents HIV Prevention Programs, Los Angeles*
- Module 8: *Asian/Pacific Islander MSM HIV Prevention Evaluation Study*
- Upcoming modules focusing on outcome evaluation: Interventions for African American youth and Latino MSM, and an intervention delivered at youth drop-in centers

Outcome research (experimental design, randomized control groups) is used to measure short-term outcomes and attribute outcomes to an intervention. The control group(s) is randomized in terms of population or site, controlling for the influence of variables unrelated to the intervention. Depending on the number of study participants, this approach can reveal short-term changes as a result of the intervention. *See:*

- Module 9: *Risk Reduction in Repeat Negative HIV Testers, San Diego County*
- Upcoming modules on available outcome research projects: an enhanced HIV counseling-and-testing multi-infection intervention designed for high-risk communities, and a small-group intervention for IDUs

What We Can Learn from the UARP-OA Collaborative Intervention Research Projects

All the intervention projects tell us about outcome monitoring in community settings, collaborations among multiple partners, tailoring and implementation of interventions, documentation of the process of implementation, consumer responses to interventions, and consumer populations in California. In some cases, the effectiveness of the intervention is assessed.

Guidelines on Use of Modules

Purpose

The intervention modules are intended to support and provide a supplemental mechanism for evidence-based planning, design, implementation, and evaluation for intervention services through the use of UARP-OA–funded community collaborative research, including behavioral risk assessments, intervention outcomes, and translation research.

Using the Modules

While best practices for adaptation/translation of tested interventions have yet to be firmly established, the following describes generally the process and practice of using modules and supporting materials for intervention work.

Assessing a Module’s Relevance to Your Organization

Step 1: Assess your organization, population, and environmental context, outstanding needs, and available resources with respect to the use of evidence-based prevention and evaluation.

Step 2: Review available intervention and evaluation strategies, findings, and tools in modules, and determine the general fit with or responsiveness to your organization’s needs, context, and target population.

Step 3: Based on the results of steps 1 and 2, determine how relevant intervention or evaluation materials and strategies could best be tailored for use by your organization for the populations you intend to serve.

Adapting and Adopting Strategies, Findings, and Materials to Your Organization

Select the components of intervention or evaluation strategies and the materials that speak to specific issues and situations facing your organization, population, and intervention needs. For example, it may be possible to select parts of an evaluation tool that answer questions you have about an intervention or population. Or there may be components of an overall intervention approach that provide relevant support for your work. Also keep in mind that evaluation findings are linked to core elements, so eliminating them could impair the effectiveness of the intervention.

- **Behavioral risk findings** can be used to guide program planning and intervention delivery.
- **Intervention findings and materials** can be used for design and delivery of interventions.
- **Tested interventions** can be adapted for implementation in local settings. Maintaining fidelity to core elements is fundamental, although key characteristics should be tailored to local context and population.
- **Research protocols and instruments** can support targeted data collection on local populations and intervention effectiveness, either in their original form or after adaptation to the individual context.
- **Training materials** can support training on delivery of interventions and implementation of program evaluation—again, either as provided or in customized form.
- **Tested interventions and existing interventions** can be linked to provide evidence-based support for existing interventions.



HIV/AIDS Prevention Intervention Among Urban, At-Risk African Americans

Principal Investigators:

Carla Dillard-Smith, California Prostitutes Education Project,
Oakland, California

Geraldine Oliva, Family Health Outcomes Project,
University of California, San Francisco

Module in a Nutshell

Reports on:

- Quasi-experimental research design
- Enhanced counseling and testing intervention
- HIV/AIDS behavioral risks for sexually active, medically underserved, at-risk African American urban population
- CBO capacity building

Provides:

- Pre- and post-test behavioral intention findings
- Informational materials on STDs and treatments
- Recruitment and retention strategies
- Lessons learned from CBO-university collaboration

CONTENTS

Purpose of Module 6	3
Research Project	3
Summary and Purpose	3
Research Methods	3
The Intervention	6
Biological Component	6
Psychological Component	6
Behavioral Component	7
Research Findings	7
Behavioral Findings	7
Key Results	8
Pre- and Post-Test Change Scores	9
Capacity Development	10
Outreach and Follow-up	10
Services	11
Intervention Development and Delivery	11
Data Management	11
Collaboration	11
Collaborative Partners	11
Processes and Key Components of Collaboration	12
Recommendations	13
Conclusion	13
References	14
Appendices	
About the Module 6 Appendices	15
Use of Materials	16
Appendix A. Consent Form	A-1
Appendix B. Locator Script and Client Locator Form	B-1
Appendix C. Baseline Survey—Health Behaviors	C-1
Appendix D. Follow-up Survey—Preventive Intentions	D-1
Appendix E. Eligibility Screener	E-1
Appendix F. Follow-up Reminder Flyer	F-1
Appendix G. Intervention Protocol	G-1
Appendix H. Medical History Form	H-1
Appendix I. Medication Fact Sheets	I-1
Appendix J. STD Fact Sheets	J-1
Appendix K. Clinic Referral Sheet	K-1
Appendix L. Hot Zone Maps	L-1
Appendix M. Clinician Protocol	M-1
Appendix N. Sample Role Model Stories	N-1
Appendix O. Workshop Information Sheet	O-1

PURPOSE OF MODULE 6

Module 6 presents findings and supporting materials from an HIV prevention project targeting at-risk African American neighborhoods in Alameda County. Carla Dillard-Smith of California Prostitutes Education Project (CAL-PEP) and Geraldine Oliva of Family Health Outcomes Project (FHOP) at UCSF were principal investigators for the project.

The research project examined the collaborative development, pilot implementation, and evaluation of an innovative bio-psycho-behavioral (BPB) HIV prevention intervention. In addition, an integral part of the project was tracking the agency's capacity gains in these and related areas, including outreach and follow-up, clinical services, expanded counseling, and data management.

Behavioral intention findings, best practices, and lessons learned—in addition to the protocols, interview instruments, and handouts developed for the intervention (see appendices)—will be of interest to AIDS service organizations (ASOs) and other community-based organizations (CBOs) looking to increase their intervention development, delivery, and evaluation capacity.

RESEARCH PROJECT

This project evolved as a response to a declared state of emergency for AIDS in the African American community of Alameda County, California. A collaboration between CAL-PEP, Oakland, and FHOP, UCSF, was established to enhance and evaluate an existing pilot intervention* designed to reduce HIV risk factors in the targeted community.

