Navy and Marine Corps Public Health Center
October 2012

Fundamentals of HIV-STI Prevention Counseling

Student Manual

A Training Program Developed by the Centers for Disease Control and Prevention

Adapted and Implemented by the Sexual Health and Responsibility Program (SHARP)

Foreword

This student manual supports the CDC-developed, SHARP-adapted course "Fundamentals of HIV-STI Prevention Counseling". The course is designed to provide Department of the Navy (DoN) health care providers and other counselors with the skills to conduct client-centered prevention counseling to assess and intervene in sexual risk taking behavior.

This training course is based on **Project RESPECT**, a study which meets CDC's HIV/AIDS Prevention Research Synthesis project criteria for relevance and methodological rigor and also has positive and significant behavioral/health findings[1]. Project Respect counseling interventions were based on the Theory of Reasoned Action and Social Cognitive Theory. Sessions were interactive and designed to change factors that could facilitate condom use, such as self-efficacy, attitudes, and perceived norms[2]. The intervention goal of Project RESPECT was to determine the effects of enhanced and brief interactive counseling interventions to reduce high-risk behavior and to prevent new sexually transmitted infections (STIs). Participants reported significantly higher condom use compared with participants in the comparison condition (didactic session). Of the counseling participants, 30% fewer had new STIs compared with participants in the didactic message condition.

Comments on this course or additional training needs are encouraged and can be forwarded to the SHARP Program Manager at:

Navy and Marine Corps Public Health Center
Sexual Health and Responsibility Program (SHARP)
620 John Paul Jones Circle, Suite1100
Portsmouth VA 23708-2617
Internet: www-nmcphc.med.navy.mil/hp/sharp
voice: (757) 953-0974; DSN 377

Views and opinions expressed are those of Project Respect and are not necessarily those of the Department of the Navy.

1. Compendium of HIV Prevention Interventions with Evidence of Effectiveness *from* CDC's HIV/AIDS Prevention Research Synthesis Project, Centers for Disease Control and Prevention, National Center for HIV, STI, and TB Prevention Division of HIV/AIDS Prevention - Intervention Research and Support, Atlanta, Georgia, November 1999

2. Efficacy of Risk-reduction Counseling to Prevent Human Immunodeficiency Virus and Sexually Transmitted Diseases: A Randomized Controlled Trial, Kamb, M.L., Fishbein, M., Douglas, J.M., Rhodes, F., et al. (1998). *Journal of the American Medical Association,* 280 (13), 1161-1167

Table of Contents

Forward……. 1

Learning Objectives…….. 3

Continuing Education Credit……. 4

Syllabus…….. 5

Pre/Post Test Knowledge Assessment Tool……. 7

Unit 1 – Task Overview……. 10
Unit 2 – Counseling Concepts and Skills……... 11
Unit 3 – HIV-STI Prevention Counseling……... 16
Unit 4 – HIV-STI Prevention Counseling Step 4…… 22
Unit 5 – HIV-STI Prevention Counseling Steps 5 and 6……. 30
Unit 6 – Role Play Practice…… 32
Unit 7 – Student Self-Assessment and Further Development…… 33

SHARP Mission, Vision, Goals, and Objectives…….. 35
Other Sources of HIV-STI Prevention Training……. 36
SHARP Course Critique Sheet……. A1
SHARP Counseling Session Feedback Form…… A2
SHARP Desktop Assistant…… A3-4
SHARP Counseling Session Evaluation Form…… A5

Efficacy of Risk-reduction Counseling to Prevent Human Immunodeficiency Virus and Sexually Transmitted Diseases: A Randomized Controlled Trial, Kamb, M.L., Fishbein, M., Douglas, J.M., Rhodes, F., et al. (1998). *Journal of the American Medical Association*, 280 (13), 1161-1167

Condoms and their use in preventing HIV and other STIs, Centers for Disease Control and Prevention, Atlanta, Georgia, September 1999

Learning Objectives

Workshop Goal (Terminal Objective)

This workshop was designed to improve the ability of providers in a variety of settings to support individuals in making behavior changes that will reduce their risk of acquiring or transmitting HIV and other STIs

Enabling Objectives

Unit 1 – Task Overview (Contact Hours: 1.75)
1.1 State verbally and in writing the goal of HIV prevention counseling
1.2 List verbally and in writing at least 3 ways that personal judgments might interfere with effective counseling

Unit 2 – Counseling Concepts and Skills (Contact Hours: 1.0)
2.1 State verbally and in writing three concepts that guide the work of HIV prevention counseling and give three reasons why these are important
2.2 State verbally and in writing four basic counseling skills
2.3 Demonstrate the 4 basic counseling skills: open-ended questioning, attending, offering options, and giving information simply

Unit 3 – HIV-STI Prevention Counseling (Contact Hours: 4.0)
3.1 State verbally and in writing steps 1, 2, an 3 of HIV-STI prevention counseling
3.2 State verbally and in writing the purpose of step 1 (introduce and orient the client to the session), and the definitions of risk behaviors and safer goal behaviors
3.3 Demonstrate steps 1, 2, and 3 of HIV-STI prevention counseling

Unit 4 – HIV-STI Prevention Counseling Step 4 (Contact Hours: 1.5)
4.1 State verbally and in writing step 4 of HIV-STI prevention counseling
4.2 Name and define verbally and in writing at least 5 factors that may influence behavior
4.3 Given a role play scenario, identify 3 scenario-specific potential barriers and benefits to the safer goal behavior(s) selected by the client
4.4 Demonstrate step 4 of HIV-STI prevention counseling

Unit 5 – HIV-STI Prevention Counseling Steps 5 and 6 (Contact Hours: 1.0)
5.1 Identify verbally and in writing three criteria of a client-centered referral
5.2 State verbally and in writing steps 5 and 6 of HIV-STI prevention counseling
5.3 State verbally and in writing the purpose of step 6 of HIV-STI prevention counseling

Unit 6 – Role Play Practice (Contact Hours: 4.0)
6.1 Demonstrate through role plays a complete HIV-STI prevention counseling session

Unit 7 – Student Self-Assessment and Further Development (Contact Hours: 0.5)
7.1 Identify further needs and opportunities for personal skill and knowledge development

Continuing Education Credit

Nurse Corps
This Educational Design I activity for 16 contact hours has been approved by the Naval Medical Education and Training Command, which is accredited as an approver of continuing education by the American Nurses Credentialing Center Commission on Accreditation. The accreditation approval number is (as of 1 Aug 2004) 040801.

Navy Independent Duty Corpsmen: This course is approved for **16** contact hours. The BUMED approval number is 53/02-9098.

Other Professions
This course is composed of 16 contact hours. Students are responsible for contacting their own respective professional organizations to determine appropriate category and documentation requirements.

Navy NITRAS/CANTRAC Course Information

CIN	B-322-0020
SHORT TITLE	HIV-STI PREVENT
CDP	745G

Syllabus

Day 1	Topic	Length
0800-0915	Introduction	-
	Trainer Introductions	5
	Participant Manual, SHARP Mission, products and services	15
	Workshop Goal and Objectives	5
	Pre-Course Knowledge Assessment	15
	Workshop Structure and Ground rules	5
	Clarifying the Intervention and the Workshop	30
0915-0930	Break	10
0930-0950	Looking at Judgment : Challenges of HIV-STI prevention counseling of military members	20
0950-1010	Exercise: Looking at Judgment	20
1010-1020	Break	10
1020-1130	Basic Counseling Skills	-
	Definition of HIV/STI Prevention Counseling	10
	Personalizing Risk - Exercise	10
	Counseling Concepts	-
	Group Exercise: Qualities of a Helping Relationship	10
	Concept 1 - Focus on Feelings	5
	Concept 2 - Manage Your Own Discomfort	5
	Concept 3 - Set Boundaries	5
	Basic Counseling Skills - Intro	1
	Skill 1 - Open-ended questions	5
	Skill 2 - Attending	5
	Skill 3 - Offer Options - Not Directives	5
	Skill 4 - Giving Information Simply	5
1115-1120	Introduction to the 6 steps of an HIV/STI prevention counseling session	5
1120-1130	Parking Lot Issues	10
1130-1230	Lunch	60
1230-1245	Step 1: Introduce and Orient Client to Session	15
1245-1315	Step 2: Identify Client Risk Behavior and Circumstances	30
1315-1345	Step 3: Identify Safer Goal Behaviors	30
1345-1355	Break	10
1355-1425	Demo: Starting an HIV Prevention Counseling Session, Steps 1-3	30
1425-1435	Counseling Tips	10
1435-1445	Break	10
1445-1615	Skills Practice Steps 1-3: Starting an HIV Prevention Counseling Session (William, Robert, Marie) Groups of 3--Counselor, Client, observer; (20 min each, including feedback)	60
1615-1630	Catch-up, Wrap-up and Discussion	20

Day 2	Topic	Length
0800-0810	Review (Include Parking Lot Issues)	10
0810-0840	Step 4: Develop a Personalized Action Plan	-
	Introduction	10
	Identify Factors that Affect Behavior Change	10
	Benefits and Barriers Group Exercise	10
0840-0850	Break	10
0850-0930	Exercise: Develop an Action Plan	40
0930-1000	Exercise: Group Reports	30
1000-1010	Break	10
1010-1025	Step 5: Make Effective Referrals	15
1025-1040	Step 6: Summarize and Close	15
1040-1055	Review of the Six Steps	15
1055-1130	Demo of Steps 1-6	35
	Role Play/Interviews Introduction	1
1130-1230	Lunch	60
1230-1350	Student Role Play	80
1350-1400	Break	10
1400-1545	Student Role Play (cont)	105
1545-1615	Evaluations	30
	Post-Course Knowledge Assessment	-
	Self-Assessment	-
	Course Evaluation	-
1615-1630	Closing: Comments/Post-Grad Survey Reminder/Certificates	15

Pre/Post-Course Knowledge Assessment

This assessment is part of an overall training evaluation plan. The Navy Environmental Health Center is dedicated to providing the knowledge and skills providers need to accomplish their goals in the prevention of HIV and STI through effective counseling.

