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**HIV COUNSELING, TESTING, AND REFERRAL SERVICES
ASSESSMENT**

By
Meredith Ruland
B.S. University of Montana, 1998

Presented for partial fulfillment of the requirements
for the degree of
Masters of Science

Department of Health and Human Performance
The University of Montana
Missoula, Montana
December 12, 2003

Approved by:


Chairperson


Dean, Graduate School

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Thesis Abstract

Ruland, Meredith, M.S. December 2003 Health and Human Performance

HIV Counseling, Testing, and Referral Services Assessment

Committee Chair: K. Annie Sondag, Ph.D.^{KAS}

The purpose of this study was to conduct an assessment of HIV Counseling, Testing, and Referral Services in the state of Montana. A client satisfaction questionnaire was distributed to individuals who accessed services during the months of June and July 2003. In addition, to gain further insight on client satisfaction, phone interviews were conducted with volunteers who had recently received CTR Services.

A combination of descriptive statistics, frequencies, and chi-square tests were used to analyze data. Results indicated that over ninety percent of the clients agreed that they were satisfied with the CTR services they received. A comparison of the responses from high and low risk groups was found to be relatively similar.

The results of this study can be used by the Department of Health and Human Performance to assess the current state of CTR Services in Montana. The methodology developed for this study can be used for future assessments of these services. Ultimately, improving the practices of CTR service provided will encourage more people to seek knowledge of their HIV status.

Acknowledgements

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To my family who raised and nurtured me to have the confidence to take on a project of this nature. Your support has helped me be where I am today.

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Introduction of the Study

Acquired Immunodeficiency Syndrome (AIDS) was first reported in 1981. In the years following, scientists learned AIDS is caused by, Human Immunodeficiency Syndrome (HIV), a deadly virus. They also learned how the virus is transmitted, and more importantly, how HIV can be prevented. In 1985, when serologic tests became available, the Centers for Disease Control (CDC) recommended counseling accompany all testing at publicly funded sites for the purpose of prevention. Since 1985 the demand for HIV counseling and testing has steadily increased. Counseling and testing is currently the largest component of the CDC's guidelines for prevention. Counseling, Testing, and Referral (CTR) Services are designed to have a client-centered approach. A client-centered approach is one that is tailored to the behaviors, circumstances, and special needs of the person being served. The counselors must design risk-reduction programs that are personalized and realistic (CDC, 1993, CDC, 2001).

As the central component of prevention, CTR Services should be evaluated to determine if they are satisfying the needs of the clients. It is important to ask the people who access these services what their needs are, including which needs are most important and which are more prevalent. Prevention strategies should be based on the feedback and analysis of the population to be served (Silvestre, A. J., et al., Silver, S., et al.).

Purpose of the Study

The purpose of this study was to assess client satisfaction in regard to the Montana HIV Counseling, Testing, and Referral (CTR) Services. Assessment criteria was based on the protocols and procedures related to

client satisfaction as outlined in the CDC's Guidelines for HIV CTR Services and the Montana Department of Health and Human Services (DPHHS) Standards of Performance for HIV Prevention Counseling, Testing and Referral. Information from this study will be used to identify current practices and determine the gaps between the current practice and standards of practice.

Research Questions

The research questions examined in this study focused on Montana's HIV Counseling and Testing system's adherence to the guidelines set forth by the CDC and DPHHS client centered model particularly as they relate to client satisfaction.

1. What are client's perceptions of:
 - CTR Services accessibility
 - Staff performance and proficiency
 - Staff empathy and non-judgment
 - Client confidentiality

2. What is the difference in perception between client's who identify as high risk and those who identify as low risk in the following areas:
 - Staff performance and proficiency
 - Staff empathy and non-judgment
 - Client confidentiality

Statement of the Problem

There is relatively little documented research in the area of client's perceptions of HIV Counseling, Testing and Referral Services. The State of Montana desires this information to identify current counseling and testing practice. Based on these findings the state will make recommendations for improvement of the current system.

Limitations

It is reasonable to acknowledge that limits exist within any study. The following are possible limitations that may exist within this study.

1. Responses will be limited to participants who volunteer to complete the questionnaire and the interviews.
2. Data will be limited by the honesty and accuracy of the participants when filling out the questionnaires, and participating in interviews.

Delimitations

The following are possible delimitations that were considered for this study.

1. Data will be collected via questionnaires, and paid client interviews.
2. Data will be restricted to participants' self report when completing questionnaires, and during interviews.
3. Participants in the study will be volunteers.

Definition of Terms

AIDS: Acquired immunodeficiency syndrome. AIDS can affect the immune and central nervous systems and can result in neurological problems, infections, or cancers. It is caused by human immunodeficiency virus (HIV) (CDC, 2001, p. 35).

Anonymous Testing: In anonymous testing, client identifying information is not linked to testing information, including the request for tests or test results (CDC, 2001, p. 35).

Client-centered HIV prevention counseling: An interactive risk-reduction counseling model usually conducted with HIV testing, in which the counselor helps the client identify and acknowledge personal HIV risk behaviors and commit to a single, achievable behavior change step that could reduce the client's HIV risk (CDC, 2001, p. 35).

Confidentiality: Pertains to the disclosure of personal information in a relationship of trust and with the expectation that it will not be divulged to others in ways that are inconsistent with the original disclosure.

Confidentiality must be maintained for persons who are recommended and/or who receive HIV Counseling, Testing, and Referral (CTR) Services (CDC, 2001, p. 35).

Confidential HIV test: An HIV test for which a record of the test and the test results are recorded in the client's chart (CDC, 2001, p. 35).

Evaluation: A process for determining how well health systems, either public or private, deliver or improve services and for demonstrating the results of resource investments (CDC, 2001, p. 35).

HIV: Human immunodeficiency virus, which causes AIDS. Several types of HIV exist, with HIV-1 being the most common in the United States (CDC, 2001, p. 35).

HIV test: More correctly referred to as an HIV antibody test, the HIV test is a laboratory procedure that detects antibodies to HIV, rather than the virus itself (CDC, 2001, p. 35).

HIV prevention counseling: An interactive process between client and counselor aimed at reducing risky sex and needle-sharing behaviors related to HIV acquisition (for HIV-uninfected clients) or transmission (for HIV-infected clients) (CDC, 2001, p. 35).

Prevention counseling: An interactive process between client and counselor aimed at reducing risky sex and needle-sharing behaviors related to HIV acquisition (for HIV-uninfected clients) or transmission (for HIV-infected clients) (CDC, 2001, p. 36).

Referral: The process through which a client is connected with services to address prevention needs (medical, prevention, and psychosocial support) (CDC, 2001, p. 37).

Risk assessment: Risk assessment is a fundamental part of a client-centered HIV prevention counseling session in which the client is encouraged to identify, acknowledge, and discuss in detail his or her personal risk for acquiring or transmitting HIV (CDC, 2001, p. 37).

CHAPTER II

Review of the Literature

The purpose of this study is to assess 15 state funded HIV counseling and testing sites in the State of Montana. This information will be used to assess the current state of Counseling, Testing, and Referral Services and to offer suggestions for improvement. This chapter will review and discuss current literature pertinent to the study purpose. It is divided into five sections: 1) AIDS, 2) HIV/AIDS Nationally, 3) HIV/AIDS in Montana, 4) Purpose of Counseling and Testing, 5) History of Counseling and Testing, 6) Guidelines, 7) Evaluation of Client Satisfaction.

