THE RESPECT EVALUATION FIELD GUIDE

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It is hoped that this guide will prove useful to those implementing RESPECT in the field. It is our goal to keep this guide and its information as current as possible. To achieve this, we welcome your comments. Please contact Dr. Gilliam, DHAP, CDC, via electronic mail at aisha.gilliam@cdc.hhs.gov with any comments or concerns.

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Monitoring and Evaluation: An Important Component of RESPECT

Introduction

This Monitoring and Evaluation (M&E) Field Guide is a resource for all HIV prevention staff to use in the development and implementation of M&E plans and activities specific to the RESPECT intervention. M&E is an essential component of any program or intervention and is required by most funders, including the Centers for Disease Control and Prevention (CDC).

M&E activities provide us with the information and data to address two critical questions:

- **Are we doing what we said we would do?**
- **Is what we are doing having its intended effect?**

The answers to these two very broad questions provide information that can be used for program management and improvement, accountability to funders and other stakeholders, and program marketing and advocacy.

You will conduct M&E activities as you implement a program evaluation for RESPECT. These activities will help you determine the following:

- Are we reaching our intended target population?
- Are we implementing all the key elements of RESPECT?
- How are our clients responding to this intervention?
- Are we making the most effective use of staff resources?
- Are we achieving our stated goals and objectives?
- Are we compliant with CDC reporting requirements?

Answering these questions will also help you determine if there is a need to make adjustments to improve your agency's implementation of RESPECT; report required information to funders; and advocate for your clients and community. Fundamentally, program evaluation will contribute significantly to the continued success and effectiveness of HIV prevention efforts by your agency and in your community.

We are assuming for the purposes of this Field Guide that after conducting formative evaluation your agency has chosen RESPECT as an effective intervention for the population you intend to serve.

> ***Formative evaluation is the process of collecting data that describes the needs of the population and the personal, interpersonal, societal and environmental factors that put them at risk for acquiring or transmitting HIV. It may also include testing programs plans, messages, materials, strategies or modifications for weaknesses and strengths before they are put into effect.***
>
> — CDC EVALUATION CAPACITY BUILDING MANUAL

What Does This Guide Contain?

This M&E Field Guide is organized into nine chapters.

In this first chapter, we describe the sections of the guide; outline how it can be used, discuss the steps you should take with others in your organization to get ready for M&E; and identify additional CDC resources that will be helpful to you as you embark upon M&E activities for RESPECT.

Chapter 2 describes the key components of M&E. It discusses approaches to consider based on how RESPECT is conducted in your agency and reviews the core elements and characteristics of RESPECT to provide a framework for your M&E plan.

In Chapter 3 we describe the first step in preparing your plan: development of a logic model to provide a clear visual description of how the RESPECT intervention is implemented in your agency. A sample logic model is presented that can be adapted to fit your agency and the community and client population you serve.

Chapter 4 focuses on the second step: developing the evaluation questions at the heart of your M&E plan and the SMART objectives to answer them. It also guides you through the process of organizing your questions and SMART objectives to identify qualitative and

quantitative measures and data sources you will use to address them, applying process monitoring to document how RESPECT is being implemented and outcome monitoring to help determine how your clients have responded to the intervention.

Chapter 5 leads you through the development of a plan for collecting data, including identifying and testing data collection tools and determining how they will be used and who will use them, from their origin to their disposal.

Chapter 6 provides advice, information, and examples for managing and analyzing your M&E data, from data compilation to data analysis.

Chapter 7 discusses how to make the best use of the data you have gathered. It covers how data can be used for program improvement and planning, advocacy efforts, and reporting to your funding sources.

Chapter 8 describes the CDC's National HIV Prevention Monitoring and Evaluation Plan (NHM&E Plan) and how the CDC data base known as PEMS can be used to capture components of the RESPECT M&E Plan.

Chapter 9 provides an overview of the tools that have been developed and included in this guide to assist you in implementing your RESPECT M&E plan. These tools are also introduced and explained throughout the guide where they are relevant to each stage of the M&E process.

Appendix – Appendix – In the Appendix you will find information about additional resources, a summary of the National HIV Prevention Monitoring and Evaluation Required Variables, and the tools described in Chapter 9.