Printed Name _____
Date: _____ Training Location: _____
Position/specialty_____

Please complete the following statements by filling in the blank with the correct response.

1. The goal of HIV/STI Prevention Counseling is to (14 pts)

   _____

   _____

2. The four most basic counseling skills are: (8 pts)

   a. _____
   b. _____
   c. _____
   d. _____

3. The work of HIV/STI prevention counseling is guided by which of following: (5 pts.)

   a. Focusing on client' s feelings
   b. Managing your discomfort
   c. Setting boundaries for responsibilities for counselor and for a client
   d. All of the above

4. List the 6 key counseling steps necessary to help a client reduce the risk of acquiring or transmitting HIV/STI. (12 pts.)

   a. _____
   b. _____
   c. _____
   d. _____
   e. _____
   f. _____

Please respond to the statements below by circling the correct answer. (2 pts each)

5. Most people will change their risky behavior if they are told that it is dangerous or risky.
   TRUE FALSE

6. Clients may vary but they all need to be given the same amount of information/ education in the counseling session.
   TRUE FALSE

7. Knowledge, skills, perceived risk, attitude and social norms are factors that can affect a person's behavior.
   TRUE FALSE

8. HIV/STI prevention counselors are required to get a complete and detailed history of all risk behaviors from clients in order to help them reduce the risk of acquiring or transmitting HIV/STI.
   TRUE FALSE

9. Clients may receive HIV/STI prevention counseling without being tested for infection.
   TRUE FALSE

10. HIV/STI related "risk" behaviors are the sex and drug-use behaviors that in and of themselves can result in transmission of HIV/STI.
    TRUE FALSE

11. HIV/STI related "safer goal behaviors" are specific behaviors that directly prevent or greatly reduce HIV/STI transmission and that a client is willing to try to adopt.
    TRUE FALSE

12. Action steps are specific incremental steps a client can take to help him or her adopt a safer goal behavior.
    TRUE FALSE

Answer the following questions by filling in the blank with the correct response.
(10 pts. each)

13. Two risk behaviors for HIV/STI are:

    a. _____

    b. _____

14. What are two HIV/STI safer behaviors a client can choose to protect him/herself from HIV/STI infection?

    a. _____

    b. _____

15. To understand what factors will help a client adopt a safer goal behavior, the counselor should help the client increase/decrease barriers and increase/decrease benefits. (Select "increase" or "decrease" for each item)

16. Characteristics of effective client-centered referrals include: (Circle all that are correct; 5 pts.)

    a. Providing a referral for each and every client concern
    b. Discussing and offering options
    c. Referring to known and trusted services
    d. If a client is not receptive, telling them they should trust your judgment
    e. Developing a follow-up plan with the client

Match the following factors that affect behavior to its appropriate action step. (10 pts)

17.

Factor	**Action Step**
Self Efficacy	My buddies will disown me from the group if I refuse to drink with them but I can switch to non-alcoholic beverages.
Access	Practice putting on and removing a Condom.
Perceived consequences	Will communicate with partner about using condoms and not have unprotected sex.
Intentions	Believes can avoid getting drunk at bars when sexual activity may occur that night.
Skills	Get free condoms from unit supply or buy from the pharmacy in my neighborhood.

Unit 1 – Task Overview

1.1 State verbally and in writing the goal of HIV prevention counseling
1.2 List verbally and in writing at least 3 ways that personal judgments might interfere with effective counseling

Definition of HIV/STI Prevention Counseling

HIV/STI Prevention Counseling is a client-centered exchange designed to support individuals in making behavior changes that will reduce their risk of acquiring or transmitting HIV/STI.

There are 2 critical components to this definition.

1. Client-centered means that counseling is tailored to the behavior, circumstances and special needs of a person.

2. Being client-centered is a process that focuses on personal risk assessment and development of a personalized action plan.

Unit 2 – Counseling Concepts and Skills

2.1 State verbally and in writing three concepts that guide the work of HIV prevention counseling and give three reasons why these are important
2.2 State verbally and in writing four basic counseling skills
2.3 Demonstrate the 4 basic counseling skills: open-ended questioning, attending, offering options, and giving information simply

Characteristics of Counseling

Counseling is communication, both verbal and nonverbal, made in response to, and in the presence of feelings. It is the work of supporting someone in making decisions when their willingness or ability to act is affected by their feelings. Effective counseling can help a client to explore, express, understand, and accept feelings so that she/he can make decisions.

Counseling is different from education, although education can be a component of counseling. Good counseling does not equal good information giving.

Good counseling is "client-centered" — that is, it is tailored to the behaviors, circumstances, and special needs of the person being served.

Counseling is not solving the client's problem for her/him or giving advice. In the counseling process, the counselor avoids taking on the client's problem or telling the client how to solve the problem or what decision or action to take. Instead, the counselor brings a set of skills to the interaction that can enable the client to reach a better understanding of the problem, deal with her/his related feelings and concerns, and assume responsibility for evaluating alternatives and making choices.

Counseling, as offered during the brief HIV/STI prevention counseling session presented in this course, is also different from ongoing therapy. This HIV/STI prevention counseling intervention is focused on an immediate presenting problem related to the services offered by the agency for whom the counselor works, in this case, the US Navy. Referrals are made for problems falling outside the scope of the clinic services or the expertise of the counselor.

Counseling Concepts

1. Focus on Feelings

2. Manage Your Own Discomfort

3. Set Boundaries

Basic Counseling Skills

1. Open-ended questions

2. Attending

3. Offering options, not directives

4. Giving information simply

The Six Steps of an HIV/STI Prevention Counseling Session

1. Introduce and orient a client to session

2. Identify client's personal risk behaviors and circumstances

3. Identify safer goal behaviors

4. Develop client action plan

5. Make referrals and provide support

6. Summarize and close session

Unit 3 – HIV-STI Prevention Counseling

3.1 State verbally and in writing steps 1, 2, and 3 of HIV-STI prevention counseling 3.2 State verbally and in writing the purpose of step 1 (introduce and orient the client to the session), and the definitions of risk behaviors and safer goal behaviors 3.3 Demonstrate steps 1, 2, and 3 of HIV-STI prevention counseling

Step 1. Introduce and Orient Client to the Session

Introduce yourself as health counselor. Describe the purpose of the session, the expected duration, and what you hope to achieve in the session. Seek consensus from the client as to the objectives of the session and agreement to maintain this focus throughout the session.

During the session, be polite, professional, and display respect, empathy, and sincerity to the client. Become involved and invested in the process and convey an appropriate sense of concern and urgency about the client's HIV/STI risk behaviors. Seek to deal with the client's concerns.

Suggested open-ended introductory questions:

We are here to talk about your risk of acquiring HIV or other STIs and ways you might be able to reduce that risk.

What would you like me to call you?

Why did you come to the clinic today?

What would you like to know before you leave here today?

What have you heard about AIDS/your STI?

How do you think the virus/this infection is passed from one person to another?

How did you decide to take the HIV test today?

What are your specific concerns about sexually transmitted diseases?

Definitions

Risk Behaviors:

These are the sex or drug abuse actions that in and of themselves can result in transmission of HIV/STI.

Safer Goal Behaviors:

These are specific actions that directly prevent or greatly reduce HIV/STI transmission and that the client is willing to try to adopt.

Action Steps:

Specific incremental steps a client can take to help him or her adopt a safer goal behavior.

Step 2. Identify Client Risk Behavior(s) and Circumstances

With the client, identify the specific behaviors that place him or her at risk for HIV/STI. Focus the client on specific behaviors, situations, and partner encounters that contribute to his or her risks. Attempt to build from the problem (symptoms, referral, etc.) and reasons that brought the client to the clinic. Establish an atmosphere that conveys a collaborative and creative exploration of the relevant issues.

Definition: Risk Behaviors are the sex or drug use actions that in and of themselves can result in transmission of HIV/STI.

Suggested open-ended risk assessment questions:

What makes you believe that you might be at risk for HIV/STI? What are you doing in your life that might be putting you at risk for HIV/STI?

Tell me about the exposure incident that brought you to the clinic today? When was the last time you had unprotected sex? Shared needles?

If you were infected, how do you think you may have been infected?

Have you been tested before? If so, when and why?

What were the results?

How many different people do you have sex with? How often?

What is your experience with using drugs? How often do you do this?

When was the last time that you put yourself at risk for HIV/STI?

What was happening then?

When do you have sex without a condom?

What are the riskiest things that you are doing?

What are the situations in which you are most likely to be putting yourself at risk for HIV/STI?