AIDS

Acquired Immunodeficiency Syndrome (AIDS) was first reported in 1981. Within three years scientists learned that AIDS was caused by exposure to a virus, Human Immunodeficiency Syndrome (HIV). The virus is transmitted by bodily fluids such as; blood, semen, vaginal fluid, breast milk and other fluids containing blood (CDC, 2002). HIV infection weakens the immune system and in turn the body has trouble fighting off certain infections. These infections are known as "opportunistic" because they take the opportunity to cause illness in a weakened immune system. Many of the infections that cause problems or may be life threatening for people with AIDS are usually controlled by a healthy immune system. The immune system of a person with AIDS is weakened to the point that medical intervention may be necessary to prevent or treat serious illness.

HIV/AIDS Nationally

According to the Centers for Disease Control and Prevention (CDC) as of December 2000, 774,467 AIDS cases have been reported in the U.S. Nationwide, 448,060 deaths have been reported since the beginning of the epidemic. Currently there are 800,000 to 900,000 people living with HIV in the U.S. Approximately 40,000 new infections occur in the U.S. every year. Despite these numbers, the mid-to-late 1990s show a decline in the number of AIDS deaths and a slowing progression from HIV to AIDS. These declines are due to advances in HIV treatments. In 1999 AIDS cases declined 3% while AIDS deaths declined 8%. These declining numbers are impressive in the context of new discoveries in medicine; however they are far less impressive when you look at the number of new cases of HIV annually. Today more people are living with HIV in the U.S. than ever before. This growing population represents an increasing need for continued HIV prevention, treatment, and care services (CDC, 2000).

HIV/AIDS in Montana

As of December 2000, The Department of Health and Human Services (DPHHS) recorded 437 cases of AIDS reported in Montana. The state's 2000 AIDS rate was 2.2 (2.2 cases per 100,000 people), compared to 1.9 in 1999 and 3.1 in 1998. This rate is comparable to other states our size, such as Idaho, Wyoming, and the Dakota's, but significantly lower than the national average of 15.7. Eighty percent of the HIV/AIDS cases in Montana are concentrated in the Western and Southwestern areas of the state. Montana is not experiencing the same trends as in other areas of our nation. Men who have sex with men are the predominant HIV exposure category reported, and

injected drug use (IDU) is secondary. Together, they have accounted for approximately 85% of the HIV/AIDS infections in Montana. Even though statistically speaking the numbers of HIV/AIDS cases in Montana is low it is still important to acknowledge HIV as a threat. HIV prevention is an important component to keeping these numbers low.

Purpose of Counseling and Testing

Counseling and Testing is the most widespread HIV prevention intervention in the United States (CDC, 1993, Silvestre, A. J., et al., 2000). The purpose of HIV Counseling, Testing and Referral (CTR) Services is to heighten public awareness of the risk of HIV infection, to change high risk behavior and to identify HIV-positive individuals. HIV counseling seeks to accomplish this by providing information regarding transmission and prevention, by assisting clients in identifying risk behaviors and committing to steps to reducing this risk. To address the prevention needs of each client, HIV counseling is designed to do more than provide factual information in a didactic manner. "Counseling is different from education. Good counseling does not equal good information giving" (CDC, 1998). Counseling is based on a client-centered model that is specifically tailored to the behaviors, circumstances, and special needs of the person being served. Empathy is a major focus of client-centered counseling. Several authors suggest empathy by the physician is an important attribute of effective communication between the patient and a physician (Bellet, P. S., & Maloney, M. J., 1991; Poole, A.D., & Sanson-Fisher, R. W., 1979). The physician must be able to understand the position the patient is in and be able to let the patient know that such understanding exists. This communication leads to a more accurate

understanding of the patient's problem and the appropriate solution for this patient. These ideas of empathy and individual customization provide the framework of the client-centered model used to address the prevention needs of each client in CTR Services.

History of Counseling and Testing

Since licensing of the HIV antibody test in 1985, Counseling, Testing, and Referral Services have been a fundamental part of the national HIV prevention strategy (Castrucci, B.C., et al., 2002). Initially, some health professionals and HIV/AIDS Organizations were concerned about HIV testing (Beardsdale, S., & Coyle, A. 1996; Silvestre, A. J., et al., 2000). They felt that those who tested positive risked psychological distress and that there was little to be offered, clinically, to help them. In addition, to the psychological distress, some were fearful of whether test results would or could be used to justify employment and insurance discrimination and other hostile actions (Silvestre, A. J., et al., 2000). In time, the controversies diminished. The Centers for Disease Control and Prevention (CDC) issued policies designed to ensure that the test was used properly and the test became an important means to facilitate early diagnosis in HIV positive people (Silvestre, A. J., et al., 2000). Early diagnosis provides HIV positive individuals with access to monitoring, prophylaxis, treatment, counseling and social support to facilitate reproductive decisions-making and a reduction in behaviors that carry risks of HIV transmission (Beardsdale, S., & Coyle, A. 1996; Silvestre, A. J., et al., 2000).

The need for counseling and testing arose in 1981, when the disease was first discovered. Initially, the number of AIDS cases was astounding.

The fatal nature of this new disease initiated concern from individuals wanting to know their HIV/AIDS status. The demand for testing services began increasing. In 1985, 79,000 tests were performed at publicly funded sites that number skyrocketed to 1, 350, 000 in 1990 and 2,091,000 in 1991 (Higgins, D. L., et al., 1991). This increase in testing placed a growing emphasis on prevention needs. CTR Services have evolved over the past 25 years.

CTR Services were initially offered to explain the limitations of the HIV antibody test, and to provide information about risk reduction. Currently C&T is used to help people assess their personal risks, to encourage and reinforce behavior change, and to refer infected individuals to clinical care (Higgins, D. L., et al., 1991).

Guidelines of Counseling and Testing

The Centers for Disease Control and Prevention (CDC) and the Department of Health and Human Services (DPHHS) have written guidelines for Counseling, Testing, and Referral (CTR) Services. Publicly funded CTR sites are required to follow these guidelines. The CDC revised its guidelines in November of 2001. These guidelines include eight areas: 1) confidentiality, 2) informed consent, 3) the option of anonymous testing, 4) information regarding the HIV test, 5) adherence to local, state, and federal regulations and policies that govern provision of HIV services, 6) services that are responsive to client and community needs and priorities, 7) services that are appropriate to the client's culture, language, sex, sexual orientation, age, and development level, and 8) high quality service. Following is a brief description of each area as defined by the CDC (CDC, 2001, p.7&8).

Confidentiality

Information revealed through CTR Services should remain private. Personal information should not be divulged without client's original consent (CDC, 2001, p.7&8).

Informed Consent

HIV testing should be voluntary and free of coercion. Informed consent before HIV testing is essential. Information regarding consent may be presented orally or in writing and should use language the client can understand. Accepting or refusing testing must not have detrimental consequences to the quality of care offered. Documentation of informed consent should be in writing, preferably with the client's signature (CDC, 2001, p.7&8).

Anonymous Testing

Consented voluntary testing conducted without a client's identifying information being linked to testing or medical records, including the request for testing or test results. Clients opting for anonymous testing should be informed that the provider cannot link the client's test result to the client by name. Therefore, if the client does not return for test results, the provider will not be able to contact the client with those results (CDC, 2001, p.7&8).

Information Regarding the HIV Test

Provide information regarding the HIV test to all who are recommended to take the test and to all who receive the test, regardless of whether prevention counseling is provided. The information should include a

description of ways in which HIV is transmitted, the importance of obtaining test results, and the meaning of HIV test results (CDC, 2001, p.7&8).

Adherence to local, state, and federal regulations and policies

Laws at the local, state, and federal levels might address aspects of HIV services or regulate how services are provided to particular persons (e.g., minors). In addition, policies, local ordinances, funding source requirements, and planning processes could also affect a provider's decisions regarding which services to provide and how to provide them (CDC, 2001, p.7&8).