Summary and Purpose

Background

Overall in the United States, the AIDS epidemic is having a substantial and disproportionate impact on African Americans. As of 1997, 12% of the U.S. population was African American, and 37% of diagnosed AIDS cases were among this population.¹ The same year in Alameda County, African Americans made up 18% of the population but 49% of newly diagnosed AIDS cases. The AIDS rate for African Americans in Alameda County in 1997

A link between STD infection and HIV transmission is strongly suggested.⁷

*CAL-PEP had been providing counseling and testing services from its mobile clinic for the previous six years.

¹Although overall the number of new AIDS cases in the county has declined substantially, the percentage of those cases that are among African Americans has continued to rise, to 58% in 2001.²

²Some research findings have suggested that “traditional HIV testing and counseling [make] no difference in rates of adoption of safer sexual behaviors among those testing negative for HIV, when compared with those not being tested.”⁵

was 65 per 100,000—higher than the national rate for African Americans and four times the rate for Latinos and whites in the county.^{1,2}

These facts prompted the declaration, in 1998, of a state of local emergency for AIDS in the African American community of Alameda County.^{1,3} In light of this event, staff from CAL-PEP and FHOP began discussing ways to address the problem through an enhanced HIV prevention intervention.

Project Objectives

Initial discussions between CAL-PEP and FHOP concerning the state of emergency suggested that a more comprehensive approach to AIDS prevention might yield better results than the brief counseling and testing (C&T) method commonly employed by outreach organizations.⁴ Multiple theories and models emphasize linkages between behavioral change and cognitive factors such as accuracy of information, risk perception, and motivation.⁶ It was thought that interventions could be made more effective by targeting three areas: biological, psychological, and behavioral.

Thus, the primary goal of the research project was to compare such a bio-psycho-behavioral (BPB) intervention with the standard C&T outreach program to examine its effectiveness in encouraging risk-reduction intentions, increasing perceptions of self-efficacy to use condoms, and promoting positive attitudes about the use of condoms.

Secondary objectives were—through the process of collaboratively designing, implementing, and evaluating the new intervention—to increase CAL-PEP's capabilities in those areas and to identify best practices for future efforts.

Because mounting evidence suggests that STDs increase the risk of HIV transmission⁷ and that treating STDs reduces the spread of HIV,⁸ education and testing for other STDs (in addition to HIV/AIDS) was incorporated into the intervention as an integral part of the capacity building objective. This also responded to the needs of the target population, which was composed of a high proportion of sex workers and their partners.

Research Methods

This section describes the research protocol, target population, outreach and recruitment, eligibility and screening, enrollment, training, and data collection, including the tools used in these processes (see the appendices). A description of the

In November 1998, the Alameda County Board of Supervisors declared that the disproportionate impact of the AIDS epidemic on the county's African American community constituted a state of local emergency.^{1,3}

intervention itself and the various protocols, instruments, and handouts used in the intervention follows this section.

Research Focus and Protocol

To achieve the project objectives, the collaborative team designed a quasi-experimental research design. Using maps of STD incidences from the Alameda County Health Department, the research team identified 10 zip codes in Alameda County with the highest rates of chlamydia and AIDS among African Americans. Those 10 neighborhoods were then assigned to either the intervention (6 zip codes) or the comparison (control) group (4 zip codes).

All eligible participants (in both intervention and comparison zip codes) were provided with a consent form (Appendix A) which contained information about the project. During the initial visit, a locator form (Appendix B) was completed, the baseline interview was administered (Appendix C), and all participants received HIV counseling and testing. Participants in comparison zip codes received the standard California State HIV counseling and testing (C&T) and received referrals for needed services. Those in intervention zip codes received the bio-psycho-behavioral intervention, which included medical screening and STD tests as well as enhanced HIV testing and counseling (see the Intervention section).

Eligibility Criteria

Participants were required to meet the following criteria:

- Have engaged in at least one of the following risk behaviors within the last year: injected drugs; used crack, amphetamines, cocaine, nitrates/ites, or Ecstasy; had sex with a sex worker; did sex work; was a man who had sex with men (MSM); or had a sex partner who had injected drugs, was HIV positive, or was an MSM.
- Have had unprotected vaginal, oral, or anal intercourse at least once in the last 5 months.
- If male, be between 18 and 55 years of age. If female, be between 18 and 44.*
- Not pregnant or intending to become pregnant or father a child within the next year.
- No plans to leave the area within the next year.
- Willing to have a physical examination.

*Only women of child-bearing age were recruited because of the unique aspect of the intervention in providing equal emphasis on the non-HIV-related reasons for using condoms—STD prevention and contraception.

On returning to the mobile clinic and receiving their test results (approximately 1 to 2 weeks after the initial visit), all participants were administered a follow-up interview (Appendix D).*

Target Population

The target population consisted of sexually active and medically underserved African Americans engaging in high-risk behaviors, including injection drug use, sex trading, MSM, or sex with a high-risk partner.

Outreach and Recruitment

Within each zip code, CAL-PEP staff identified neighborhoods where African American sex workers and drug users congregated and found suitable locations for CAL-PEP's mobile clinic to use. Staff also tried to find a local CBO in the area that would lend rooms for conducting interviews.

Once a location was selected in either an intervention or control neighborhood, outreach workers posted flyers about the upcoming mobile clinic visit. They also visited public housing projects and areas known to be frequented by sex workers and injection drug users and their sex partners, including particular street corners, crack houses, single-room occupancy (SRO) hotels, shelters, recovery homes, and other similar venues.

Two to three days prior to the visit date, the outreach workers distributed flyers to prospective subjects in the neighborhood and described the services they could get from the mobile clinic. (The mobile clinic provided HIV testing and counseling and referrals for services to all individuals; no one was turned away from the mobile clinic.)

Overall, the study recruited 729 potential subjects. After ineligible candidates were eliminated, a total of 667 participants remained—365 in the intervention condition and 302 in the comparison group.

Eligibility and Screening

When potential subjects arrived at the mobile clinic, a CAL-PEP staff member administered a screening questionnaire (Appendix E) to determine their eligibility for the study.[†] In addition to members of the target population, participants' sexual partners were also eligible for the study, regardless of their racial or ethnic group.[‡] Partners who were enrolled received the same services and referral information as their partners.