How often do you use drugs or alcohol? How does this influence your HIV/STI risk behaviors? When was the last time you had sex while high on alcohol or drugs?

Step 3. Identify Safer Goal Behaviors

Reinforce the client s previous HIV/STI risk-reduction efforts.

Identify specific safer goal behaviors that the client is willing to try to adopt.

Definition: Safer Goal Behaviors are specific actions that directly prevent or greatly reduce HIV/STI transmission and that the client is willing to try to adopt.

Suggested open-ended questions to explore participant HIV/STI risk-reduction attempts and safer goal behaviors:

Is there a specific time that you remember where you were able to practice safer sex (used needles safely, used a condom)?

What did you do?

What made it possible for you to do it?

How was that for you?

What are you presently doing to protect yourself?

What would you like to do to reduce your risk of HIV/STI?

Suggested statements reinforcing positive change already made:

It's great that you are here!

You've taken the first step; you're doing a great job; keep it up!

The fact that you're concerned about HIV/STI is important.

It's important that you recognize that you've really been thinking about reducing your HIV/STI risk.

Look at how much you've already done to protect yourself (be specific).

SAFER GOAL BEHAVIORS

Abstain from sex or delay sex
People can choose to not have sex. People can also decide to wait, or delay sex, until a later time in their life. They may choose to have personal relationships that do not involve sex.

Outercourse vs. Intercourse
Outer-course is non-penetrative contact, such as massaging, hugging, and kissing. Non-penetrative contact vs. intercourse can eliminate transmission risk for HIV and many (though not all) STIs.

Monogamy
Monogamy is sex between two people, who only have sex with each other, as part of a long-term relationship. If neither partner is infected, there is no risk of disease transmission. Getting to know your partner and his/her sexual history before you decide to have sex can also reduce your chance of exposure to disease. A series of short-term relationships is not as safe because of the increased risk that one of those partners will be infected.

Use Condoms and other barriers
When used correctly and consistently, condoms significantly reduce the risk of getting a sexually transmitted disease. A variety of male condoms are available. Female condoms and oral barriers are also available. Condoms can reduce both the risk of pregnancy and the risk of disease transmission. A new condom/barrier should be used for each act of anal, oral, or vaginal sex.

Reduce # of partners
Many people who are infected with an STI don't know it, and you can't tell just by looking at them. The more people a person has sex with, the more likely it is that one (or more) will be infected with an STI. Though not as safe as monogamy, reducing the number of people a person has sex with can reduce risk by reducing the number of exposures.

Do not have sex with "high-risk" people
You can't tell if potential partners are "high risk" just by looking at them. People who may be at higher risk of having a sexually transmitted infection including those who trade sex for money or sex for drugs, because they may have sex with many other people. Other people who may be at higher risk are people who share needles, because this activity can result in HIV, Hepatitis B and C infections, which can then be spread sexually. Non-monogamous men who have sex with men are also at higher risk of being infected with HIV and Hepatitis B because the risk of transmitting these viruses is greater with receptive anal intercourse than with vaginal or oral intercourse and because these men may have many sex partners. Though not as safe as abstinence or monogamy, avoiding sex with people you know engage in these risk behaviors can reduce your risk of exposure to an STI.

Do not share needles or "works"
The safest thing a person can do is to not inject (non-prescription) drugs. For people who do continue to inject drugs, use a new, sterile needle from a reliable source each time. If sterile needles cannot be used, disinfect needles and syringes before and after each use.

Note: Use of drugs or alcohol can affect sexual behavior because of reduced inhibitions and clouded judgment.

Counseling Tips

Tips for Giving Feedback

Give feedback, not suggestions.

Be specific — state:

"I liked it when you....."
"I wish you had....."

Focus on the things the counselor can change.

Tips for Receiving Feedback

Respond objectively, not personally.

Do not defend yourself.

Do seek clarification, as needed and immediately.

Ask for suggestions only as desired and time permits.

HIV/STI Prevention Counseling Risk Reduction Plan, Steps 1-3

1. Client name or ID #: _____
   Date: _____
   Counselor: _____
   (State the purpose, scope, and duration of the session)

2. Current Risk Behavior(s)

   Circumstances:

3. Safer Goal Behavior(s):

   Previous successes:

   Safer Goal Behaviors (as agreed to by the client):

Unit 4 – HIV-STI Prevention Counseling Step 4

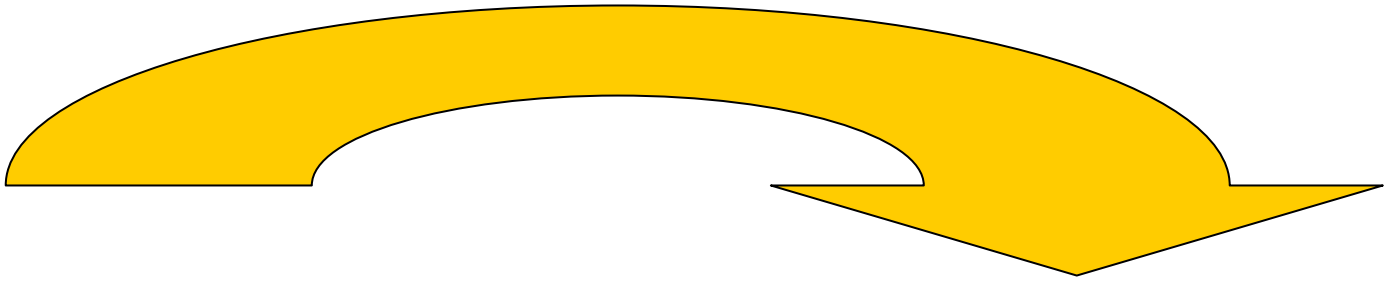
4.1 State verbally and in writing step 4 of HIV-STI prevention counseling
4.2 Name and define verbally and in writing at least 5 factors that may influence behavior
4.3 Given a role play scenario, identify 3 scenario-specific potential barriers and benefits to the safer goal behavior(s) selected by the client
4.4 Demonstrate step 4 of HIV-STI prevention counseling

Step 4. Develop a Personalized Action Plan
Working with a client to develop a realistic plan for reducing her/his HIV/STI risks.

Help the client establish a personal plan to reduce his/her risks of HIV/STI. The plan should be realistic, yet challenging, and should address the specific behaviors identified by the client during the risk assessment phase of the session. It should also incorporate the client's previous attempts, perceived personal barriers, and perceived personal benefits to reducing HIV/STI risk.

Discuss what barriers there are to adopting the new behavior and what benefits there are. Identify concrete, incremental steps the client can start to take to achieve his/her goal. Discuss how the client will put the plan into operation, using specific and concrete steps. Establish a back-up plan. Confirm that this plan is personalized and is acceptable to the participant. Solicit questions and reinforce the client's initiative in agreeing to try to negotiate a risk-reduction plan.

Definition: Action Steps are specific incremental steps a client can take to help him or her adopt a safer goal behavior.



Step 2	Step 4	Step 3
Risk Behavior	**Action Steps**	**Safer Goal Behavior**
unprotected intercourse (with new partners)	**1. carry condoms** **2. practice communication / negotiation**	**use condoms consistently and correctly (with new partners)**

Suggested open-ended questions to explore participant HIV/STI risk-education attempts and personal <u>barriers and benefits</u> to adopting safer behaviors:

Is there a specific time that you remember where you were able to practice safer sex (use needles safely)? What did you do? What made it possible for you to do it? How was that for you?

What are you presently doing to protect yourself?

What would you like to do to reduce your risk of HIV/STI?

What do you see as advantages or good things about adopting (the safer behavior)?

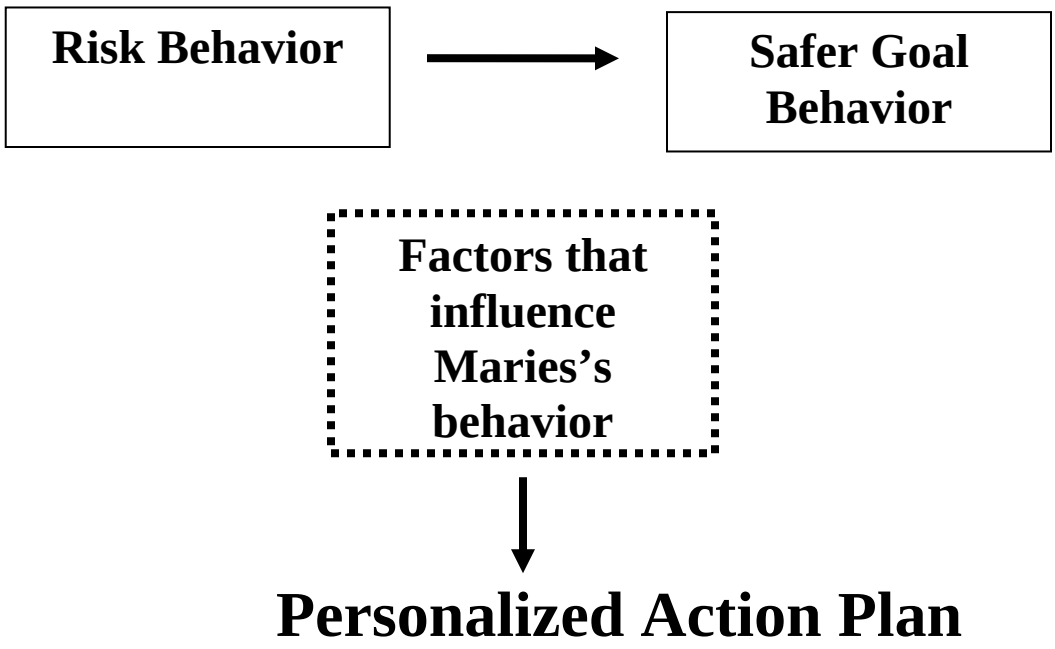
What do you see as disadvantages or bad things about adopting (the safer behavior)?