Services that are responsive to client and community needs and priorities

Providers should work to remove barriers to accessing services and tailor services to individual and community needs. To ensure that clients find services accessible and acceptable, services can be offered in nontraditional settings (i.e., community-based or outreach settings); hours of operation can be expanded or altered; unnecessary delays can be eliminated (e.g., integrating counseling and testing for STDs/HIV with counseling and testing for hepatitis); test results can be obtained more easily (e.g., with rapid testing or by telephone in certain situations); and less-invasive specimen collection can be used (e.g., oral fluid, urine, or finger-stick blood) (CDC, 2001, p.7&8).

Services that are appropriate to the client's culture, language, sex, sexual orientation, age, and developmental level.

These factors could affect how the client seeks, accepts, and understands HIV services. Providers should consider these factors when designing and providing HIV services to increase the likelihood of return for

test results and acceptance of counseling and referral services (CDC, 2001, p.7&8).

High quality services

To ensure ongoing, high-quality services that serve client and community needs, providers should develop and implement written protocols for CTR and written quality assurance and evaluation procedures. Many state and local health departments have substantial expertise in providing and monitoring the quality of HIV CTR Services and can be a resource to private providers or community-based or outreach settings initiating these services (CDC, 2001, p.7&8).

Evaluations of Client Satisfaction

One key factor when evaluating a Counseling and Testing Program is the perception of the client. For many clients, receiving substandard service could cause them to fail to return for test results and posttest counseling (Silver, S., et al., 1998). One of the largest studies evaluating Counseling, Testing, and Referral (CTR) Services was conducted in 1996. The State of Pennsylvania's Bureau of HIV/AIDS contracted with the University of Pittsburgh Graduate School of Public Health to evaluate 257 publicly funded HIV sites. The evaluation consisted of four evaluation methods; a mail questionnaire to all 257 sites, 30 randomly chosen site visits and interviews, participant observation at 30 randomly chosen sites, and client satisfaction questionnaires from 50 randomly selected sites. The four-part evaluation was developed on the basis of the then-current CDC HIV counseling and testing standards. The client satisfaction questionnaire was designed for use at the client's prevention or pretest counseling session. The questionnaire was

preceded by a letter from The Bureau of HIV/AIDS and included an explanation of the evaluation and a request for full participation. The questionnaires packets were then mailed to each site. Each questionnaire packet included a memo with directions for implementation, a short script for the counselors to use when explaining the questionnaire to the clients, and adequate number of questionnaires, and an equal number of self addressed stamped envelopes. The questionnaire was implemented for a four-week period. They were color and design coded for each site. This allowed the researcher to determine an individual return rate for each site. The study conducted in Pennsylvania is the most comprehensive study published thus far evaluating CTR Services (Silvestre, A. J., et al., 2000). The study concluded that most clients indicated a high satisfaction with the content and delivery of counseling and testing. Two areas for improvement were highlighted. They included, more availability of free, and easily accessible condoms, and an increased support and guidance for counselors to make client referrals to other needed services (Silvestre, A. J., et al., 2000).

Another study was conducted in Washington D.C. in 1998. This study consisted of a direct evaluation of HIV counseling and testing. Researchers trained adolescents to address critical issues using undercover fictional stories at actual sites that advertised HIV/AIDS counseling and testing to teenagers. The study first examined extrinsic factors surrounding the site that might influence a youth to move forward or away from testing. The second component to the study was an intrinsic evaluation, which was only conducted if the site passed the extrinsic evaluation. The intrinsic evaluation consisted of data gathered from various resources and client experiences.

The intrinsic evaluation was mostly subjective because there were certain characteristics important in the counselor-client relationship that were essential to evaluate but difficult to explain as an objective standard, such as “openness of the counselor” or “negative body language” (Silver et al., 1998, p. 296). The adolescents immediately reported their experiences on detailed assessment forms. The assessment forms were comprehensive and included sections on: the environment, content, communication, rapport, psychological issues, risk assessment and reduction, testing, content of posttest counseling, and medical management issues for clients with positive results. This study presents data that is extensive as well as impressive. Overall, the researchers found that less than 40% of the sites which advertised HIV counseling and testing services to adolescents qualified for recommendation. There was no single criterion that kept sites from being recommended. Most evaluators found the counselors non-judgmental in regards to the presented risk behaviors. However, the majority of female evaluators experienced a “critical or paternalistic” response by site personnel when they portrayed risky behavior involving sexual activity. Many female evaluators reported being advised to abstain from or reduce their sexual activity even if they portrayed protected sexual activities (Silver, S., et al., 1998).

This study utilized a direct assessment approach by training adolescents and sending them to the clinics for testing. They sent more than one student to each clinic for testing which allowed for a more comprehensive study. This direct assessment approach worked well in Washington D.C.; however, it would not be economically feasible for the state of Montana.

Another study evaluated an adolescent specific program to determine if high risk youth (aged 12-24) utilized Counseling and Testing Services (Goodman, E., 1999). The study employed a logistic regression analysis. The results of the study indicated that despite targeted, youth specific, developmentally appropriate and culturally sensitive outreach and intervention efforts, youth of color and high risk youth were poorly accessing Counseling and Testing Services.

Chapter III

Methodology

The purpose of this study was to assess client's perceptions of Montana's Counseling and Testing Services. The study focused on accessibility of CTR Services, staff performance and proficiency, staff empathy and non-judgment, and client confidentiality. The results from this study will be used to assess the current state of Counseling and Testing in Montana.

Target Population

The population assessed in this study was volunteers over the age of eighteen, who received CTR Services from the one of the fifteen state funded sites in Montana, who completed a questionnaire or participated in an interview. Feedback was obtained directly from clients in an attempt to gain insight into clients' experiences with Counseling, Testing, and Referral (CTR) Services in Montana.

Protection of Human Subjects

Consent forms and human subject application material were completed in accordance with The University of Montana Institutional Review Board (IRB) (see Appendix A).

Procedures

Selection of Samples

Questionnaire

Counselors at the fifteen Counseling, Testing, and Referral (CTR) Service sites were asked to offer each client they saw a brief anonymous

questionnaire. Clients could decline the questionnaire, complete it at the clinic or take it with them to complete at their leisure.

Interview

At the end of the questionnaire was a written invitation for clients to participate in an interview. The researcher's name and a private phone number were included with instructions asking clients to contact the researcher if they would like to share their CTR experiences. Each site was sent one or more posters to display in the waiting area advertising the interview information. A twenty-dollar incentive was offered for each interview.

Instrumentation

Questionnaire

A questionnaire instrument was developed to identify clients' perceptions of CTR Services in Montana (see Appendix B). Questions for the questionnaire were adapted from the examination of various existing tools and were categorized into priority areas identified through review of the literature and through interviews with the Montana State HIV prevention staff. The questionnaire consisted of fifteen statements that addressed 4 priority areas: accessibility of CTR Services, staff performance and proficiency, staff empathy and non-judgment, and client confidentiality. The final section of the questionnaire was devoted to demographic data. The instrument was voluntary and anonymous for all participating subjects.

The questionnaire was examined for face and content validity by state CTR program staff and several site coordinators. In addition, 5-10 volunteers

from the DPHHS HIV Community Planning Group pilot tested the questionnaire and provided feedback to the researchers.

Interview

Formal structured telephone interviews were conducted with ten moderate to high risk clients. This interview process was selected to add depth and meaning to the information gathered from the questionnaire. Questions for the formal interview (see Appendix C) focused on staff performance and proficiency, and staff empathy and non-judgment. A script preceded each interview (see Appendix D).

Data Collection

Primary data was collected via questionnaire and formal interview. Data collection began June 7, 2003 and continued through October 31, 2003.