How to Use This Guide

This guide can be useful for

- assessing your capacity to conduct M&E
- identifying staff to participate in M&E activities
- designing your RESPECT M&E plan
- selecting tools for data collection, analysis, and quality assurance activities
- developing and implementing staff training on M&E.

M&E plans should always be tailored to the particular needs and characteristics of your agency. There is no 'one way' to implement M&E. We have designed this guide for you to use according to your needs. Some chapters and tools may be more pertinent to your work than others. All of the ideas and tools presented can be adapted to fit your particular agency's need and capacity.

A few symbols and text flags are used throughout this guide.

RECOMMENDED ACTIVITY - Signifies a recommended activity for your agency.

TIME-SAVER - Signifies a "time-saver," usually identifying a tool included in the guide that can be tailored to your agency's needs.

TIP - Signifies a tip for how to approach an activity.

Who Should Use This Guide?

This guide is intended for all staff who will be involved with any aspect of your RESPECT M&E plan. This includes staff directly involved in conducting the RESPECT intervention, program supervisors, and agency administrators, among others.

Laying the Foundation for M&E

Key to successful implementation of M&E is an assessment of your agency's capacity to conduct program M&E. Monitoring and evaluation may involve staff from a variety of departments and disciplines with varying experience and attitudes towards evaluation. Staff may be concerned about the added burden related to data collection needs and may be fearful that the evaluation will be used to highlight weaknesses, not program accomplishments. Taking stock of your current ability to conduct M&E will help you determine a realistic plan and develop strategies you may need to build buy-in and capacity among staff.

Most importantly, develop an M&E plan that is consistent with your agency's capacity.

It is important to involve the right staff in M&E activities. Conducting an effective RESPECT M&E plan will require the participation of a variety of staff in your agency. Typically, staff who have the following roles and responsibilities contribute to M&E, although this will vary by agency, and in some instances one person may serve in multiple roles:

- **RESPECT providers** record information about their sessions with each client, using tools such as those suggested in this guide to document implementation of the RESPECT protocol. They may need to enter data on client interactions into a database.
- **Supervisors** implement quality assurance measures; supervise providers; conduct observations and record information; conduct chart reviews; and participate in data analysis.
- **Data entry staff and/or providers** collect and enter data from session records.
- **Program managers** oversee implementation of the evaluation plan; participate in data analysis; and use data for reporting, improvement, program planning, and advocacy.

Some agencies retain a **consultant** to assist them with program M&E. The consultant can serve as an evaluation leader and provide technical support on all aspects of the M&E plan. If you choose to work with a consultant, make sure their roles and responsibilities are clearly defined and included in their contract. The consultant should also be fully informed about the program's goals and objectives and any evaluation plans that may have already been developed.

Clients can also provide input into your M&E plan via a consumer advisory board or other mechanism. They can offer valuable insights into aspects of the program that might not be captured otherwise, such as identification of barriers to participation, ways to make your program more culturally sensitive, and comments about the intervention and providers.

TIP

Practical and useful steps to engage staff in M&E

- **Be sure to communicate the reasons for and the goals of the RESPECT M&E plan with all key staff likely to be involved with and/or impacted by the evaluation. (See below for a discussion of staffing.)**
- **Provide staff training on M&E.**
- **Involve staff in the development of your M&E plan.**
- **Address staff concerns and fears about evaluation from the outset.**
- **Identify additional resources you may need to implement the M&E plan.**

Additional Resources

Other resources are available to assist you as you plan and implement M&E activities for RESPECT. They include more detailed information on program evaluation and should be helpful as complementary materials providing substantial additional detail to supplement the information and tools presented in this guide. We will refer to these materials when relevant within this Guide.