What makes it easy (what situations make it easier for you) to (the safer behavior)?

What makes it difficult (what situations make it difficult for you) to do (the safer behavior)?

Who (individuals or groups) would approve or support you in adopting (the safer behavior)?

Who (individuals or groups) would disapprove or object to you adopting (the safer behavior)?



1)_____
2)_____
3)_____

Suggested open-ended questions to use when assisting the client to develop a personal risk-reduction plan:

What one thing can you do to reduce your risk right now?

What can you do that would work for you?

What could you do differently?

How would your sexual practices (drug-use practices) have to change for you to stay safe?

Now that you have identified some steps you could take, how can you go about making this happen?

What could you do to make it easier to take these steps?

Who would support you in taking these steps?

When do you think you will have the opportunity to first try this (behavior, discussion, etc.)?

How realistic is this plan for you?

What will be the most difficult part of this for you?

What might be good about changing this?

What will you need to do differently?

How will things be better for you if you...?

How will your life be easier or safer if you change...?

Suggested statements supporting and reinforcing the client :

You have really done something good for yourself in putting this plan into place.

You've taken very positive steps today to help meet some important personal goals.

Factors that Affect Behavior Change

Factor	Definition	Examples:
Knowledge	Basic factual information on how one gets a disease and how to protect oneself from it.	
Perceived risk	A feeling of vulnerability to a health problem.	
Perceived consequences	What one believes will happen, either positive or negative, as a result of performing a new behavior.	
Access	The existence, affordability, and accessibility of services and products needed to support a particular behavior.	
Skills	The abilities necessary to perform a particular behavior.	
Self-efficacy	Belief or confidence that one can do a particular behavior.	
Actual consequences	Actual experiences, both positive and negative, in doing a particular behavior.	
Attitudes	General thoughts and feelings about a current behavior or new behavior.	
Intentions	What one intends to do in the future.	
Perceived social norms	What a person believes the people important to him/her want him/her to do.	
Policy	Laws and regulations affecting a behavior.	

Barriers and Benefits:

1. What do (did) you see as the disadvantages or bad things about your doing this new behavior?

2. What do (did) you see as the advantages or good things about your doing this new behavior?

3. What makes (made) it more difficult for you to do the new behavior?

4. What makes (made) it easier for you to do the behavior?

5. Who individual or groups do you think would (or did) disapprove or object to your doing the new behavior?

6. Who individual or groups do you think would (or did) approve or support your doing the new behavior?

1. Client name or ID #: William
Date:
Counselor:

2. Current Risk Behavior(s):

Unprotected vaginal sex (with multiple partners; exchanges money for sex)

3. Safer Goal Behavior(s):

Previous successes:

Has used condoms consistently in past

Safer Goal Behavior:

Use condoms with new partners for vaginal sex
Reduce the number of sexual partners
Cease to exchange money for sex

4. Personal Action Plan

Barriers to adopting the goal behavior:

Benefits of adopting the Goal Behavior:

Group Exercise: Possible Action Steps for William

Instructions: For each barrier and benefit, identify an action step(s) that William can take to (a) Cease exchanging money for sex, (b) decreasing the number of people he has sex with, and/or (c) use condoms whenever he has sex. And, for each factor, identify something a counselor could do to support William in taking the action step. For some factors, there may be no appropriate action step. In some cases the counselor will support him in what he is already doing or saying.

Barriers:

Actual Consequence: Doesn't like condoms (lowers sensitivity / ruins the mood).

-What could William do?

-What could the counselor do to support William?

Skills: Wouldn't know how to bring up condom use – little experience.

-What could William do?

-What could the counselor do to support William?

Perceived Consequences: Wouldn't want to lose sex partners because they don't like them.

-What could William do?

-What could the counselor do to support William?

Perceived Consequences: Doesn't want to give up sex while deployed – too long to wait.

-What could William do?

-What could the counselor do to support William?

Self-Efficacy: Alcohol sometimes takes over – loses control.

-What could William do?

-What could the counselor do to support William?

Benefits:

Social Norms: His buddies would support him being "in control".

-What could William do?

-What could the counselor do to support William?

Attitudes: Would not have to worry about infecting his special woman or about losing her by getting caught.

-What could William do?

-What could the counselor do to support William?

Perceived Consequences: Would not have to "pay" for sex anymore.

-What could William do?

-What could the counselor do to support William?

Perceived Consequences: Would avoid getting HIV and affecting his career.

-What could William do?

-What could the counselor do to support William?

Unit 5 – HIV-STI Prevention Counseling Steps 5 and 6

5.1 Identify verbally and in writing three criteria of a client-centered referral
5.2 State verbally and in writing steps 5 and 6 of HIV-STI prevention counseling
5.3 State verbally and in writing the purpose of step 6 of HIV-STI prevention counseling

Step 5. Make Effective Referrals and Provide Support

1. **Help client define priorities:**

2. **Discuss and offer options:**

3. **Offer referrals:**

4. **Refer to known and trusted services:**

5. **Assess client response to referral:**

6. **Facilitate active referral:**

7. **Develop a follow-up plan:**

Step 6. Summarize and Close

1. Identify the major points, including feelings, that have been discussed, and tie them together.

2. Formulate a concise statement of client's issues and decisions, including content, feelings, and connection between them.

3. Check that client "owns" the summary.

Signs of ineffective summarizing, closure:

- Client balks, says you have missed the main or major point(s)
- Client does not leave
- Client leaves without acknowledging an understanding

Unit 7 – Student Self-Assessment and Further Development

7.1 Identify further needs and opportunities for personal skill and knowledge development

Counseling Skills Assessment and Development Form

You have had an opportunity to engage in several role plays in this workshop. Please reflect on those experiences, and answer the two questions below.

What are your greatest strengths as a counselor? Don't be modest! You may use the categories below to list your answers, as you wish.

Counseling Strengths

Knowledge and Life Experience

Sensitivities and Attitudes

Verbal and Nonverbal Skills

What one area do you want to improve? This may be a skill you need to refine or use more often, an approach you want to change, or an attitude or assumption that interferes with your effectiveness.

One Area for Improvement

Write below the plan you devise to support you in working on the area that you have identified for improvement. You may wish to consult the suggested activities listed at the bottom of this page. Include any specific "contract" you make to receive help and support from your colleagues.

Development Plan

What I will do?

1)

2)

3)

Support from Colleagues

1)

2)

Suggested Activities for Professional Development

Reading and formal training are always appropriate means of professional development, and both are expanding widely for HIV/STI prevention counselors. Reading is, however, somewhat limited in its impact on attitudes and skills. Formal training, while very effective, is a rare treat for many counselors. Listed below are some interactive, but informal, means of professional development.

<u>For Developing Attitudes and Sensitivities</u>

- organizing/attending staff discussions with program “graduates” (clients who have succeeded in behavior change)
- attending (by special arrangement) supportive groups meetings — AA/NA/AlAnon, gay/lesbian groups, “Positively Positives”

<u>For Developing Skills</u>

- role playing with a friend or co-worker and getting feedback
- inviting a co-worker, supervisor, or consultant to observe you counseling (with client’s permission) and give you feedback afterward
- staffings or case consultations, during which you review actual counseling situations and obtain feedback from co-workers

Navy and Marine Corps Public Health Center
Sexual Health and Responsibility Program (SHARP)
Fundamentals of HIV/STD Prevention Counseling

Opinion Poll

Instructions:

Do **not** write your name on this paper!

Circle your opinion for each statement read aloud:

Statement 1: It is hard for me to understand why people…

Strongly agree Agree Disagree Strongly disagree

Statement 2: Anal intercourse…

Strongly agree Agree Disagree Strongly disagree

Statement 3: I would personally trust a condom…

Strongly agree Agree Disagree Strongly disagree

(opinon.doc) (12/27/07)

Navy and Marine Corps Public Health Center
Sexual Health and Responsibility Program (SHARP)
www-nehc.med.navy.mil/hp/sharp
(757) 953-0974 [DSN 377]

HIV-STD Prevention Counseling
Desktop Assistant

HIV-STD Prevention Counseling

Client-centered exchange designed to support people in making behavior changes that will reduce their risk of acquiring or transmitting HIV/STD

6 Steps of HIV-STD Prevention Counseling

and some suggested open-ended questions

1. Introduce and Orient

- names
- duration of session
- purpose:

"We are here to talk about your risk of acquiring HIV or other STDs and ways you might be able to reduce that risk"

Risk Behavior

sex or drug-use behaviors that in of themselves can result in the transmission of HIV or other STD

2. Identify Risk Behaviors

"What are you doing in your life that might put you at risk of getting HIV and other STDs?
"Tell me more about that"
"What were the circumstances?"

"Do you give/receive oral, anal, vaginal sex?"

"What are your experiences with drugs / alcohol?"