Questionnaire

Prior to implementing the study, all fifteen state funded sites received a letter from DPHHS requesting their participation in the assessment. The researcher contacted each site to determine an estimate of the number of questionnaires necessary for the eight-week period. Following the letter, each site coordinator received a packet of materials from the researcher. Included in that packet was a cover letter explaining the purpose of the study, a list of instructions to the counselor who would distribute the questionnaire, and questionnaires with SES envelopes attached. Questionnaires were color coded per site in order to establish return rates for each site.

Counselors were instructed to offer a questionnaire to all clients over the age of 18 who completed the pre-test counseling. Clients who chose to complete the questionnaire returned it directly to The University of Montana

via the SES envelope. Due to a low return rate each site was contacted via telephone and asked to extend questionnaire distribution for an additional two weeks. An e-mail was sent as a reminder to the counselors and asked them to encourage client participation.

Interview

Clients who were interested in participating in an interview contacted the researcher by leaving a message on a private telephone. The message consisted of a first name, contact phone number, and a convenient time for the interview. The researcher contacted the client at the time mentioned and recorded the formal interview. The interview was confidential. The tapes were transcribed and immediately destroyed. No identifying information was connected to the transcript. Due to the low response rate an extension was granted. Site supervisors were contacted and asked to encourage clients to participate in interviews.

Data Analysis

Collected data consisted of responses to a questionnaire and formal interview. Quantitative analysis was used for the questionnaire. Qualitative analysis was used for the interview.

Questionnaire

Questionnaire responses were analyzed using the SPSS Computer Program. Questionnaire analysis included descriptive statistics to report the perceptions of clients who use HIV CTR Services. Frequency and modes were established for each variable. Participants were divided into two groups based upon risk behavior. Individuals who self-reported injecting drug use and/or men who self-reported engaging in sex with another man were placed

in the high risk group while the remaining participants were placed in the low risk group. Frequencies for each group were examined for differences between groups for each variable.

Chi-square tests of significance were conducted on two response categories (strongly agree and agree) to determine statistical difference between the groups.

Interview

Interview data was qualitatively analyzed. Immediately following the telephone interviews, the researcher transcribed the tapes. The researcher then reviewed the notes and the tapes to make sure the tapes were clear and made sense, identified any areas of ambiguity or uncertainty, and reviewed the overall quality of the information received.

The notes from the interviews were compared with the tape transcriptions to check for accuracy. Analysis involved identifying themes, patterns, perceptions, general impressions and concerns identified by the participants.

CHAPTER IV

Results

The purpose of this study was to conduct an assessment of the Montana state funded HIV Counseling, Testing and Referral (CTR) Services from a client perspective. Results of the demographic data from the questionnaires will be reported first, followed by results from the questionnaires, and lastly interview data will be reported.

Questionnaire

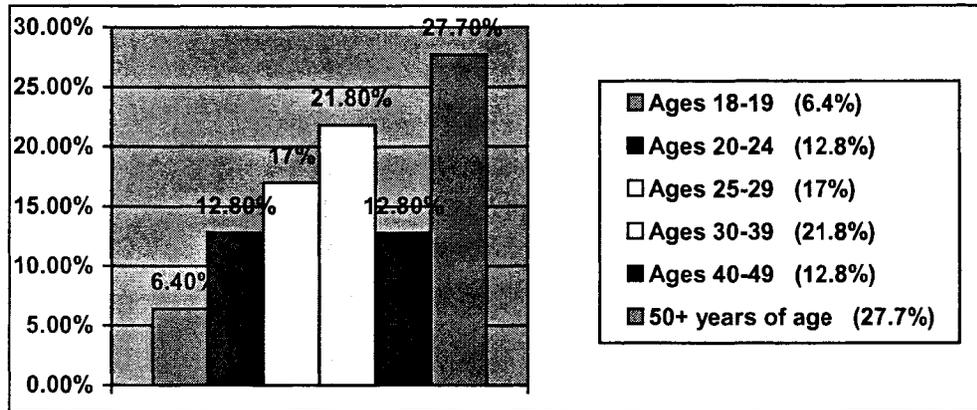
Client satisfaction questionnaires were distributed to 15 state funded CTR sites across Montana. Forty-seven questionnaires were returned during the eight-week time period spanning from June 7, 2003 to July 31, 2003. Information regarding the number of actual tests conducted during this time were provided from DPHHS. In June and July of 2003 approximately 436 tests were conducted. These figures were used to determine a return rate. If we assume every client receiving Counseling and Testing services was offered a questionnaire, we can estimate a return rate of approximately eleven percent.

Demographics

Participants' gender and age.

Forty-seven percent (n=22) of the participants were female, and 53% (n=25) were male. Participants' ages varied with the largest number of participants' (28%) being 50 years or older. See Chart 1 for reported age of respondents (n=47):

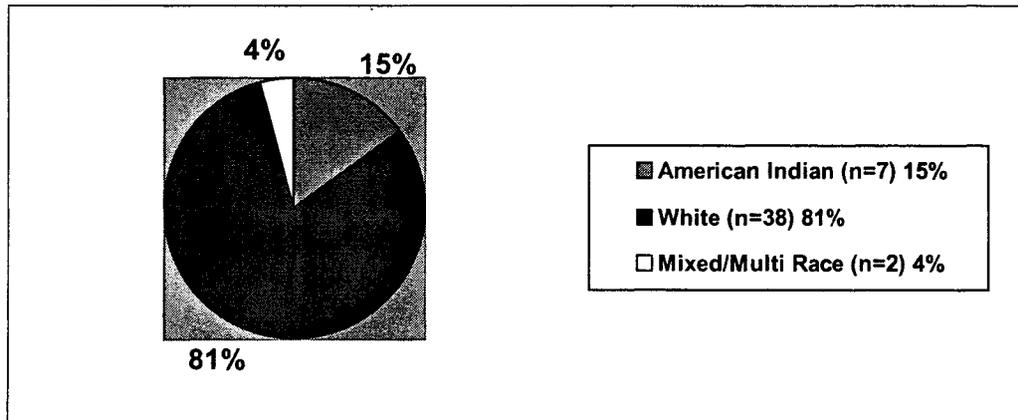
Chart 1. Age.



Race

Approximately four-fifths of the questionnaire respondents identified their race as white, followed by American Indian and Mixed or Multi Race. These demographics actually signify a slight over-representation of Native Americans in Montana where seven percent of residents are Native American. See Chart 2 for reported race of respondents (n=47):

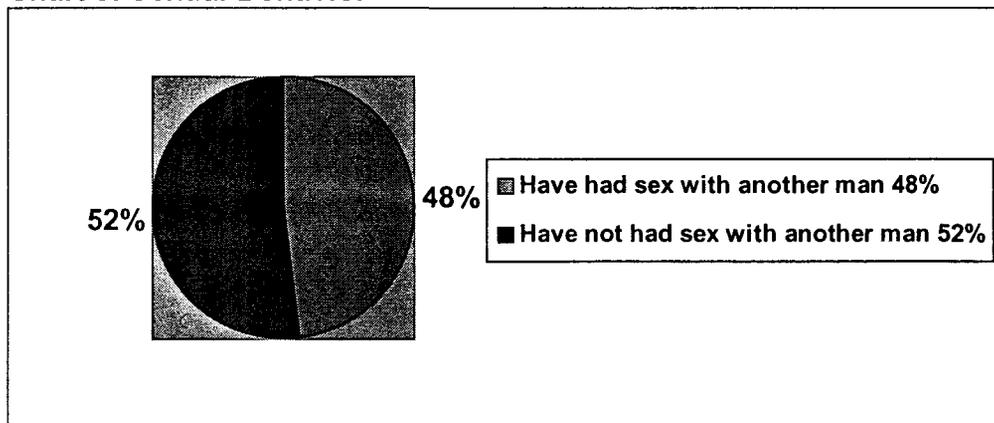
Chart 2. Race.