*In the original design, participants in both conditions were to return for follow-up at 6 months and 12 months after enrollment. Various funding, timing, and retention issues occurred that prevented completion of the follow-up portion of the project.

[†]When possible, those who were ineligible for this study were referred to another CAL-PEP project for which they were eligible. Those with medical conditions were referred to the nearest county health center for additional services.

[‡]Participants found to have an STD were encouraged to bring their partners in for treatment or were given antibiotic doses for partners.

Enrollment and Consent

After administering the screening questionnaire and determining the participant’s eligibility, the staff member invited the subject to participate in a study on “health behaviors.” Participants signed a consent form (see Appendix A) that described study components and procedures (both intervention and control), incentives, and risks. Risks included:

- Psychological discomfort and anxiety from diagnosis of HIV or another STD
- Discomfort caused by survey questions regarding sex and drug use
- Minor physical discomfort during physical exam
- Minor injury or infection from drawing blood
- Adverse reaction to STD treatment

Follow-up

Follow-up was an important part of the study, and this made participant anonymity infeasible.* Testing and follow-up necessitated that CAL-PEP be able to locate participants. Using a script written for the purpose, staff explained this requirement, and then collected contact information (phone, address, etc.) on a locator form (see Appendix B).

To help remind participants to return for their test results and complete the follow-up survey (see Appendix D), a flyer (Appendix F) was developed and posted in the neighborhood prior to the mobile clinic’s return visits.

Training

Training was ongoing throughout the project. UCSF staff participated with intervention staff in regular “quality assurance” meetings with CAL-PEP and UCSF project directors to discuss the study protocol (Appendix G) and instruments. Feedback from staff was used in revising and refining those documents. (See the Processes and Key Components of Collaboration section.)

Specific staff training took place for HIV test counselors, interviewers, physicians assistants and data entry personnel:

- HIV test counselors learned the expanded counseling format as well as skills in providing clients with both test results and visual information in education materials.

*Unique subject numbers were used to make every effort at confidentiality, and all data was stored in a locked, secure environment in a separate location from the consent and locator forms.

Incentives

Participants received cash incentives and food vouchers at each visit. Due to variations in the funding sources for different services provided, the amount and type of incentives differed for participants in the two different conditions, as shown below.

	Intervention	Comparison
Interview (baseline)	\$10 cash	\$10 cash
HIV testing ^a	\$5 grocery voucher	\$5 grocery voucher
STD testing ^b	\$5 voucher	
Follow-up visit	\$10 cash	\$10 cash
(results and referrals)	+ \$10 voucher	+ \$5 voucher
Total received	\$40	\$30

^aFunds provided by contract with Alameda County Public Health Department.

^bFunds provided by Office of Minority Health, U.S. Department of Health and Human Services.

- Interviewers learned how to probe for the reasons for condom use that would be most relevant to the particular client. For example, stressing the effectiveness of condoms in maintaining reproductive health—in order to make healthy babies in the future—was more effective with some participants than concerns about getting HIV.

The intervention required that HIV counselors be familiar with information about STDs, the epidemiology of the AIDS in Alameda County, and some basic psychological- and behavioral-theory concepts, and that they use that information effectively in the counseling sessions.

Data Collection

For all participants, whether in the comparison or intervention group, an HIV test and a baseline interview (see Appendix C) were administered at the initial visit. A reminder card was given to the client before their departure from the mobile clinic. When they returned to the mobile clinic, a follow-up interview (Appendix D) was administered after they received their test results. Depending upon their assigned condition, participants received a form of counseling and services and/or referrals.

UCSF provided data-entry and data-management training and developed quality-control procedures. The baseline questionnaire (see Appendix C) took 60 to 75 minutes to administer (depending on the client) and included measures of HIV and STD risk perceptions, decisional balance scales for condom use, self-efficacy for condom use, sexual and drug-use practices, and future intentions to change these behaviors. Questions regarding demographic data, health insurance status, use of health services, and medical conditions were also included. The follow-up questionnaire (see Appendix D)

lasted approximately 10 to 15 minutes (depending on the client) and repeated the questions from the baseline questionnaire on risk perceptions, decisional balance scales, self-efficacy, and future behavioral intentions.

Comparison Condition

Participants in the control group were interviewed with the same instruments (see Appendices C and D) used for the intervention group at the baseline and the follow-up visits. In lieu of the physical examination and enhanced counseling (see The Intervention, below) the comparison group received HIV testing (an Orasure saliva test) and the standard HIV counseling outlined by the California Department of Health Services, Office of AIDS.¹ When they returned for test results they received further standard counseling and any referrals for needed services.

THE INTERVENTION

The intervention evaluated in this research project included biological, psychological, and behavioral (BPB) components, to test the hypothesis that a more comprehensive type of intervention might be a more effective method of reducing HIV risk than the standard testing-and-counseling approach.

Components in the various categories included medical exams and tests, counseling, and handouts, in addition to the interviews described previously. In all, 365 people received the intervention.

Biological Component

The biological part of the intervention included, in addition to HIV testing:

- Collection of medical history data (Appendix H), including information about the participant's general health, sexual history, sexual/reproductive health including history of STDs, and history of drug use.
- Urine tests for chlamydia and gonorrhea, as well as a pregnancy test for women.
- A physical examination, which for women included a pelvic exam, and wet mounts (slides) for trichomoniasis and bacterial vaginosis.
- Those diagnosed with an STD received appropriate treatment and a packet containing information sheets on their prescribed medication (Appendix I), the diagnosed STD (Appendix J), and where to go for further medical care (Appendix K).

Counseling and testing was integrated into the physical exam process. For example, the HIV test counselor who took the medical history and collected urine samples for tests, also introduced the topic of STDs. Participants were shown a spe-

The "Hot Zone" Concept

An important part of the intervention's psychological component is the connection between STDs and HIV and the state of emergency among African Americans in Alameda County. Counselors present AIDS and chlamydia "Hot Zone" maps* (see Appendix L) that illustrate the number and ethnicity of AIDS and chlamydia cases in the county by city and zip code. The aim was to increase awareness that engaging in risky behavior in a neighborhood with high HIV and STD infection rates puts you at greater risk than would engaging in the same behaviors where those rates were lower.⁴

*Color versions of the maps, which better represent the materials handed out to participants, are available on the Web at http://uarp.ucop.edu/ca_collaborations/modules/module6a_app.html.

cifically developed tool, the "Hot Zone" maps (Appendix L; see also sidebar) and pictures of STD symptoms. They also received fact sheets on chlamydia and gonorrhea (see Appendix J).