"How has your use of drugs / alcohol influenced your sexual behavior and your use of condoms and other safer behaviors?"

In the past **3 months / 12 months**…Sex with:

- male?
- female?
- anonymous partner?
- injection drug user?
- while intoxicated or high?
- exchanged money/drugs for sex
- (female only) sex with MSM?

3. Identify Safer Goal Behaviors

How do you feel about getting this infection / getting an infection in the future?

How do you think this infection might affect your life / career / plans?

What have you done to protect yourself from infection in the past?

What do you think you could do to protect yourself in the future?

⇨ Support positive statements
⇨ Clear-up misconceptions
⇨ Offer other options / safer behaviors

Safer Goal Behaviors

A -Abstain from sex or delay sex
or Outer-course vs. Intercourse
B - Monogamy
C - Condoms and other barriers
D - Decrease # of partners
E – Evade "high-risk" people / positions

Do not share needles or "works"

Note: Use of drugs or alcohol can affect sexual behavior because of reduced inhibitions and clouded judgment.

4. Action Plan

What do you see as the advantages of doing [each safer goal behavior]?
⇨ Support positive statements

What do you see as the disadvantages of doing [each safer goal behavior]?
⇨ Offer ways to make this a positive

How will you do [the safer goal behavior]?

How will things be better?
⇨ Support positive statements

What about [the safer goal behavior] will be difficult for you?

5. Make Effective Referrals

"Would you like me to help you see someone about [the referral issue]?

"How would you feel about coming back in a month to discuss your progress?"

6. Summary and Close

"Will you do [the safer goal behavior]?

"Do you feel better able now to [do the safer goal behavior]?"

3 Selected Counseling Concepts

Focus on Feelings

In successful helping interactions, the focus must first be placed on how the client feels.

Until the counselor attends the client's feelings, the client will not hear much of what the counselor says.

Be willing to bring up, listen to, and respond to the client's feeling-level reactions, beliefs, and issues.

Manage Your Own Discomfort

Examine and know your own values and seek to understand how others feel.

Recognize your discomfort and manage it – don't let it become a barrier to communication with the client.

Set Boundaries

Both the counselor and the client must be in charge of their own lives.

Don't allow the client to make the counselor's behavior the focus of the session.

Counselor's should not assume responsibility for the client's behavior or expect to solve the client's problems – only the client can do these things.

4 Selected Counseling Skills

Open Ended Questions

Open-ended questions can't be answered with a simple "yes" or "no".

Be careful about using "why" questions – they may be received as threatening.

Use polite imperatives like "Tell me more about…"

Attending

Show the client you are listening through positive verbal and non-verbal cues.

Offer Options, Not Directives

Giving directives sets up a power struggle between the counselor and client.

Offer a "buffet" of all relevant options.

Avoid "You need to.." statements.

Give information Simply

Offer the client information that is relevant to their life circumstances and their risk behaviors.

Use terms and language the client can understand.

It's Okay to say "I don't know".

Selected Factors that Influence Behavioral Change

Knowledge – The client's understanding of how transmission happens and how it can be prevented.

Perceived Risk - Does the client feel at risk for HIV-STD?

Perceived consequences - What the client thinks will happen if he/she tries the safer behavior?

Access - Can the client get to the product/service needed for the safer behavior?

Skills - Can the client perform the safer behavior?

Self-efficacy - Does the client believe he/she can do the safer behavior?

Actual consequences - What has happened in the past when the client tried the safer behavior?

Attitudes - What is the client's general feeling about the new behavior?

Intentions - What does the client intend to do now?

Perceived social norms - What do the people in the client's life think about the safer behavior?

Policy - What laws encourage or inhibit the safer behavior?

HIV EVALUATION AND TREATMENT UNIT
NAVAL MEDICAL CENTER, _____

COUNSELING STATEMENT

I, _____, acknowledge that I have been counseled by

_____, and understand the following:

1. That I have the antibodies to Human Immunodeficiency Virus (HIV) indicating infection in my body. This means that my blood and bodily fluids (semen, vaginal fluids and breast milk) can transmit this virus to others. Therefore, prior to engaging in sexual activity, or any activity in which my bodily fluids may be transmitted to another person, I must verbally advise any prospective sexual partner that I am HIV positive and that there is a risk of possible infection. If my partner consents to sexual relations, I shall not engage in sexual activities without the use of a condom. I must also advise my potential sexual partner that the use of a condom does not guarantee that the virus will not be transmitted. Failure to inform my partners of my condition and the associated risks will make me liable for criminal prosecution under the UCMJ as well as State and Federal Criminal Statues and may also subject me to civil law suits.

2. When I seek medical or dental care, I must inform the health care providers that I am HIV positive before treatment is initiated. In the event I require emergency care, I will inform personnel responding to my emergency that I am HIV positive, conditions permitting (e.g., unconscious). I will refrain from any injection using an air gun and I shall not donate blood, sperm, body tissue, organs or any other body fluids.

3. I should cooperate with military and civilian preventive medicine and public health officials in notifying other people with whom I have had intimate contact who may be at risk of being infected with HIV.

4. It is recommended that I take precautions to prevent pregnancy as HIV may be transmitted to the baby if the mother is infected.

5. That in the event of a potential sexual exposure (the condom breaks), I will advise my partner to seek immediate medical attention and evaluation.

_____ _____
Members Signature Date

_____ _____
Provider's Signature & Stamp Date

Pt Name:
SSN:

Navy and Marine Corps Public Health Center
Sexual Health and Responsibility Program (SHARP)

Fundamentals of HIV-STD Prevention Counseling

Counseling Session Feedback Form

Counselor:			**Observer:**		
Did the counselor adhere to the 3 counseling concepts?	**yes**	**no**	***Did the counselor positively demonstrate the 4 counseling skills?***	**yes**	**no**
- Focus on Feelings			- Open-ending Questions		
- Manage Discomfort			- Attending		
- Set Boundries			- Offer Options/Not Directives		
			- Give Information Simply		

Did the Counselor cover the 6 steps?	**yes**	**no**
- Introduce and Orient (*name, duration, scope*)		
- Identify Risk Behavior. W*hat risk behaviors were identified?* *What were the circumstances? (where, when, with whom)*		
- Identify Safer Goal Behavior. *What Safer Goal Behaviors were offered?* *Which did the client want to try?*		
- Develop Action Plan. *Barriers identified?* *Benefits identified?* *What action steps were agreed to?*		
- Make Effective Referrals		
- Summarize and Close		

I really liked it when you:

I wish you would have:

Other helpful feedback / positive comments:

Navy and Marine Corps Public Health Center
Sexual Health and Responsibility Program (SHARP)

Fundamentals of HIV-STD Prevention Counseling

Counseling Session Feedback Form

Counselor:			**Observer:**		
Did the counselor adhere to the 3 counseling concepts?	**yes**	**no**	***Did the counselor positively demonstrate the 4 counseling skills?***	**yes**	**no**
- Focus on Feelings			- Open-ending Questions		
- Manage Discomfort			- Attending		
- Set Boundries			- Offer Options/Not Directives		
			- Give Information Simply		

Did the Counselor cover the 6 steps?	**yes**	**no**
- Introduce and Orient (*name, duration, scope*)		
- Identify Risk Behavior. W*hat risk behaviors were identified?* *What were the circumstances? (where, when, with whom)*		
- Identify Safer Goal Behavior. *What Safer Goal Behaviors were offered?* *Which did the client want to try?*		
- Develop Action Plan. *Barriers identified?* *Benefits identified?* *What action steps were agreed to?*		
- Make Effective Referrals		
- Summarize and Close		

I really liked it when you:

I wish you would have:

Other helpful feedback / positive comments:

CME/CE ACTIVITY EVALUATION

NMCPHC-SHARP

Fundamentals of HIV-STD Prevention Counseling _____ _____
(Name of Activity) (Dates) (Location)

I. Please evaluate this education activity as a whole by checking the appropriate box, below:

OVERALL EVALUATION						
	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR	N/A
Usefulness						
Quality						
Facilities/Management						
Registration						
Environment						
Audiovisuals						
Food & Beverage						

II. Rate the extent to which you agree that each of the following objectives were met using the following rating scale:

A. Strongly Agree
B. Agree
C. Disagree
D. Strongly Disagree
E. Not applicable or unable to assess.

Goals

I, as an adult learner, have achieved the program goal "to improve the ability of providers in a variety of settings to support individuals in making behavior changes that will reduce their risk of acquiring or transmitting HIV or other sexually transmitted diseases." **A B C D E**

Objectives

At the completion of this offering, I am now able to/or the following objectives were met:

1. State (verbally and in writing) the goal of prevention counseling and 3 ways personal judgment might interfere with counseling. **A B C D E**

2. Identify (verbally and in writing) the 3 counseling concepts and demonstrate the 4 basic counseling skills. **A B C D E**

3. Demonstrate steps 1-3 of HIV-STD prevention counseling. **A B C D E**

4. State (verbally and in writing) and demonstrate step 4 of HIV-STD prevention counseling, including defining 5 factors that may influence behavior and identifying 3 potential barriers and benefits to safer goal behavior. **A B C D E**