Sexual Behavior

Male respondents (n=25) were asked if they had ever participated in sex with another man. Forty-eight percent of male respondents self-reported having sex with another man. See Chart 3 for responses.

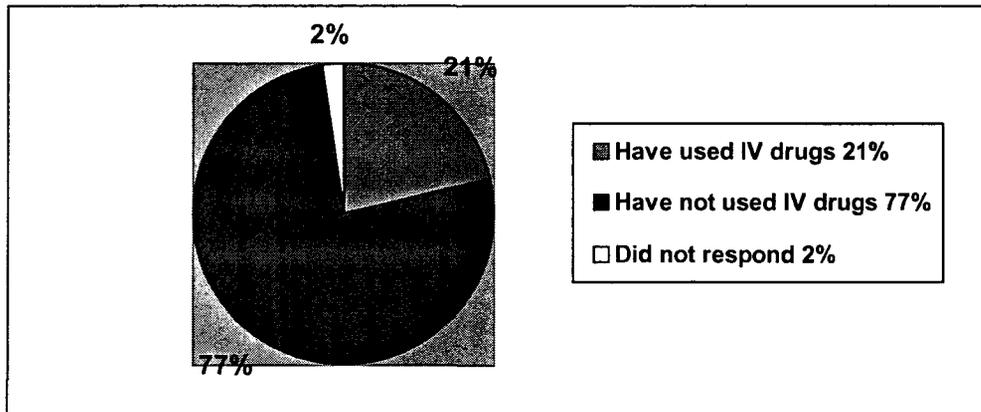
Chart 3. Sexual Behavior



Drug Use

All respondents (n=47) were asked if they had ever used intravenous drugs. Approximately one-fifth of the respondents reported having used intravenous drugs to get high. See Chart 4 for results.

Chart 4. Drug Use.



Descriptive Data

The following table displays responses from the 47 participants who returned the survey. In statements one through sixteen a five-point Likert Scale of “strongly agree,” “agree,” “disagree,” “strongly disagree,” or “doesn’t apply” was used as response categories. Frequencies of responses are listed in the table below for statements one through fifteen.

QUESTION	RESPONSES % (n)				
	Strongly Agree	Agree	Disagree	Strongly Disagree	Doesn't Apply
The counselor was knowledgeable about HIV/AIDS and the testing process.	78.7 (n=37)	19.1 (n=9)	2.1 (n=1)	(n=0)	(n=0)
The counselor explained the differences between confidential and anonymous testing.	74.5 (n=35)	17 (n=8)	4.3 (n=2)	2.1 (n=1)	2.1 (n=1)
The counselor answered all of my questions about HIV/AIDS clearly.	74.5 (n=35)	25.5 (n=11)	(n=0)	(n=0)	2.1 (n=1)
I felt at all times my confidentiality was protected.	78.7 (n=37)	17 (n=8)	2.1 (n=1)	2.1 (n=1)	(n=0)
I felt comfortable asking the counselor sensitive questions.	70.2 (n=33)	25.5 (n=12)	4.3 (n=2)	(n=0)	(n=0)
Before my test, the counselor talked with me about risky behaviors that put me at risk for HIV infection.	74.5 (n=35)	25.5% (n=12)	(n=0)	(n=0)	(n=0)
The counseling I received before and after testing was specific to my situation.	66 (n=31)	34 (n=16)	(n=0)	(n=0)	(n=0)
As a result of my talk with the counselor I plan to engage in safer behaviors.	59.6 (n=28)	27.7 (n=13)	(n=0)	4.3 (n=2)	8.5 (n=4)
I felt comfortable telling the counselor about my behaviors that put me at risk for HIV infection.	74.5 (n=35)	21.3 (n=10)	2.1 (n=1)	(n=0)	(n=0)
I felt like I was given a choice to test or not to test for HIV.	78.7 (n=37)	19.1 (n=9)	2.1 (n=1)	(n=0)	(n=0)
I would still come for testing even if it was no longer anonymous.	66 (n=31)	19.1 (n=9)	8 (n=4)	6.4 (n=3)	(n=0)
The counselor gave referrals for other services you needed.	44.7 (n=21)	10.6 (n=5)	2.1 (n=1)	(n=0)	40.4 (n=19)
The location and hours of the testing site were convenient for me.	80.9 (n=38)	17 (n=8)	2.1 (n=1)	(n=0)	(n=0)
I would feel comfortable referring my friends and family here for testing.	83 (n=39)	14.9 (n=7)	2.1 (n=1)	(n=0)	(n=0)
I am likely to return for my test results.	80.9 (n=38)	10.6 (n=5)	(n=0)	(n=0)	6.4 (n=3)

The majority of responses in questions one through fifteen were “Strongly Agree” or “Agree”. There were two exceptions to this response pattern. Approximately, fifteen percent of clients disagreed with the statement regarding whether or not participants would still come for testing if it was no longer anonymous. And, approximately forty percent of clients felt that the statement regarding whether or not the counselor gave referrals for other services did not apply to them. Responses to statements sixteen through twenty-one can be found in Demographics (see above).

Comparison of High and Low Risk Groups

Participants were divided into a high risk and low risk group. The high risk group consisted of eighteen participants who self-reported injecting drug use and/or men who self-reported having sex with other men. Six women and two men self-reported injecting drug use, eight men self-reported having sex with other men, and two men self-reported both having sex with other men and injecting drug use. The low risk group consisted of thirty-nine participants who did not report either of these risk behaviors. Percentages for both groups, for each statement, were calculated. These percentages are listed in the table on the following page.

Low Risk Group (n=28): Highlighted in White

High Risk Group (n=18): Highlighted in Gray

QUESTION	RESPONSES %				
	Strongly Agree	Agree	Disagree	Strongly Disagree	Doesn't Apply
The counselor was knowledgeable about HIV/AIDS and the testing process.	86	14	0	0	0
	66	28	6	0	0
The counselor explained the differences between confidential and anonymous testing.	77	17	0	6	0
	66	17	11	0	6
The counselor answered all of my questions about HIV/AIDS clearly.	86	14	0	0	0
	55	39	0	0	6
I felt at all times my confidentiality was protected.	89	11	0	0	0
	61	33	6	6	0
I felt comfortable asking the counselor sensitive questions.	80	14	0	0	6
	61	33	0	0	6
Before my test, the counselor talked with me about risky behaviors that put me at risk for HIV infection.	82	18	0	0	0
	61	19	0	0	0
The counseling I received before and after testing was specific to my situation.	75	25	0	0	0
	50	50	0	0	0
As a result of my talk with the counselor I plan to engage in safer behaviors.	86	7	0	0	4
	72	17	0	0	11
I felt comfortable telling the counselor about my behaviors that put me at risk for HIV infection.	75	25	0	0	0
	61	28	11	0	0
I felt like I was given a choice to test or not to test for HIV.	89	11	0	0	0
	61	33	6	0	0
I would still come for testing even if it was no longer anonymous.	75	18	4	4	0
	50	22	17	11	0
The counselor gave referrals for other services you needed.	40	7	0	0	14
	55	17	6	0	22
The location and hours of the testing site were convenient for me.	89	11	0	0	0
	66	28	6	0	0
I would feel comfortable referring my friends and family here for testing.	89	11	0	0	0
	72	22	6	0	0
I am likely to return for my test results.	86	7	0	0	4
	72	17	0	0	17

When the response categories of strongly agree and agree and strongly disagree and disagree are combined, the differences between the high risk and low risk groups are more definitive. However, an examination of differences between the strongly agree and agree categories reveal slight differences. On all statements but one individuals in the high risk group did not agree as strongly as those in the low risk group. Chi-square tests were used to examine differences but did not reveal statistical significance. However, it is important to note that nearly one-third (29%) of the participants in the high risk group reported they would not come for testing if it were not anonymous, while only eight percent of those in the low risk group reported they would not come.