The physical exam was then conducted by CAL-PEP's clinician* (a doctor or physician's assistant) who followed a protocol designed for the intervention (Appendix M) that also included information about STD infection and symptoms, pregnancy, condom use, and douching.

Psychological Component

The psychological component was integrated throughout the intervention through one-to-one counseling, during the physical exam, and in conjunction with the behavioral skills sessions, as described below.

One-on-one counseling focused on two areas: risk perceptions/information, and motivation/cost and benefits.

Risk Information

- Diagnosis for STD infection (if positive)
- Figures and maps (see Appendix L) showing STD crisis in African Americans in Alameda County
- Threats posed by HIV and STDs, including their high prevalence and synergistic relationship
- Personal behaviors associated with HIV/STD risks (injection drug use, multiple partners, anal sex, unprotected sex, needle sharing, douching)

*Because CAL-PEP was not a medical provider, a series of obstacles had to be overcome in order to provide physical examinations, including issues around certification, supervision, insurance, and clinician turnover. As a result, of the 365 people enrolled in the intervention, only 221 had physical exams.

- Partner behaviors associated with HIV/STD risks (having multiple partners, sex with MSMs, sex with IDUs, sex with someone who has been in prison)
- The need to examine self and partner for signs of STDs, to talk about STDs with partners, and to seek regular medical screening for latent disease

Motivational Costs and Benefits

- Benefits of risk reduction and protective behaviors as they relate to HIV
- Benefits of risk reduction *not* related to HIV (pregnancy prevention, protection of genital health and fertility, overall health)
- Additional counseling services as needed to enhance motivation to protect health, including substance abuse, family reunification, and domestic violence counseling

Referrals were also given as needed for assistance in finding housing, food, and job training.

Behavioral Component

As with the psychological component, behavioral skills were emphasized throughout the counseling and physical exam.

Self-Efficacy and Behavioral Skills

- Instruction on condom and latex use and practice using penile models
- Instruction on harm reduction for injection drug use
- Discussion and role playing of safer sex negotiations
- Presentation and discussion of role model stories about people who took action to change risky behaviors* (samples in Appendix N)
- An optional group workshop[†] (Appendix O)

RESEARCH FINDINGS

This section provides the findings for the research project. Data describing the sociodemographic characteristics of the total sample, HIV and STD infection, and HIV risk factors are presented in the Key Results (see page 8). Other findings highlighted in this section include condom use attitude and intentions, needle sharing and risk perception, and pre- and post-test change scores measuring condom attitudes and self efficacy.

Behavioral Findings

To assess the effect of completing a structured interview, subjects' reported behaviors over the last 30 days (see Appendix H) were compared with their reported intentions to increase HIV preventive behaviors as reported on their baseline survey (see Appendix C). These two sets of data⁹ are presented in the sections that follow.

Attitudes about Condom Use

The surveys included questions that asked participants to rate the pros and cons of condom use. At baseline:

- 67%–89% of subjects rated the pros and cons of using condoms with a *main partner* as very important in their decision to use condoms.
- 71%–93% rated the pros of using condoms with *other partners* as very important.
- 17%–40% rated the cons of using condoms (e.g., “Condoms make sex feel unnatural”) as important in their condom decision-making.

Overall Finding: The pros of using condoms were given higher importance ratings in the decision to use condoms than were the cons. This was especially true with regard to condom use decisions with other partners.

Condom Use Intentions

Regarding efficacy to use condoms, at baseline:

- 48%–59% of subjects reported being very confident that they could use condoms with main partners.
- 63%–73% reported being very confident that they could use condoms with other partners in a variety of situations.
- 26% of subjects with a main partner reported always using condoms.
- 39% expressed intentions to always use condoms in the future with a main partner.
- 55% of subjects with other partners reported always using condoms with those partners in the last 30 days.
- 81% of subjects with other partners reported an intention to always use condoms with other partners in the future.

Overall Finding: In their baseline interviews, approximately 84% of participants reported intending to use condoms more in the next 30 days.[‡]

*These stories were developed to provide clients with models for behavior changes (this was a strategy that had been used in earlier projects). The stories are about individuals who have engaged in risky behaviors and have taken some action to become safer either before or after suffering a negative consequence.

[†]The earlier version of the intervention developed by CAL-PEP prior to the collaborative research project included testing and counseling and a workshop to increase safer sex and safer drug use behavior (e.g., safer sex negotiation and safer needle use) for clients and their sexual partners who attended the mobile clinic. The workshops were held in community locations such as hotels, jails, homeless shelters and encampments, at the mobile clinic, housing projects, and clients' homes. Facilitators were trained harm-reduction counselors or certified HIV counselors.

[‡]It could not be determined whether subjects' intention to adopt safer behaviors was a result of a desire to give the “right” answers, nor whether the impending HIV test and questions about risk behaviors might have caused anxiety that is relieved by committing to safer behaviors.⁹

KEY RESULTS (N = 667)

Intervention condition subjects: 365
Standard T&C condition subjects: 302
Return rate for test results: 70.6%
(does not differ significantly between conditions)

HIV Infection

- 1.6% HIV (11/667 tested)

STD Infection^a

- 16% any non-HIV STD (55/344 tested)^b
- 26.3% bacterial vaginosis (26/99 tested)^c
- 9.1% trichomoniasis (9/99 tested)^c
- 5.0% chlamydia (16/320 tested)
- 2.2% gonorrhea (7/319 tested)

HIV Risk Factors

Traded Sex for Money, Drugs or Shelter in Past Year

- 29.1% total
- 43.9% (113/304) of women
- 16.8% (61/364) of men

More Than One Sex Partner in Past 6 Months

- 59.1% total
- 60.4% of men
- 57.4% of women

Used Crack Cocaine in Past Year

- 39.2% total
- 45.5% of women
- 34.1% of men

Injection Drug Use in Past Year

- 21.7% total
- 26.1% of men
- 16.5% of women

Injected Drugs in Past 30 Days (N = 118)

- Shared needles: 29.7% (35)
 - 32.5% (13) women
 - 28.2% (22) men

^aIntervention condition only.

^bThe physical exams performed by the clinician yielded more STD diagnoses: 20.4% of those clients received an STD diagnosis, versus only 8.2% of clients who had a urine screening but no physical.