5. State (verbally and in writing) steps 5 and 6 of HIV-STD prevention counseling. **A B C D E**

6. Demonstrate through role-play a complete HIV-STD prevention counseling session. **A B C D E**

CME/CE ACTIVITY EVALUATION

Overall Evaluation

1. The presenter was an effective teacher:

A. _____ **A B C D E**

B. _____ **A B C D E**

2. The content was relevant to the objectives. **A B C D E**

3. The teaching methods were effective. **A B C D E**

4. The physical setting was conducive to learning. **A B C D E**

5. I was able to achieve my personal objectives. **A B C D E**

III. General Comments:

1. Do you feel the program was fair, balanced, and free from commercial bias? **Yes No N/A**

   If No, please state reasons. _____

2. Suggested topics and/or speakers you would like for future programs:

_____

3. Did the presenters provide verbal disclosure? **Yes No N/A**

4. Did presenters provide information regarding unapproved/off-label use of products **Yes No N/A**

5. This Education activity has contributed to my professional effectiveness and improved my ability to:

	Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**	**N/A**
Treat/Manage Patients					
Communicate with Patients					
Manage my Medical Practice					
Other:					

NMCPHC, SHARP 620 John Paul Jones Circle, Suite 1100, Portsmouth VA 23708; **FAX 757-953-0688**

HIV-STD Prevention Counseling Evaluation Form

Dear Supervisor/Trainer,
Your subordinate has completed the CDC-developed course "Fundamentals of HIV-STD Prevention Counseling". To validate these new skills, provide helpful feedback, and ensure quality in this task, we encourage you to observe a counseling session. Use this form (and the Prevention Counseling *Desktop Assistant* found in their Student Manual) to conduct and document your evaluation.
When you are satisfied the counselor has demonstrated competence, sign and send the form to NMCPHC-SHARP. Your subordinate will receive a SHARP lapel pin as certification of their skills. We also encourage periodic supervisory evaluations to ensure continuous improvement and quality, as recommended by the CDC (MMWR 50;RR-19;page 7; 9 Nov 01).

Supervisor/Trainer name and command:	**Counselor name and mailing address:**
Date:	**Supervisor/Trainer signature:**

Did the counselor adhere to the 3 counseling concepts?	**yes**	**no**	***Did the counselor positively demonstrate the 4 counseling skills?***	**yes**	**no**
- Focus on Feelings			- Open-ending Questions		
- Manage Discomfort			- Attending		
- Set Boundaries			- Offer Options/Not Directives		
			- Give Information Simply		

Did the Counselor cover the 6 steps?		**yes**	**no**
- Introduce and Orient	(Did the counselor cover his/her name, duration and scope of the session, and begin to establish rapport?)		
- Identify Risk Behavior. *What risk behaviors were identified?* *What were the circumstances?*	(Listen for unprotected vaginal, oral, or anal intercourse or needle sharing) (Did the counselor learn where, when, under what conditions, and with whom the client engaged in risky behavior?)		
- Identify Safer Goal Behavior. *What Safer Goal Behaviors were offered?* *Which did the client want to try?*	(Did the counselor discuss all of the appropriate "safer goal behavior" options listed on the *Desktop Assistant* ?) (Did the client understand their safer goal behavior options and choose one or more they want to try?)		
- Develop Action Plan. *Barriers identified?* *Benefits identified?* *What action steps were agreed to?*	(Did the counselor learn what would be difficult about the safer goal behavior for the client?) (Did the counselor learn what benefits the client perceives in the safer goal behavior?) (Did the counselor elicit and support a definite incremental step the client wants to make toward the safer goal behavior?)		
- Make Effective Referrals	(Did the counselor offer appropriate referrals and encourage the client to return a follow-up discussion of their progress?)		
- Summarize and Close	(Did the counselor restate the main points, action steps and referrals agreed to? Did the counselor close with a question or statement that affirms the client's intentions?)		

Interview Record

Patient ID | Condition(s) 1 2 | Case ID 1 2 | Lot # | Interview Record ID

Neurological Involvement? C P N U

900 Site Type | 900 Site Zip Code | 900 Agency ID

Patient Name | Case ID | Lot #

Name

Last Name | First Name | Middle Name

Preferred Name / AKA | Maiden Name

Phone/Contact

Home Phone

Work Phone

Cellular Phone

Pager

E-Mail Address(es)

Emergency Contact Name

Emergency Contact Phone

Emergency Contact Relationship

Address

Residence Street | (Apt. #) | City

State | Zip | County | District | Country

Living With | Residence Type

Time At Address W M Y | Time In State W M Y | Time In Country W M Y

Currently Institutionalized? Y N U | Name of Institution | Institution Type

Demographics

Date of Birth | Sex at Birth M F | Current Gender M F MTF FTM U R | If additional Gender, Specify:

English Speaking? Y N U

Age | Marital Status S M Sep D W C U R | Race AI/AN A B NH/PI W U R | Hispanic/ Latino? Y N U R | Primary Language

Pregnancy

Pregnant at Exam? Y N U R # Weeks | Pregnant at Interview? Y N U R # Weeks | Currently in Prenatal Care? Y N U R | Pregnant in Last 12 Mos? Y N U R | Pregnancy Outcome D S M A U

Condition 1 Reporting Information

Method of Case Detection | Other

OP Condition | OP Case ID

Facility First Tested

If Other, Describe | Laboratory Report Date

Interviewed? Y N | If not, why not? | If Other, Describe | Interview Period (mos.)

Place of Interview: | If Other, Describe | PEMS Site ID

Date First Assigned for Interview | DIS # | Date Reassigned for Interview | DIS #

Date Original Interview | DIS # | Date First Re-Interview | DIS #

Date Case Closed | DIS # | Supervisor #

Imported Case? N C S J D U | Import Location

Condition 2 Reporting Information

Method of Case Detection | Other

OP Condition | OP Case ID

Facility First Tested

If Other, Describe | Laboratory Report Date

Interviewed? Y N | If not, why not? | If Other, Describe | Interview Period (mos.)

Place of Interview: | If Other, Describe | PEMS Site ID

Date First Assigned for Interview | DIS # | Date Reassigned for Interview | DIS #

Date Original Interview | DIS # | Date First Re-Interview | DIS #

Date Case Closed | DIS # | Supervisor #

Imported Case? N C S J D U | Import Location

Case ID

RISK FACTORS

Y-Yes, Anal or Vaginal Intercourse (with or without Oral Sex) **O**-Yes, Oral Sex Only **U**-Unspecified Type of Sex
N-No **R**-Refused to Answer **D**-Did Not Ask

Within the past 12 months has the patient:

1. Had sex with a male?
2. Had sex with a female?
3. Had sex with a transgender person?
4. Had sex with an anonymous partner?
5. Had sex without using a condom?
6. Had sex while intoxicated and/or high on drugs?
7. Exchanged drugs/money for sex?
8. **[Females only]** Had sex with a person who is known to her to be an MSM?
9. Had sex with a person known to him/her to be an IDU?

Y- Yes **N**-No **R**-Refused to Answer **D**-Did Not Ask

Within the past 12 months has the patient: Y/N/R/D

10. Been incarcerated?
11. Engaged in injection drug use?
12. Shared injection drug equipment?

13. During the past 12 months, which of the following injection or non-injection drugs have been used? (Y/N/R/D)

- None
- Crack
- Cocaine
- Heroin
- Methamphetamines
- Nitrates/Poppers
- Erectile dysfunction medications (e.g., Viagra)
- Other, specify: _____

14. Other Risk, Specify: _____

Social History

Places Met Partners

Type | Name

- Did not ask
- Refused to answer

Places Had Sex

Type | Name

- Did not ask
- Refused to answer

Partners in Last 12 Months

Female | Unknown U | Refused R
Male | Unknown U | Refused R
Transgender | Unknown U | Refused R

Interview Period Partners

	Condition 1		Condition 2	
	Unknown	Refused	Unknown	Refused
Female	U	R	U	R
Male	U	R	U	R
Transgender	U	R	U	R

Additional Social History Comments

Local Use: A B C D E F G H I J K L

Case ID

STD Testing

Date Collected	Provider	Test	Specimen Source	Qualitative Result	Quantitative Result
/ /				P N I U Q C	1:
/ /				P N I U Q C	1:
/ /				P N I U Q C	1:
/ /				P N I U Q C	1:

HIV Testing

Tested for HIV at this event? Y N U R Not Asked

Previously Tested for HIV? Y N U R Not Asked

Self Reported HIV Test Result: 01 02 03 04 66 77 99

Date of Self Reported Test: / /

Date Collected	Provider	Test	Specimen Source	Qualitative Result	Provider Confirmed
/ /				P N I U Q C	
/ /				P N I U Q C	
/ /				P N I U Q C	

Signs and Symptoms

	Signs/ Symptoms	Earliest Observation Date	Anatomic Site	Clinician Observed?	Patient Described?	Duration (Days)
1.		/ /				
2.		/ /				
3.		/ /				

If Other, Please Describe:

STD History

Previous STD History? Y N U R

	Condition	Dx Date (mm/yyyy)	Rx Date (mm/yyyy)	Confirmed?
1.		/	/	
2.		/	/	
3.		/	/	

STD/HIV Treatment/Counseling

Treatment Date	Provider	Drug and Dosage
/ /		
/ /		
/ /		

Treatment Comments:

Incidental Antibiotic Treatment in Last 12 Months? Y N U

Rx Date (mm/yyyy)	Drug/Dosage/Duration	Condition
/		
/		

Anti-Retroviral Therapy for Diagnosed HIV Infection? In Last 12 Months? Y N U R Ever? Y N U R