Telephone Interviews

Ten telephone interviews were conducted with volunteers who had recently received CTR Services. Interview information specifically requested interviews with high risk clients. Seven of the ten interviewees were high risk reporting one and/or both of the high risk behaviors stated above, and the other three were low risk. Eight of the interviewees were men and two were women. Three of the ten clients reported they had injected drugs to get high. Five of the eight men interviewed reported that they had sex with another man. Immediately after each interview the audiotapes were transcribed and data was organized into common themes. Themes for each interview question are reported on the following page by interview questions.

Question #1: Could you describe the way you were treated when you entered the CTR facility?

All clients seeking CTR services reported professionalism and other positive attributes associated with feeling comfortable. Clients describe their treatment as professional, respectful and similar to other doctor visits.

One participant stated: "Um, well I guess decently, it's just like any other normal doctors visit. I mean nobody looked at me funny or anything."

Another stated: "The lady was absolutely sweet about it. She didn't make me feel uncomfortable at all about it."

Question #2: Could you describe how the counselor treated you while you were being counseled and tested?

The majority of the clients reported in positively using general terms. They used words like kind, polite and nice to describe the counselors.

One participant stated: "She was very courteous. First we discussed if there was a specific reason why I had initially come in to be screened. Or, how did I feel about this? She was good. She was concerned about me, my emotions and my feelings. And then she went on to explain that the test was anonymous and all that good stuff."

Another stated: "You know they were like why are you here? When was the last time you shot dope? It was kind of awkward and strange but the lady was really nice."

Question #3: How comfortable were you talking about sensitive issues and behaviors that put you at risk for HIV?

The majority of clients felt comfortable disclosing personal information to the counselors.

One client stated: "I usually don't talk to women about those sensitive issues but it really didn't bother me as much as I thought it would. She had some really great questions I would have never thought to ask her."

Another said: *“Well you know I’m gay and the counselor I go to, I’m pretty sure is gay too, so I feel pretty comfortable with him. I’m not sure I would feel as comfortable with a straight woman. Probably more so than I would with a straight man. I know it shouldn’t matter but it still does.”*

A couple of clients mentioned they were nervous initially but after talking with the counselor became comfortable.

One client stated: *“It was really weird at first, because everyone in town is basically clean cut. So I thought it would be really weird but once I got in there they were really helpful.”*

Question #4: Would you recommend that your friends get tested by this counselor?

The majority of clients would suggest that their friends get tested by this counselor. These clients answered with basic variations of “yes I would.”

However a couple of clients suggested that their friends not get tested by a particular counselor.

One client stated: *“Um, you know probably not, I would think there are probably other places that could have done better.”*

Question #5: How would you describe the counselor to your friend?

The majority of clients describe the counselor as friendly, professional, helpful, nice, and thorough.

One client stated: *“She was cute. Just that she was a really nice lady.”*

Another client stated: *“I would say it was confidential, easy, and efficient.”*

Question #6: During your visit was a plan set up to help you decrease behaviors that put you at risk for HIV?

The majority of the clients acknowledged a plan was set up to help them decrease their risk behaviors. Clients answered this question with specific “yes/no” responses.

Question #7: Did you feel the plan was specific to your situation?

Slightly more than half of the clients commented that the plan was specifically tailored to them. However they felt like the counseling the received seemed like something the counselors did with everyone.

One client stated: *"Yeah, there was like twenty questions that they asked. Most didn't apply to me but there were some that did and when we got to those ones we talked about them."*

Another client stated: *"She tried to make it specific to my situation."*

Slightly less than half of the clients felt the plan was not specific to their situation. These clients reported that the plan the received was general, and it could apply to any individual utilizing CTR Services.

One client stated: *"It seemed like general information that they gave to everyone."*

Question #8: Did you participate in creating the plan?

The majority of clients who felt the plan was specific to their situation affirmed that they helped to create the plan.

Question #9: Were you given names and phone numbers to contact if you needed other services? Did you request any referrals for other services?

Slightly more than half of the clients reported being offered referrals for other services. The services noted were testing for Hepatitis A, B, and C, written information, and information regarding support services.

One client stated: *"Information about a seminar, and literature to read, and she told me to call him if I had any more questions."*

Another client stated: *"She offered information about a support group in town. I was already aware of them but it helped to remind me."*

Slightly less than half of the clients stated that they were not offered referral services nor did they request them.

Chapter V

The purpose of this study was to conduct an assessment of client's perceptions of CTR Services in Montana. The study was divided into four categories of client's perceptions of:

1. CTR Services accessibility
2. Staff performance and proficiency
3. Staff empathy and non-judgment
4. Client confidentiality

In addition to describing general perceptions of clients regarding CTR Services, an attempt was made to examine the differences among clients who self-identify as high risk and those who identify as "low risk."

This chapter serves to highlight and discuss the major findings of this study. In this chapter possible limitations within study design, recommendations, and suggestions for further research will be discussed.

Summary of Findings

In this section, data from the questionnaire and interviews are synthesized. Summaries of findings related to the above mentioned four categories are reported below.

CTR Services accessibility

Results of this study indicate that most clients believe that CTR Services in Montana are convenient. Specifically, it can be said that most clients:

- Believe the location and hours of the CTR site were convenient (97.9%)
- Feel they were seen in a timely manner (95.7%)

- Think they are likely to return for test results (91.5%)

Staff performance and proficiency

The responses to statements and questions regarding the performance and proficiency of the staff were high. Specifically it can be said that most clients:

- Felt the counselor explained the difference between confidential and anonymous testing (91.5%)
- Were of the opinion they were given a choice to test or not to test for HIV (97.8%)
- Agree the counselor had them identify their risk behaviors for HIV (100%)
- Deem the counseling they received before testing was specific to their situation (100%)
- Believe the counselor was knowledgeable regarding testing and answered all of their questions about HIV/AIDS clearly (97.9%)
- Felt comfortable referring family and friends to the site for testing (97.9%)

Findings from the interviews also support these above-mentioned notions as the majority of the participants agreed that the CTR counselor was professional and proficient.

Staff empathy and non-judgment

The responses to questions regarding the staff empathy and non-judgment were very positive. Specifically it can be said that most clients:

- Felt comfortable telling the counselor about behaviors that put them at risk for HIV infection (95.8%)

- Were comfortable asking the counselor sensitive, personal questions (95.7%)
- Felt comfortable referring family and friends to the site for testing (97.9%)

Interview transcriptions also support these claims.

Confidentiality

The responses to questions regarding confidentiality were also strong.

Specifically it can be said that most clients:

- Believed their confidentiality would be protected at all times (95.7%)
- Felt comfortable asking the counselor sensitive, personal questions (95.7%)
- Felt comfortable referring family and friends to the site for testing (97.9%)
- Would still come for testing even if it was no longer anonymous (85.1%)
- Were likely to return for test results (91.5%)

Discussion

The largest percentage of Montana's HIV Prevention funding is allocated to CTR Services. Because of the high percentage of financial and other resources dedicated to CTR Services it is important to evaluate the current practice. Findings from this study will provide information regarding current practices of CTR Services in Montana, and serve as a baseline for recommendations and further research. Information from this study will assist DPHHS in determining if CTR Services are meeting the needs of high risk

populations. In addition, the instruments should be useful in conducting future research regarding CTR Services in Montana.