^cWet mount slide obtained during physical exam for limited number of women.

Sociodemographic Characteristics

Gender

- 45% (303) female
- 55% (364) male

Age

- 18–25: 22.5%
- 26–35: 25.8%
- 36–45: 42.6%
- 46–55: 9.1%

Sexual Partners

Males:

- 94.0% women only
- 0.6% men only
- 5.5% men and women

Females:

- 66.7% men only
- 5.6% women only
- 27.4% men and women

Ethnicity

- 88% African American

Education

- 45% less than high school diploma

Employment

- 50% unemployed

Income

- 37% have household incomes under \$500/month

Marital Status

- 71.7% unmarried

Living Situation

- 24% live with a spouse or sex partner
- 27.4% live with children
- 40% homeless within last year

Needle Sharing

Overall Finding: Among injection drug users (IDUs), reported self-efficacy to not share needles was very high at baseline: 73% to 87% expressed that they were very confident that they would not share needles in the next 30 days under a variety of circumstances.

Risk Perception

At baseline:

- 69% of subjects believed there was no chance that they had an STD.
- 63% believed there was no chance they currently had HIV.
- 50% believed there was no chance they would get an STD.
- 45% believed there was no chance they would become infected with HIV.

Overall Finding: Many participants perceived little chance of becoming infected with an STD or HIV.

Pre- and Post-Test Change Scores

To assess the effect of the BPB intervention on subjects’ attitudes, intentions, and possible behavioral changes, scores at baseline and follow-up (after receiving test results) from specific variables on the surveys were compared. Just over 70% of participants returned for their test results: 71.5% in the control group, and 70% in the intervention.⁹

Attitudes and Risk Perceptions

Change scores were used to measure changes in condom attitudes between baseline and follow-up. Participants who maintained their rating of an item as “At least somewhat important” or who increased their rating, received a score of 1. Those whose ratings decreased or stayed at “Not at all important,” received a score of 0.⁹ Table 1 summarizes the significant results.⁴

Finding: The counseling component of the intervention was successful.

The data suggest that the counseling component of the intervention was successful: “Significantly more clients in the intervention condition [are] likely to maintain or increase

Table 1 Condom Attitudes: Percentage of Responses Maintaining or Increasing Factor as at Least Somewhat Important

Factor	Intervention	Comparison
With Main Sex Partner		
You would be safe from disease.	51.7% (N = 77)	27.6% (N = 41)
You would feel more responsible.	55.3% (N = 84)	32.9% (N = 49)
Condoms protect you and your partner.	56.3% (N = 85)	26.7% (N = 40)
You (she) would be safer from pregnancy.	51.2% (N = 65)	30.7% (N = 39)
Condoms keep you healthy to make babies in the future.	53.1% (N = 68)	26.4% (N = 34)
Condoms are easy to get.	51.4% (N = 76)	30.1% (N = 44)
With Other Sex Partner(s)		
You would be safe from disease.	52.8% (N = 47)	26.2% (N = 17)
You would feel more responsible.	48.3% (N = 42)	28.4% (N = 19)
Condoms protect you and your partner.	46.2% (N = 42)	22.4% (N = 19)
You (she) would be safer from pregnancy.	48.8% (N = 40)	26.8% (N = 15)
Condoms keep you healthy to make babies in the future.	33.9% (N = 47)	33.9% (N = 19)
Condoms are easy to get.	51.8% (N = 48)	30.7% (N = 19)

Table 2 Self-Efficacy: Percentage of Responses Maintaining or Increasing Some Self-Efficacy to Use Condoms in a Given Situation with Main Partner

Situation	Intervention	Comparison
When you think that the risk for disease is low.	55.8% (N = 72)	38.9% (N = 51)
When a condom is not right on hand.	58.9% (N = 73)	46.2% (N = 60)
When you have been using alcohol or other drugs.	59.0% (N = 69)	42.5% (N = 54)
When you are sexually aroused.	62.3% (N = 76)	41.4% (N = 53)
When you think your partner might get mad about using it.	56.3% (N = 67)	39.6% (N = 53)
When you are already using another method of birth control.	58.9% (N = 66)	42.2% (N = 57)

Note: Changes in self-efficacy were measured only for subjects who had both pretest and post-test measures.

perceptions of the importance of the pros of condoms in their decision to use condoms with both main and other partners when compared to clients in the control condition.”⁹ (Data also were collected on the perceived cons of condom use. However, comparing change scores between the intervention and comparison groups—for items concerning either main or other partners—yielded no significant results.⁹)

Finding: Stressing non-HIV related reasons for using condoms is an effective intervention strategy.

The data also suggest that the intervention strategy of stressing non-HIV-related reasons for using condoms is effective: “At follow-up almost 40% of intervention clients felt that it was very important that ‘condoms keep you healthy to make babies in the future,’ compared to only 13% in the control condition.”⁹

Efficacy to Use Condoms

Change scores were also calculated for efficacy to use condoms. Participants who (from baseline to follow-up) maintained an efficacy rating of at least “somewhat confident” or increased their rating for a given scenario, received a score of 1 for that item. Participants who selected “No confidence at all” for a given situation or whose sense of self-efficacy decreased, received a score of 0.⁹ Table 2 summarizes the significant results.⁴

Finding: Self-efficacy for condom use with main partner improved or was maintained in the intervention group.

Significantly more clients in the intervention condition than in the comparison group reported improving or maintaining at least some sense of self-efficacy to use condoms with their main sex partner in five out of six situations.⁴ Maintaining or improving self-efficacy for condom use with other partners did not vary significantly between the intervention and control groups.

CAPACITY DEVELOPMENT

As a result of the research project, CAL-PEP was able to build its capacity in several areas: participant outreach and follow-up, clinical services, intervention development and delivery, and data management, as detailed in the following sections.*

Outreach and Follow-up

Within the zip codes assigned to the study, CAL-PEP staff identified neighborhoods where African American sex workers and drug users congregated and found places to park the mobile clinic. Once a location was selected, outreach workers approached people in the area, described the services the clinic would provide, and told them when it would be there.

The goal for the research project was a return rate of at least 70%—a significant challenge with the target population. To figure out the best methods of contacting people, CAL-PEP conducted a discussion group with clients to solicit their input. As a result, staff made up flyers (see Appendix F) advertising that an incentive was available to participants who returned for test results, and placed them in locations frequented by the target population. Reminder cards were also developed and distributed at the end of the first visit.