Results Provided: Y N

900+ Only:

Referred to Medical Care: Y N

If Yes, did Client Attend First Appt.:

Case ID

Partner, Social Contact, & Associate Information

1

Last Name | First Name | AKA | Jurisdiction

Referral Basis | First Exposure ___/___/___ | Freq. | Last Exposure ___/___/___ | Gender M F T U R | Pregnant Y N U R | Spouse Y N U R

	Ix Date	Init. Date	Ix DIS #	Ix Type	Type Ref.	FR#	Dispo	Dispo Date	Cond.	DIS #	SO/SP
Condition 1	___/___/___	___/___/___						___/___/___			
Condition 2	___/___/___	___/___/___						___/___/___			

2

Last Name | First Name | AKA | Jurisdiction

Referral Basis | First Exposure ___/___/___ | Freq. | Last Exposure ___/___/___ | Gender M F T U R | Pregnant Y N U R | Spouse Y N U R

	Ix Date	Init. Date	Ix DIS #	Ix Type	Type Ref.	FR#	Dispo	Dispo Date	Cond.	DIS #	SO/SP
Condition 1	___/___/___	___/___/___						___/___/___			
Condition 2	___/___/___	___/___/___						___/___/___			

3

Last Name | First Name | AKA | Jurisdiction

Referral Basis | First Exposure ___/___/___ | Freq. | Last Exposure ___/___/___ | Gender M F T U R | Pregnant Y N U R | Spouse Y N U R

	Ix Date	Init. Date	Ix DIS #	Ix Type	Type Ref.	FR#	Dispo	Dispo Date	Cond.	DIS #	SO/SP
Condition 1	___/___/___	___/___/___						___/___/___			
Condition 2	___/___/___	___/___/___						___/___/___			

4

Last Name | First Name | AKA | Jurisdiction

Referral Basis | First Exposure ___/___/___ | Freq. | Last Exposure ___/___/___ | Gender M F T U R | Pregnant Y N U R | Spouse Y N U R

	Ix Date	Init. Date	Ix DIS #	Ix Type	Type Ref.	FR#	Dispo	Dispo Date	Cond.	DIS #	SO/SP
Condition 1	___/___/___	___/___/___						___/___/___			
Condition 2	___/___/___	___/___/___						___/___/___			

5

Last Name | First Name | AKA | Jurisdiction

Referral Basis | First Exposure ___/___/___ | Freq. | Last Exposure ___/___/___ | Gender M F T U R | Pregnant Y N U R | Spouse Y N U R

	Ix Date	Init. Date	Ix DIS #	Ix Type	Type Ref.	FR#	Dispo	Dispo Date	Cond.	DIS #	SO/SP
Condition 1	___/___/___	___/___/___						___/___/___			
Condition 2	___/___/___	___/___/___						___/___/___			

Marginal Partners, Social Contacts, & Associates

	Name	Sex	Age	Race	Height	Weight	Hair	Exposure	Locating Information
1									
2									
3									
4									
5									

Case ID

Interview / Investigation Comments

Travel History and Internet Use

Case ID

Investigation Plans & Supervisory Review

Date Submitted: ________________ **Initial Review Date:** ________________

Date	DIS #	DIS Investigation Plans	Date	Sup #	Supervisory Comments

Case ID

Investigation Plans & Supervisory Review

Date Submitted: ______________ **Initial Review Date:** ______________

Date	DIS #	DIS Investigation Plans	Date	Sup #	Supervisory Comments

Interview Record Codes

Disease/Diagnosis Codes

030 - HepB acute w/o delta
031 - HepB acute w/ delta
033 - HepB chronic w/o delta
034 - HepB chronic w/ delta
042 - Hepatitis delta
051 - Hepatitis C, acute
053 - Hepatitis E
054 - Hepatitis C, chronic
070 - Hepatitis, unknown
100 - Chancroid
200 - Chlamydia
300 - Gonorrhea (uncomplicated)
350 - Resistant Gonorrhea
400 - Non-Gonoccocal Urethritis (NGU)
450 - Mucopurulent Cervicitis (MPC)
490 - PID Syndrome
500 - Granuloma Inguinale
600 - Lymphogranuloma Venereum (LGV)
710 - Syphilis, primary
720 - Syphilis, secondary
730 - Syphilis, early latent
740 - Syphilis, unknown duration
745 - Syphilis, late latent
750 - Syphilis, late w/ symptoms
800 - Genital Warts
850 - Herpes
900 - HIV Infection
950 - AIDS (Syndrome)

Neurological Involvement

C - Yes, Confirmed
P - Yes, Probable
N - No
U - Unknown

Residence Type

A - Apartment
B - Mobile Home
C - Migrant Camp
D - Dorm
G - Group Home
H - House/Condo
J - Jail
M - Hotel/Motel
N - Homeless
O - Other
P - Prison
Q - Mental Health Center
R - Rehabilitation Center
U - Unknown
X - Drug Treatment/Detox Center
Y - Juvenile Detention

Gender/Sex:

M - Male
F - Female
MTF - Male to Female Transsexual
FTM - Female to Male Transsexual
T - Transgender
U - Unknown
R - Refused to Answer

Institution Types

G - Group Home
J - Jail
O - Other
P - Prison
Q - Mental Health Center
R - Rehabilitation Center
X - Drug Treatment/Detox Center
Y - Juvenile Detention

Marital Status

S - Single, Never Married
M - Married
SEP - Separated
D - Divorced
W - Widowed
C - Cohabitation
U - Unknown
R - Refused to Answer

Hispanic/Latino

Y - Yes, Hispanic/Latino
N - No, not Hispanic/Latino
U - Unknown
R - Refused to Answer

Race

AI/AN - American Indian or Alaskan Native
A - Asian
B - Black or African American
NH/PI - Native Hawaiian or Other Pacific Islander
W - White
U - Unknown
R - Refused to Answer

Pregnancy Outcome

D - Live Birth
S - Stillborn
M - Miscarriage
A - Abortion
U - Unknown

Type of Facility

01 - HIV Counseling/Testing Site
02 - STD Clinic
03 - Drug Treatment
04 - Family Planning
05 - RETIRED (Not to be used)
06 - TB Clinic
07 - Other HD Clinic
08 - Private MD/HMO
09 - RETIRED (Not to be used)
10 - Hospital (ER)
11 - Correctional facility
12 - Lab
13 - Blood Bank
14 - Labor and Delivery
15 - Prenatal
16 - Job Corps
17 - School-based Clinic
18 - Mental Health Services
29 - Hospital (Other)
66 - Indian Health Services
77 - Military
88 - Other
99 - Unknown

Y/N/U/R

Y - Yes
N - No
U/UN - Unknown
R - Refused to Answer

Time

W - Weeks
M - Months
Y - Years

Method of Case Detection

20 - Screening
21 - Self-Referred (symptomatic patients seeking testing)
22 - Patient Referred Partner
23 - Health Department Referred Partner
24 - Cluster Related (Social Contact (Suspect) or Associate)
88 - Other

Reasons Not Interviewed:

U - Unable to locate
P - Physician Refusal
R - Refused to Answer
D - Deceased
L - Language Barrier
O - Other

Place of Interview

C - Clinic
F - Field
T - Telephone
I - Internet
O - Other

Imported Case

N - Not an imported case
C - Yes, imported from another country
S - Yes, imported from another state
J - Yes, imported from another county/jurisdiction in the state
D - Yes, imported but not able to determine source county, state, and/or country
U - Unknown

Specimen Source

01 - Cervix/Endocervix
02 - Lesion - Genital
03 - Lesion – Extra Genital
04 - Lymph Node Aspirate
05 - Oropharynx
06 - Ophthalmia/Conjuctiva
07 - Other
08 - Other Aspirate
09 - Rectum
10 - Urethra
11 - Urine
12 - Vagina
13 - Blood/Serum
14 - Cerebrospinal Fluid (CSF)
88 - Not Applicable
99 - Unknown

Anatomic Site

A - Anus/Rectum
B - Penis
C - Scrotum
D - Vagina
E - Cervix
F - Naso-Pharynx
G - Mouth/Oral Cavity
H - Eye-Conjunctiva
I - Head
J - Torso
K - Extremities (Arms, Legs, Feet, Hands)
N - Not Applicable (N/A)
O - Other
U - Unknown

Qualitative Lab Result

P - Positive
N - Negative
I - Indeterminate/Equivocal
UN - Unknown/ No Result
Q - Quantity Not Sufficient
C - Contaminated specimen

Places met or had sex with partners

A - Adult Book Store/Cinema
B - Bars
C - Cruising in Automobile
D - Dance Halls
E - Escort Services
F - Baths/Spas/Resorts
G - Place of Worship
H - Home
I - Chat Rooms/Lines/Email/Internet
J - Jail/Prison
K - Clubs
L - Beach
M - Motel/Hotel
N - Shopping Mall
O - Other
P - Project/Shelter
Q - School
R - Gyms/Health Clubs
S - Partner's Home
T - Street
U - Circuit Party
V - Cruise (Boat)
W - Work
X - Park/Rest Area

Interview Record Codes

Signs/Symptoms

A - Discharge or MPC
B - Chancre, Sores, Lesions, or Ulcers
C - Rash
D - Dysuria
E - Itching
F - Alopecia (Hair loss)
G - Condylomata Lata
H - Bleeding
I - Pharyngitis (Sore Throat)
J - Painful Sex
K - Abdominal Pain
L - Swelling/Inflammation
M - Mucous Patch
N - Lymphadenopathy
O - Other
P - Balanitis
Q - Fever
R - Cervical Friability
S - Ectopy
T - Epididymitis
V - Proctitis
W - Adnexal tenderness/Cervical motion tenderness

STD History

Y - Yes, patient has a history of STD
N - No, patient has never had a prior STD
U - Unknown if patient has had a prior STD
R - Patient refused to answer any questions regarding prior STD History

Interview Type

O - *Original Interview* the initial interview with an infected patient.
R - *Re-Interview* any interview after the Original Interview of an infected patient.
C - *Cluster Interview* any interview of a partner or cluster regarding the index case.
U - *Unable to interview* (may include situations where the original patient was not interviewed, but sex partners and/or clusters were initiated from other activities).