Results from this study reveal that professionals working in CTR Services are following the "Standards of Practice." Clients reported positive impressions of CTR Services in Montana in the areas of accessibility to services, staff performance, and staff empathy and non-judgment. The positive assessment of CTR Services by clients in Montana is similar to results of an extensive study of CTR Services conducted in Pennsylvania in 1996 (Silvestre, A.J., et al., 2000). In addition to reporting positive experiences when testing, clients from both studies felt as though their confidentiality was protected when seeking CTR Services.

More importantly, suspicions that persons who engage in risky behavior might be treated differently than low risk persons were not confirmed. In a comparison of low and high risk clients, both felt positive about the services they received. However, it is important to note that while high risk participants felt positively about the services received, they did not feel as strongly as the low risk participants. When examining only the response category of strongly agree, a greater percent of low risk clients strongly agreed with fourteen of the fifteen statements. Chi-square tests were conducted to determine statistical significance. With an alpha level of $<.05$ the difference in responses for the high and low risk groups was not statistically significant. This lack of statistical significance may be due in part to low numbers in each group. However, the response differences for the groups may have practical significance. As mentioned above it is important to note that the low risk group was slightly more satisfied with CTR Services.

Percent differences for responses in the “Strongly Agree” category ranged from a low of 14% to a high of 28%. Nine of the fifteen statements had a percent difference greater than or equal to 20% in the “Strongly Agree” categories. And, while it is difficult to determine reasons for this difference, it is possible that counselors were slightly less comfortable with clients who report high risk. However, it is equally possible that clients who report high risk are aware of the stigma attached to their behavior and, therefore, feel slightly less comfortable despite counselors’ efforts to help them feel comfortable.

Limitations of the Study

As with all studies there are possible limitations. Limitations to this study consist of methods of distribution of client satisfaction questionnaires, methods for recruiting interview participants, self-report measures, and low response rate.

Distribution of Questionnaires: Several issues may have influenced the number of questionnaires returned, and the type of individual who responded. First, because the counselors themselves distributed the questionnaires, it is impossible to know if every client was offered a questionnaire and equally encouraged to participate. Secondly, because of the counselors knowledge of being evaluated may have influenced their behavior. Lastly, it is possible that clients who had a positive experience were more likely to take the time and effort to complete the questionnaire than those who had a negative experience. If clients completed the questionnaire at the clinic, they may have felt that their anonymity was compromised. Because of the above-mentioned issue regarding counselor

encouragement and distribution of the questionnaire it is difficult to determine an accurate return rate.

Recruitment of Participants in Interviews: Participants for interviews were recruited via a written invitation at the end of the client satisfaction questionnaire they were given following their CTR appointment and/or through posters that were displayed at the counseling and testing sites. The invitation specifically requested participation from individuals who were at high risk and offered potential participants a \$20.00 incentive. Several issues may have influenced the number and type of individuals who volunteered to be interviewed. First, the invitation to interview asked specifically for individuals who suffer from social stigma (men who have sex with men and injecting drug users) – individuals may have been hesitant to call for fear of having their identity and/or risk behavior exposed. Second, access to phones and particularly the ability to make long distance calls may have been a barrier. Counselors at several sites reported high risk individuals who were interested in participating but, did not have use of a phone.

Self-Report Data Collection Methods: All self-report measures suffer from the bias of social desirability, individual's memory, and willingness and ability to honestly report feelings and behaviors.

Low Return Rate: While all of the above limitations affected the return rate for this project, a separate discussion of the consequences of the low return rate is critical in the interpretation of results. Researchers must always ask the question "what were the characteristics of the of the CTR clients who did not return surveys or participate in interviews?" It is possible that counselors were more likely to encourage clients with whom they had positive

interactions to complete the questionnaire. In this case, those clients with positive CTR experiences would be over represented in the sample. It is just as likely that counselors encouraged each client equally to complete the questionnaire, but that those clients with less positive experiences may not have been as motivated as those who had very positive experiences. It is also possible that counselors were busy and did not always think to offer each client a questionnaire at the end of the counseling session. In this case, the actual return rate in terms of questionnaires distributed compared to questionnaires returned would actually be much higher. In all cases, the researchers have little idea what the characteristics and experiences are of those clients who did come for CTR Services, but who did complete the questionnaire.

Recommendations

Results from this study provide the information needed to begin improving CTR Services in Montana. The following recommendations can be made to all parties.

- Overwhelmingly, CTR clients reported feeling positive about CTR services in Montana. We recommend that coordinators and counselors at the CTR sites that participated in this assessment be commended for their good work.
- Results from the client satisfaction questionnaire indicate that nearly one-third of the high risk people tested would not come for testing if it was no longer anonymous. We recommend that anonymous counseling and

testing continue to be available to all individuals seeking services in Montana.

- Evaluation of client satisfaction needs to be ongoing. Incentives for counselors to distribute questionnaires and for clients to complete them need to be established to ensure a higher return rate. Evaluation of services will become increasingly important with the introduction of rapid testing in Montana.
- Although the low number of completed surveys made it difficult to determine statistical significance between the high risk and low risk groups in regard to satisfaction with CTR Services, there does appear to be slight differences. We recommend further investigation into the apparent differences in the degree of satisfaction between the high and low risk groups.
- Implement a structured protocol for quality assurance assessment based on the DPHHS Standards of Practice. The CTR services should be assessed on an annual basis.

Conclusions

Results from this assessment reveal that professionals working in CTR Services are following the Standards of Practice. Clients reported positive impressions of CTR Services in Montana in the areas of accessibility to services, staff performance, and staff empathy and non-judgment. An ongoing process for quality assurance needs to be implemented to ensure that this practice continues.

More importantly, suspicions that persons who engage in risky behavior might be treated differently than low risk persons were not confirmed. In a comparison of low and high risk clients, both felt positive about the services they received. However, it is important to note that while high risk participants felt positively about the services received they did not feel as strongly as the low risk participants. When examining only the response category of strongly agree a greater percent of low risk clients strongly agreed with fourteen of the fifteen statements. Although, there were not statistical differences between the two groups, the response differences may have practical significance. As mentioned above it is important to note that the low risk group was slightly more satisfied with CTR Services. And, while it is difficult to determine reasons for this difference, it is possible that counselors were a little less comfortable with clients who report high risk behaviors. However, it is equally possible that clients who report high risk behaviors are aware of the stigma attached to their behavior and therefore feel slightly less comfortable despite counselors' efforts to put them at ease. Indeed, all participants in this project highlighted the professionalism and competence of CTR staff.

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Appendix A
Institutional Review Board Approval

For Internal Use Only

RECEIVED
Form IRB-08 (Rev. 7/00)

The University of Montana
INSTITUTIONAL REVIEW BOARD (IRB)
CHECKLIST

APR 01 2003

UNIVERSITY OF MONTANA
INSTITUTIONAL REVIEW BOARD FOR RESEARCH

Submit one completed copy of this Checklist, including any required attachments, for each course involving human subjects. The IRB meets monthly to evaluate proposals, and approval is granted for one academic year. See IRB Guidelines and Procedures for details.

Project Director: K. Ann Sondag Dept.: HHP Phone: 243-5215

Signature: [Signature] Date: 4/1/03

Co-Director(s): _____ Dept.: _____ Phone: _____

Project Title: HIV Counseling, Testing and Referral Services Assessment

Project Description: The purpose of this project is to assess current CTR practices (in nontechnical language) and determine gaps between the current practice and standards of practice as outlined in The Center for Disease Control's Guidelines for HIV CTR services and the public health department's standards of performance.

All investigators on this project must complete the NIH self-study course on protection of human research subjects. Certification: I/We have completed the course - (Use additional page if necessary)

Signature	Date	Signature	Date
<u>[Signature]</u>	<u>4/1/03</u>	_____	_____
<u>[Signature]</u>	<u>4/1/03</u>	_____	_____
<u>[Signature]</u>	<u>4/1/03</u>	_____	_____

Students Only:

Faculty Supervisor: _____ Dept.: _____ Phone: _____

Signature: _____

(My signature confirms that I have read the IRB Checklist and attachments and agree that it accurately represents the planned research and that I will supervise this research project.)