Some changes to the intervention protocol drew on focus group discussions with clients.⁴

*An upcoming special issue of *AIDS Education and Prevention* will include an article by the principal investigators of the project described in this module.⁴ It details training components and other elements of capacity building that took place at CAL-PEP during the collaborative project. The special issue as a whole will explore the role of community collaborative research as a mechanism for bringing about capacity building.

CAL-PEP staff learned when collecting locator information to try to detect false addresses. This effort included verifying contact phone numbers by trying them during the initial visit, before clients left. Staff initiated efforts to locate clients who failed to return for test results.

These various follow-up efforts yielded a return rate slightly better than the 70% goal.

Services

Because CAL-PEP was not a medical provider, providing medical services required considerable capacity development. For example, CAL-PEP staff were trained to equip and maintain an examination room and to process urine specimens for STD screening.

A physician's assistant had to be hired, and a clinic found to provide both supervision of the clinician and malpractice insurance. The Alameda County Health Department agreed to serve in that capacity, but required that FHOP develop clinical protocols for the physical exam, STD screening, and treatment, as well as that CAL-PEP secure Clinical Laboratory Improvement Amendments (CLIA) certification. Despite the hurdles posed by the certification, supervision issues, and clinician turnover, CAL-PEP was ultimately able to provide the full package of clinical services to more than 200 intervention participants.

Intervention Development and Delivery

In jointly developing the intervention, CAL-PEP and USCF researchers learned the importance of piloting intervention components, soliciting feedback from the clients and field staff, and then refining the components. (See the Processes and Key Components of Collaboration section for more on this process.)

An important part of the intervention involved staff presenting epidemiological data to clients and using that information as a tool to help motivate behavior change. HIV test counselors probed and individualized discussions with clients to stress the benefits of safer sex behaviors—for example, staying healthy to make babies in the future might be more relevant to a particular client than concerns about HIV.

Data Management

Another area in which CAL-PEP wanted to increase its capacity was data entry and management. As a result, CAL-PEP staff did all the data entry using templates developed by UCSF. The latter also provided training and developed quality-control procedures.

This turned out to be the most problematic area for capacity building. Staff turnover and lack of experience with data entry for a research project created delays and caused mistakes to be made. When an additional staff member who had academic training in this area was assigned to supervise the process, things greatly improved.

COLLABORATION

This section describes in greater detail the partners in the collaborative research project, the framework of the collaboration, and the processes the partners followed in working together to devise, implement, and evaluate the enhanced HIV intervention.

Collaborative Partners

California Prostitutes Education Project (CAL-PEP)

The California Prostitutes Education Project has been operating in the San Francisco Bay Area since 1984, employing various strategies to provide HIV prevention services to individuals at high risk (primarily sex traders, injection drug users, and IDUs' sexual partners). Much of CAL-PEP's funding has been for conducting HIV testing and counseling. The CBO has been involved in previous research projects.

In the mid-1990s, CAL-PEP participated in a collaborative effort with the California Health Outreach Project that involved using a mobile clinic to provide physical exams, STD screening and treatment, HIV testing and counseling, and safer sex workshops (see Appendix O). Evaluations of the project indicated that it was successful in operating the mobile clinic, conducting outreach to bring in new clients, and in reducing STD infections rates in the communities served.¹⁰

Subsequently, CAL-PEP has been striving to secure funds to provide more comprehensive services in the mobile clinic for underserved and hard-to-reach populations. The declaration of a state of emergency for African Americans regarding AIDS in Alameda County contributed to an infusion of new funding. Ultimately, this enabled the project to move forward.

Carla Dillard-Smith, CAL-PEP deputy director, was co-principal investigator on the project. Ife Udoh from CAL-PEP served as project coordinator.

UCSF Family Health Outcomes Project (FHOP)

Founded in 1992 by Geraldine Oliva, the Family Health Outcomes Project (FHOP) at the University of California, San Francisco, has the mission of improving the health of children, families, and communities by building the capacity of public health departments, nonprofit agencies, and communities to use data- and evidence-based strategies for planning, monitoring, and evaluating health programs.

Past FHOP projects include a number of federally and university-sponsored HIV prevention research studies,

“Counselors are able to articulate easily understandable, realistic suggestions for risk reduction that are acceptable to clients.”⁴

including the Perinatal HIV Reduction Education Demonstration Activities (PHREDA).

Geraldine Oliva was co-principal investigator for this study. Jennifer Rienks, also from FHOP, served as project coordinator.

Processes and Key Components of Collaboration

Responsibilities and tasks were allocated between the partners to best draw on the strengths of each. The basic study design and the development of the intervention were carried out collaboratively by staff from both organizations, as is described further below. UCSF took primary responsibility for developing clinical and counseling protocols, producing the materials used in the intervention, creating data collection

instruments, and analyzing the data. CAL-PEP delivered the intervention, collected the data, and completed data entry prior to analysis.

Employing a collaborative process in this project meant that the strengths and practical experience of CAL-PEP could be combined with the academic and research expertise of FHOP. For example, CAL-PEP staff were able to learn directly from the researchers their

“Meetings provide support to counselors, who may become discouraged or overwhelmed by the complexity of medical and social problems presented by their clients.”⁴

approach to intervention development, including problem analysis and use of epidemiological data and key findings from the literature.

The FHOP group learned from the peer counselors about recruitment and working in at-risk neighborhoods. The peer counselors provided experience from the street that made access to the area and recruitment of the targeted population feasible.

This section describes the portions of the collaborative method the partners found most effective in carrying out the research and implementing the intervention.

Teamwork and Development of Research Questions and Project Design

CAL-PEP and the FHOP/UCSF team met regularly while developing the evaluative component for the enhanced C&T intervention. This early stage of collaboration included review of the literature and a redesign of the mobile clinic process. The BPB intervention resulted from this collaborative work and incorporated biological, psychological, and behavioral factors that other research had identified as associated with HIV.

Design of Study Protocols and Survey Instruments

CAL-PEP and UCSF met regularly throughout the project. Ideally, meetings were held weekly during the first four months. Project-development meetings involved all staff members at CAL-PEP who would be gathering the data and delivering the intervention. Because many of the CAL-PEP test counselors were former sex workers or drug addicts, they often had valuable insights to contribute about effective counseling techniques. By incorporating CAL-PEP staff members' expertise and experience, the team was able to make the study protocols and survey instruments more workable in the field.