Referral

1 - Patient (Client): No health department involvement in the referral of this partner/cluster.
2 - Provider: DIS or other health department staff were involved in the referral of this partner/cluster .
3 - Dual (contract): A combination of provider and patient effort to bring contact/cluster to services.

Source/Spread

SO - The source of infection for the original patient
SP - A spread from the original patient.
U - Partner infection is not related to the original patient.
UN (Unknown) - It is unknown whether a partner infection is related to the original patient.

Partner/Cluster

PARTNER - Persons having sexual activities (of any type) or sharing needles with the original patient.
- **P1** - Sex Partner
- **P2** - Needle sharing Partner
- **P3** - Both Sex and Needle sharing Partner

SOCIAL CONTACT (Suspect) - Persons named by an infected person (e.g., the original patient or an infected partner or cluster).
- **S1** - Person who has or had symptoms suggestive of the Condition(s) documented.
- **S2** - Person who is named as a sex partner of a known infected person.
- **S3** - Any other person who would benefit from an exam (i.e., someone who has engaged in a behavior that might put them at risk).

ASSOCIATE - Persons named by an uninfected partner or cluster.
- **A1** - Person who has or had symptoms suggestive of the Condition(s) documented.
- **A2** - Person who is named as a sex partner of a known infected person.
- **A3** - Any other person who would benefit from an exam (i.e., someone who has engaged in a behavior that might put them at risk).

Dispositions

STD Dispositions

A - Preventative Treatment
B - Refused Preventative Treatment
C - Infected, Brought to Treatment
D - Infected, Not Treated
E - Previously Treated for This Infection
F - Not Infected
G - Insufficient Information to Begin Investigation
H - Unable to Locate
J - Located, Refused Examination and/or Treatment
K - Out Of Jurisdiction
L - Other

HIV Dispositions

1 - Previous Positive
2 - Previous Negative, New Positive
3 - Previous Negative, Still Negative
4 - Previous Negative, Not Re-tested
5 - Not Previously Tested, New Positive
6 - Not Previously Tested, New Negative
7 - Not Previously Tested, Not Tested Now
G - Insufficient Information to Begin Investigation
H - Unable to Locate
J - Located, Refused Counseling and/or Testing
K - Out Of Jurisdiction
L - Other

Condoms and STDs:

Fact Sheet for Public Health Personnel

Consistent and correct use of male latex condoms can reduce (though not eliminate) the risk of STD transmission. To achieve the maximum protective effect, condoms must be used both consistently and correctly. Inconsistent use can lead to STD acquisition because transmission can occur with a single act of intercourse with an infected partner. Similarly, if condoms are not used correctly, the protective effect may be diminished even when they are used consistently. The most reliable ways to avoid transmission of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), are to abstain from sexual activity or to be in a long-term mutually monogamous relationship with an uninfected partner. However, many infected persons may be unaware of their infections because STDs are often asymptomatic or unrecognized.

This fact sheet presents evidence concerning the male latex condom and the prevention of STDs, including HIV, based on information about how different STDs are transmitted, the physical properties of condoms, the anatomic coverage or protection that condoms provide, and epidemiologic studies assessing condom use and STD risk. This fact sheet updates previous CDC fact sheets on male condom effectiveness for STD prevention by incorporating additional evidence-based findings from published epidemiologic studies.

Sexually Transmitted Diseases, Including HIV Infection

Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS. In addition, consistent and correct use of latex condoms reduces the risk of other sexually transmitted diseases (STDs), including diseases transmitted by genital secretions, and to a lesser degree, genital ulcer diseases. Condom use may reduce the risk for genital human papillomavirus (HPV) infection and HPV-associated diseases, e.g., genital warts and cervical cancer.

There are two primary ways that STDs are transmitted. Some diseases, such as HIV infection, gonorrhea, chlamydia, and trichomoniasis, are transmitted when infected urethral or vaginal secretions contact mucosal surfaces (such as the male urethra, the vagina, or cervix). In contrast, genital ulcer diseases (such as genital herpes, syphilis, and chancroid) and human papillomavirus (HPV) infection are primarily transmitted through contact with infected skin or mucosal surfaces.

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

Theoretical and empirical basis for protection. Condoms can be expected to provide different levels of protection for various STDs, depending on differences in how the diseases are transmitted. Condoms block transmission and acquisition of STDs by preventing contact between the condom wearer's penis and a sex partner's skin, mucosa, and genital secretions. A greater level of protection is provided for the diseases transmitted by genital secretions. A lesser degree of protection is provided for genital ulcer diseases or HPV because these infections also may be transmitted by exposure to areas (e.g., infected skin or mucosal surfaces) that are not covered or protected by the condom.

Epidemiologic studies seek to measure the protective effect of condoms by comparing risk of STD transmission among condom users with nonusers who are engaging in sexual intercourse. Accurately estimating the effectiveness of condoms for prevention of STDs,

CS124752

however, is methodologically challenging. Well-designed studies address key factors such as the extent to which condom use has been consistent and correct and whether infection identified is incident (i.e., new) or prevalent (i.e. pre-existing). Of particular importance, the study design should assure that the population being evaluated has documented exposure to the STD of interest during the period that condom use is being assessed. Although consistent and correct use of condoms is inherently difficult to measure, because such studies would involve observations of private behaviors, several published studies have demonstrated that failure to measure these factors properly tends to result in underestimation of condom effectiveness.

Epidemiologic studies provide useful information regarding the magnitude of STD risk reduction associated with condom use. Extensive literature review confirms that the best epidemiologic studies of condom effectiveness address HIV infection. Numerous studies of discordant couples (where only one partner is infected) have shown consistent use of latex condoms to be highly effective for preventing sexually acquired HIV infection. Similarly, studies have shown that condom use reduces the risk of other STDs. However, the overall strength of the evidence regarding the effectiveness of condoms in reducing the risk of other STDs is not at the level of that for HIV, primarily because fewer methodologically sound and well-designed studies have been completed that address other STDs. Critical reviews of all studies, with both positive and negative findings (referenced here) point to the limitations in study design in some studies which result in underestimation of condom effectiveness; therefore, the true protective effect is likely to be greater than the effect observed.

Overall, the preponderance of available epidemiologic studies have found that when used consistently and correctly, condoms are highly effective in preventing the sexual transmission of HIV infection and reduce the risk of other STDs.

The following includes specific information for HIV infection, diseases transmitted by genital secretions, genital ulcer diseases, and HPV infection, including information on laboratory studies, the theoretical basis for protection and epidemiologic studies.

HIV, the virus that causes AIDS

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

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

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

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

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

Other Diseases transmitted by genital secretions, including Gonorrhea, Chlamydia, and Trichomoniasis

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

STDs such as gonorrhea, chlamydia, and trichomoniasis are sexually transmitted by genital secretions, such as urethral or vaginal secretions.

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

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

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms can protect against the transmission of STDs such as chlamydia, gonorrhea and trichomoniasis.

Genital ulcer diseases and HPV infections

Genital ulcer diseases and HPV infections can occur in both male and female genital areas that are covered or protected by a latex condom, as well as in areas that are not covered. Consistent and correct use of latex condoms reduces the risk of genital herpes, syphilis, and chancroid only when the infected area or site of potential exposure is protected. Condom use may reduce the risk for HPV infection and HPV-associated diseases (e.g., genital warts and cervical cancer).

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

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

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

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms provide limited protection against syphilis and herpes simplex virus-2 transmission. No conclusive studies have specifically addressed the transmission of chancroid and condom use, although several studies have documented a reduced risk of genital ulcers associated with increased condom use in settings where chancroid is a leading cause of genital ulcers.

Condom use may reduce the risk for HPV-associated diseases (e.g., genital warts and cervical cancer) and may mitigate the other adverse consequences of infection with HPV; condom use has been associated with higher rates of regression of cervical intraepithelial neoplasia (CIN) and clearance of HPV infection in women, and with regression of HPV-associated penile lesions in men. A limited number of prospective studies have demonstrated a protective effect of condoms on the acquisition of genital HPV.

While condom use has been associated with a lower risk of cervical cancer, the use of condoms should not be a substitute for routine screening with Pap smears to detect and prevent cervical cancer, nor should it be a substitute for HPV vaccination among those eligible for the vaccine

Selected References are available at:
www.cdc.gov/condomeffectiveness/references.html

CS124752