For IRB Use Only

IRB Determination:

- Approved Exemption from Review
- Approved by Administrative Review
- Full IRB Determination:

- Approved
 Conditional Approval (see attached memo)
 Resubmit Proposal (see attached memo)
 Disapproved (see attached memo)

Signature IRB

Chair: _____ Date: _____

(over)

Project Information

1. Is Exemption from Review requested? Yes No
 (See outline in Section B of the IRB Guidelines and Procedures)

2. Human Subjects. Describe briefly (include age/gender): Individuals over 18 years of age who participate in CTR services at one of 15 designated sites. And, staff at the state public health department and at community based agencies who are involved in delivering CTR services

Are any of the following included? Check all that apply.

Minors (under age 18) If YES, specify age range(s): _____

Members of physically, psychologically or socially vulnerable population? Explain why: Individuals who participate in CTR services may have engaged in behaviors that put them at risk for HIV. Gay men and Injecting Drug users may be vulnerable because of the social stigma attached to homosexual sex and drug use.

3. How are subjects selected/recruited? Explain briefly: All subjects will be asked to volunteer for the study

4. Identification of subjects in data.

Anonymous, no identification Identified by name and/or address or other Confidentiality Plan

5. Subject matter or kind(s) of information to be compiled from/about subjects.

Describe briefly: Subjects will be asked to describe their perceptions of CTR services. Limited demographic data will be collected on CTR clients including a description of their sexual orientation and whether or not they inject drugs.

Is information on any of the following included? Check all that apply.

- Sexual behavior Illegal conduct
 Alcohol use/abuse Drug use/abuse
 Information about the subject that, if it became known outside the research, could reasonably place the subject at risk of criminal or civil liability or be damaging to the subject's financial standing or employability.

6. Means of obtaining the information. Check all that apply.

- Field/Laboratory observation Mail survey (Attach questionnaire/instrument)
 Tissue/Blood sampling On-site survey (Attach questionnaire/instrument)
 Measurement of motions/actions records, data, etc. Examine public documents,

- In-person interviews/survey (Attach questionnaire/instrument) _____ Examine private documents, records, data, etc. _____ Use of standard educational tests, etc.
- Telephone interviews/survey (Attach questionnaire/instrument) _____
- _____ Other means (specify): _____

Will subjects be videotaped, audiotaped or photographed? videotaped interviews

7. Is a written consent form being used? _____ Yes (attach copy) No

8. Will subject(s) receive an explanation of the research before and/or after the project?

Yes (attach copy) _____ No

9. Is this part of your thesis or dissertation? _____ Yes No

If YES, date you successfully presented your proposal to your committee: _____

10. Are you applying for funding for this project? Yes _____ No

If YES, please name the sponsor: Department of Public Health and Human Services

Appendix B
Client Satisfaction Questionnaire

Help Us Improve HIV Testing in Montana

The Montana State Department of Public Health and this clinic are interested in improving the quality of the HIV counseling and testing services offered. Please take a few minutes to answer the following questions; your opinions will help improve this service. Your answers will be voluntary and anonymous.

Please mark (X) to indicate your choice:

	Strongly Agree	Agree	Disagree	Strongly Disagree	Doesn't Apply
The location and hours of the testing site were convenient for me.					
I felt a counselor saw me in a timely manner.					
The counselor explained the difference between confidential and anonymous testing.					
I felt like I was given a choice to test or not to test for HIV.					
I felt at all times my confidentiality would be protected.					
Before my test, the counselor had me identify my risk behaviors for HIV.					
The counseling I received before testing was specific to my situation.					
I felt comfortable telling the counselor about my behaviors that put me at risk for HIV infection.					
The counselor answered all of my questions about HIV/AIDS clearly.					
I felt comfortable asking the counselor sensitive, personal questions.					
The counselor was knowledgeable about HIV/AIDS and the testing process.					
As a result of my talk with the counselor I plan to engage in safer behaviors					
The counselor gave referrals for other services I requested.					
I would feel comfortable referring my friends and family here for testing.					
I would still come for testing even if it was no longer anonymous.					
I am likely to return for my test results					

Please turn over

What is your age? (check one)

- 18-19
 20-24
 25-29
 30-39
 40-49
 50 or older

What is your race? (check one)

- American Indian
 Asian
 Black/African American
 White
 Native Hawaiian or Other Pacific Islander
 Mixed/Multi Race
 Other – please describe: _____

What is your gender? (check one)

- female male transgender/other

If you are male, have you ever had sex with another male? (check one)

- yes no

Have you ever injected drugs to get high? (check one)

- yes no

Do you have any comments about this testing site or your counselor, or any suggestions on how we can improve our services?

Thank you for answering these questions. Please place the completed questionnaire in the self addressed stamped envelope and return it to the receptionist or drop in any mailbox.

\$20.00 OFFER

10 minute interview

We would like to hear more about the HIV testing experiences of men who have had sex with men and individuals who inject drugs. We are particularly interested in the way they were treated by the staff and by the counselor who did their test. If you are willing to participate in a 10 minute telephone interview please leave a message for Meredith at The University of Montana _____ with your first name only, a phone number, and time when you can be reached.

Your name and identity will be kept confidential. All information from telephone interviews will be reported as group information.

The Contractor is offering \$20.00 for these interviews. The money will be mailed in a plain envelope immediately after the interview.

Appendix C

Client Satisfaction Interview Questions

CLIENT INTERVIEW QUESTIONS

1. Tell me about your experience, how you were treated by the staff at the testing site when you arrived for your appointment?
2. Please describe how you were treated by the counselor while you were being counseled and tested?
 - a. What was the counselor's attitude toward you?
 - b. How comfortable were you talking about sensitive issues and behaviors that put you at risk for HIV?
 - c. Would you recommend that your friends get tested by this counselor?
 - d. If you were talking to a friend how would you describe this counselor?
3. Describe what kind of a plan was set up to help you decrease behaviors that might put you at risk for HIV?
 - a. Was the plan specific to your situation?
 - b. How did you participate in creating the plan?
 - c. How likely is it that you will carry out the plan?
4. Tell me what kinds of other services were offered to you by the counselor?
 - a. Were you given names and phone numbers to contact if you needed to use the other services?
 - b. Were the other services offered helpful?

Appendix D

Client Satisfaction Interview Script

CLIENT SATISFACTION INTERVIEW VERBAL SCRIPT

Hi my name is Meredith. I am a research assistant at The University of Montana and I am doing the HIV testing client satisfaction interviews for the State of Montana Public Health Department. Thank you for your interest in participating in this interview.

Before we start, I would like to give you some information about this project and make sure that you want to participate. The purpose of this project is to assess HIV Counseling, Testing and Referral Services offered at agencies funded by the state public health department. Your answers will help the state public health department decide what they need to do to improve HIV Testing Services throughout the state.

The risks of participating in this project are minimal. I am going to ask you a few questions about your experience of being tested. At the end I will ask you a few questions about yourself. If any of my questions make you feel uncomfortable, you can refuse to answer them. If you decide at any time that you would like to end the interview please just let me know. You will still receive the \$20.00 incentive just for making this call.

Your name will not in any way be associated with the information you give me. At the end of the interview I will ask you for an address where I can mail your \$20.00. The name and address you provide will only appear on the envelope which will be mailed immediately after the interview.

If you have any questions or concerns please contact Bruce at the State Health Department 406-440-9028 or Annie at The University of Montana 406-243-5215.

Do you have any questions for me now? Would you like to continue with the interview?