Project Implementation

Once the project commenced, the project-development meetings were replaced by regular project-management meetings. These meetings were led by the PIs and attended by outreach workers, interviewers, HIV test counselors, and the clinician. These meetings were used to:

- Ensure quality control
- Coordinate collaborative activities
- Provide overall direction for the project
- Share insights on the impact of the study on the community
- Solicit staff recommendations from field experiences

Quality-assurance meetings with the counseling staff helped ensure the consistency of the intervention delivery. Importantly, it also allowed staff to share and process their experiences, thus helping to prevent burnout.

Modifications to the survey instrument and further testing and refinement of intervention materials, including the Hot Zone concept, resulted from the project management meetings.

Communication Exchange During Project

Collaborative meetings were also held every few weeks with key personnel from CAL-PEP and UCSF. At these meetings, staff recommendations were considered, troubleshooting and problem solving took place, and any necessary decisions about issues and planning were made.

Training

The UCSF research team associated with the project made regular visits to CAL-PEP to work with the research assistants on interviewing techniques and with the data entry staff on data management, data templates, and data entry issues.

RECOMMENDATIONS

In devising and implementing this innovative intervention and study, targeted to a specific hard-to-reach, at-risk population, the collaborating partners gleaned several valuable pieces of information about what works in such situations:⁴

- **Recontacting clients:** Consult with the target group for strategies on how to best track clients and locate them for follow-up. Collect and where possible verify locator information while client is still available. For a population frequently in and out of jail, record prison identification. Initiate aggressive attempts to locate clients who do not return for follow-up.
- **Providing clinical services:** To interact successfully with professional licensing institutions and develop adequate protocols and quality assurance practices associated with clinical services, CBOs need to partner with an existing clinic or identify a partner (or paid consultant) with clinical and administrative expertise.
- **Developing and implementing enhanced protocols:** Staff who will be delivering the counseling intervention should be involved in the development of new counseling protocols whenever possible. Conduct regular trainings and quality assurance meetings to make any needed adjustments to the protocols. Share strategies and ensure adherence to the agreed-upon protocols.
- **Assuring data accuracy:** If possible, identify CBO staff who already have experience in data management, and make their primary responsibility the management of data and data entry. Conduct regular quality assurance checks for accurate entry. Optimally, an independent, well-trained data entry individual would be on staff and sufficiently free of other CBO demands that they are able to double-enter the data and ensure its accuracy.

CONCLUSION

The collaborating partners, CAP-PEP and FHOP, each had prior research and field experiences that led to a joint commitment for HIV/AIDS prevention efforts incorporating a comprehensive intervention. The BPB model was developed jointly, and responsibility for the different components of the study allowed the partners' respective areas of expertise to be shared. UCSF took primary responsibility for developing clinical and counseling protocols, producing the materials used in the intervention, creating data-collection instruments, and analyzing the data. CAL-PEP was responsible for intervention delivery, data collection, and data entry.

This collaborative partnership responded to the needs of numerous at-risk communities within Alameda County. Over the years, the CBO and the community had established a relationship based on trust and discretion. Recruitment by peer

outreach workers for HIV/AIDS counseling and testing at the mobile van parked in the neighborhood, and the administration of services by the peer HIV counselors, encouraged community members to participate in the enhanced C&T intervention during the research project. The evaluation component of the research project showed positive results, and the findings indicate that CAL-PEP outreach workers succeeded in reaching a very high-risk population and recruiting them for services.

Ultimately, expansion of services within this organization resulted in large part from the research project. While serving the needs of the targeted, at-risk community, the skills and expertise of CBO staff were augmented through collaboration with the researchers at the university. The collaboration between the university and the CBO afforded networking that led to a legitimization of the organization by the county health department. This in turn led to recognition of the organization as an important provider of services to a specific population of at-risk people within the county. In fact, the local health department is encouraging the CBO to acquire a clinic license, which will enable it to bill Medi-Cal and Family PACCT. Eventually, this means that the underserved, hard-to-reach clientele that has always been targeted by the CBO will have a more reliable service provider.

Lessons Learned⁴

- Complex interventions can mean competing objectives and competition for limited resources.
- Providing comprehensive services may require assistance from outside agencies, but may also open the door to additional resources.
- Project timelines appropriate to the scope of the project are crucial. More complex studies require more time for follow-up.
- Initial goals need to be in line with existing capabilities of the CBO. Over time, complexity can be added as capacity increases.
- Staff should be assigned for the duration of the project, and all partners should have a voice in staffing decisions.

References

1. UARP grants CR00-CPEP-124 and CR00-SF-125, "Reducing HIV in African Americans: A Comprehensive Approach."
2. Alameda County Public Health Department, *AIDS Epidemiology Report, Alameda County, California, 1980-2001* (September 2001).
3. Alameda County Public Health Department, *AIDS in the African American Community of Alameda County* (1998).
4. G. J. Oliva et al., "A University and Community-Based Organization Collaboration to Build Capacity to Develop, Implement, and Evaluate an Innovative HIV Prevention Intervention," in *University and CBO Collaborations to Build Capacity*, special issue of *AIDS Education and Prevention* (forthcoming 2004).
5. L. S. Weinhardt et al., "Effects of HIV Counseling and Testing on Sexual Risk Behavior: A Meta-analytic Review of Published Research, 1985-1997," *American Journal of Public Health* 89, no. 9 (1999): 1397-1405.
6. A. Bandura, "Social Cognitive Theory and Exercise of Control Over HIV Infection," in *Preventing AIDS: Theories, Methods, and Behavioral Interventions*, edited by R. DiClemente and J. Peterson (New York: Plenum, 1994).
J. D. Fisher and W. A. Fisher, "Changing AIDS-Risk Behavior," *Psychological Bulletin*, 111 (1992): 455-74.
7. N. K. Janz and M. H. Becker, "The Health Belief Model: A Decade Later," *Health Education Quarterly* 11 (1984): 1-47.
J. E. Maddaux and R. W. Rogers, "Protection Motivation and Self-Efficacy: A Revised Theory of Fear Appeals for Attitude Change," *Journal of Experimental Social Psychology* 19 (1983): 469-79.
J. O. Prochaska and C. C. DiClemente, *The Transtheoretical Approach: Crossing the Traditional Boundaries of Therapy* (Homewood, Ill.: Dow-Jones/Irwin, 1984).
I. M. Rosenstock, "The Health Belief Model and Preventive Health Behavior," *Health Education Monographs* 2 (1974): 354-86.
7. Centers for Disease Control and Prevention. *Prevention and Treatment of Sexually Transmitted Diseases as an HIV Prevention Strategy* (update, June 1998).
8. J. N. Wasserheit, "Epidemiologic Synergy: Interrelationships Between Human Immunodeficiency Virus Infection and Other Sexually Transmitted Diseases," *Sexually Transmitted Diseases* 9 (1992): 61-77.
9. Annual Progress Report, UARP grants CR00-CPEP-124 and CR00-SF-125 (2002).
10. Harder and Company Community Research, *Health to the Streets: An Assessment of Outreach Services for the Community Health Outreach Project*, report submitted to the California Department of Health Services, Division of Communicable Disease Control and Sexually Transmitted Disease Control Program (1995).

Appendices

- A. Consent Form
- B. Locator Script and Client Locator Form
- C. Baseline Survey—Health Behaviors
- D. Follow-up Survey—Preventive Intentions
- E. Eligibility Screener
- F. Follow-up Reminder Flyer
- G. Intervention Protocol
- H. Medical History Form
- I. Medication Fact Sheets
- J. STD Fact Sheets
- K. Clinic Referral Sheet
- L. Hot Zone Maps
- M. Clinician Protocol
- N. Sample Role Model Stories
- O. Workshop Information Sheet

ABOUT THE MODULE 6 APPENDICES

This appendix material contains tools that can be used to:

- Learn more about a client population actively involved in high-risk activities in an urban area
- Recruit, follow-up, and retain hard-to-reach clients for HIV counseling and testing
- Operate a street outreach program for sexually active and medically underserved African American urban population

Sample materials in the appendices include:

- Fact sheets about STDs
- Fact sheets about the medications used for the treatment of STDs
- Health education handouts: stories about typical clients and changes in their high-risk behavior
- Community-based health education tools to explain the epidemiology of STDs
- Baseline and follow-up surveys that provide information about pre- and post-testing change behavior
- Community workshop agenda

Each of the appendices is briefly described below.

Appendix A. Consent Form

The Consent Form is signed by the intervention participants after their eligibility is determined using the Appendix E questionnaire. It describes the study components and procedures for the intervention and comparison groups, the incentives, and the risks.

Appendix B. Locator Script and Client Locator Form

The Locator Script is used by the outreach worker to explain to the participant why contact information is being collected using the locator form.

The Client Locator Form is administered during initial visit to:

- Collect information that can be used to find a client (e.g., name, phone, address, places where client hangs out) and provides emergency contact (family or relative, social/case worker, medical provider) information.
- Provide for follow-up status, especially if client has been incarcerated.

Appendix C. Baseline Survey—Health Behaviors

The baseline interview is used for both the intervention group and the comparison group. Questions measure the client's HIV and STD risk perceptions, decisional balance scales for condom use, self-efficacy for condom use, sexual and drug use practices, and future intentions to change these behaviors.

- Administered during the initial contact with eligible participants.
- Takes approximately 60–75 minutes to administer.

Appendix D. Follow-up Survey—Preventive Intentions

This survey provides the format for the follow-up interview administered when client returns for test results.

- Repeats the risk perception, decisional balance scales, self-efficacy, and future behavioral intention questions from the baseline survey. Answers can be compared to baseline survey to determine knowledge and behavior change.
- Takes approximately 10–15 minutes to administer.

Appendix E. Eligibility Screener

This form is a sample client eligibility screening questionnaire to be administered by CBO staff. It includes eligibility criteria and interview questions.

Appendix F. Follow-up Reminder Flyer

This sample flyer is posted in the intervention neighborhood.

- Prompts clients to remember location of survey and incentives to participate.
- Lists location, dates and times that the health van will return to the neighborhood for to provide test results and follow-up.

Appendix G. Intervention Protocol

This form provides the intervention protocol to be used by outreach workers.

- Outreach staff can use this script to walk through the intervention step by step with the client.
- Explains requirements and reasons for each step, and reminds the outreach worker which forms need to be completed and/or signed.

Appendix H. Medical History Form

This form is used to collect client general health, sexual/reproductive health, and sexual and drug use behavior history.

- Provides space for clinician to record results from the physical examination and laboratory testing—diagnosis, treatment, and referrals.
- Can be used in conjunction with intentions reported in the baseline survey (Appendix C) to determine any increase in HIV preventive behaviors.

Appendix I. Medication Fact Sheets

Information—written in easy-to-understand layperson’s language—that educates the client on instructions for use and potential side effects of drugs prescribed to treat STDs.

Appendix J. STD Fact Sheets

Information, written in easy-to-understand layperson’s language, that educates the client on symptoms and treatment protocols for STDs.

Appendix K. Clinic Referral Sheet

Provides client with the names, locations, and phone numbers of local hospitals, clinics, and other health care providers that they can contact for follow-up medical care.

Appendix L. Hot Zone Maps

These maps show the locations of reported HIV and STD cases in Alameda county by city and in the city of Oakland by zip code. The maps were compiled using data from the California Department of Health Services and shown to clients by counselors during intervention interviews. The maps provide a vivid illustration of the neighborhoods in which engaging in risky behavior will put the client at greatest risk of contracting HIV or other STDs.

Appendix M. Clinician Protocol

This form provides a step-by-step examination protocol to be used by the intervention clinician. It reminds the clinician what symptoms to check for and what diagnosis, treatment, and risk reduction information needs to be communicated to the client.

Appendix N. Sample Role Model Stories

These brief role model stories are told from the viewpoint of individuals who have engaged in past risky behaviors but have taken some action to become safer.

Appendix O. Workshop Information Sheet

Sample protocol provides guidelines for conducting a risk reduction and prevention education “safer sex” workshop.

Use of Materials

All the resources presented in the appendices for Module 6 are derived from materials developed and used as part of the project listed below. These materials may be freely used for HIV/AIDS prevention intervention evaluation programs. Publications that use any of the forms, surveys, and so forth, or that are based on any of the materials included in these appendices, should provide a citation of the original project and principal investigators:

Reducing HIV in African Americans: A Comprehensive Approach

UARP grants CR00-CPEP-124 and CR00-SF-125

Principal investigators:

Carla Dillard-Smith, California Prostitutes
Education Project

Geraldine Oliva, Family Health Outcomes Project,
UCSF