- **Framework for Program Evaluation in Public Health. Centers for Disease Control and Prevention. MMWR 1999; 48 (no. RR-11). 1-42.** The CDC framework for program evaluation is a valuable overview of the key components of public health program evaluation. A diagram presenting a visual overview of the framework is presented in Chapter 2 of this Guide.
- **Evaluation Capacity Building Guide** - This guide provides an overview of monitoring and evaluation for evidence-based interventions, with particular focus on process monitoring and evaluation activities, tools, and templates (CDC, 2008a).
- **National Monitoring and Evaluation Guidance for HIV Prevention Programs (NMEG)**. This document describes how to use the NHM&E DS to improve program, inform programmatic decisions, and answer local M&E questions (CDC, 2008b).
- Information that is uniformly collected by all funded HIV prevention programs, known as the **National HIV Prevention and Monitoring Data Set (NHM&E DS)**. The complete list and description of all M&E variables required for reporting to CDC and optional for local M&E and specific to certain interventions (CDC, 2008d) The variables you will be expected to collect and report to CDC for RESPECT will be described in this chapter.
- **2-Session RESPECT HIV Prevention Counseling Manual** - The RESPECT manual provides an overview of the core components of the RESPECT intervention. It includes detailed information on the structure of RESPECT sessions and the protocols for RESPECT quality assurance. It is important to remember that while the QA protocol is an essential component of monitoring, it is only one component of your M&E plan. The QA protocol is used to help you ensure implementation of RESPECT as it was originally designed and documented to be effective.
- **Performance Indicators** - CDC has developed a series of performance indicators for M&E. Consult with your project officer for the most recent version of the required indicators for RESPECT and HIV Counseling, Testing, and Referral (CTR) to be sure that you are collecting the data you need to calculate the performance indicators for RESPECT.

- **NHM&E Plan Resources** - There are a variety of tools to assist you with collection and submission of the National HIV Prevention and Monitoring Data Set (NHM&E DS.) These include the Data Variable Dictionary and the PEMS User Manual. CDC also has developed a web site that contains valuable information, tools, and training materials on the NHM&E Plan: *http://team.cdc.gov*. Consult your CDC Project Officer for help accessing these resources.

DISCLAIMER: The reporting requirements for the National HIV Prevention Program Monitoring and Evaluation Data Set presented in this document are current as of September 2008. Please refer to the PEMS Web site (*https://team.cdc.gov*) for the most current reporting requirements.

These documents provide a foundation for monitoring and evaluating HIV prevention programs and reporting required data using PEMS software. Health departments and organizations directly funded by CDC can request monitoring and evaluation technical assistance through the Capacity Building Branch's Web-based system, Capacity Request Information System (CRIS). For more information about and access to CRIS, visit *http://www.cdc.gov/hiv/cba*. Additional information or technical assistance for the National HIV Prevention Program Monitoring and Evaluation Plan and the PEMS software may be accessed through the Program Evaluation Branch's National HIV Prevention Program Monitoring and Evaluation Service Center, which you can reach by calling 1-888-PEMS-311 (1-888-736-7311) or e-mailing *pemsservice@cdc.gov*; visiting the PEMS Web site (*http://team.cdc.gov*); or contacting the DHAP Help Desk (1-877-659-7725 or dhapsupport@cdc.gov).

Chapter 1 Summary

In this chapter we have

- introduced the concepts of monitoring and evaluation
- introduced what is contained in this guide
- given tips on how to use this guide
- provided additional resources for conducting monitoring and evaluation of RESPECT.

2

Your Monitoring and Evaluation Plan: Key Components of Your Monitoring and Evaluation Plan

This chapter describes the essential components of a monitoring and evaluation (M&E) plan for the RESPECT intervention. The M&E process is described here as steps, each of which is explained in detail in subsequent chapters.

A thorough understanding of RESPECT Core Elements and Key Characteristics, as well as your approache to the RESPECT intervention will help you use this guide effectively to develop and carry out your M&E plan.

Your M&E plan will identify **evaluation questions** – key questions about how RESPECT is being implemented. The answers to those questions will help you determine how well you are implementing RESPECT and what changes might need to be made.

An M&E plan also outlines a **process** for answering your evaluation questions. It should include schedules and/or descriptions of

- how you will monitor and evaluate RESPECT
- who is responsible for carrying out each of the steps in the process
- tools that will be used to collect data, and how those tools will be used
- how data will be analyzed
- how M&E data will be used to improve program implementation
- report generation and dissemination, as appropriate, to stakeholders.

RECOMMENDED ACTIVITY

Once your program is established, you will need to review your implementation plan on a regular (semiannual or annual) basis.

Tools

As noted in Chapter 1, this guide includes tools that were created to help you develop your plans for implementing M&E, organize your data collection activities, analyze your data, and make the best use of your data. These tools include a logic model, a data planning matrix, a sample data management plan, and a data analysis tool, among others. They can be found in the Appendix and will be discussed in detail as they are introduced in subsequent chapters.

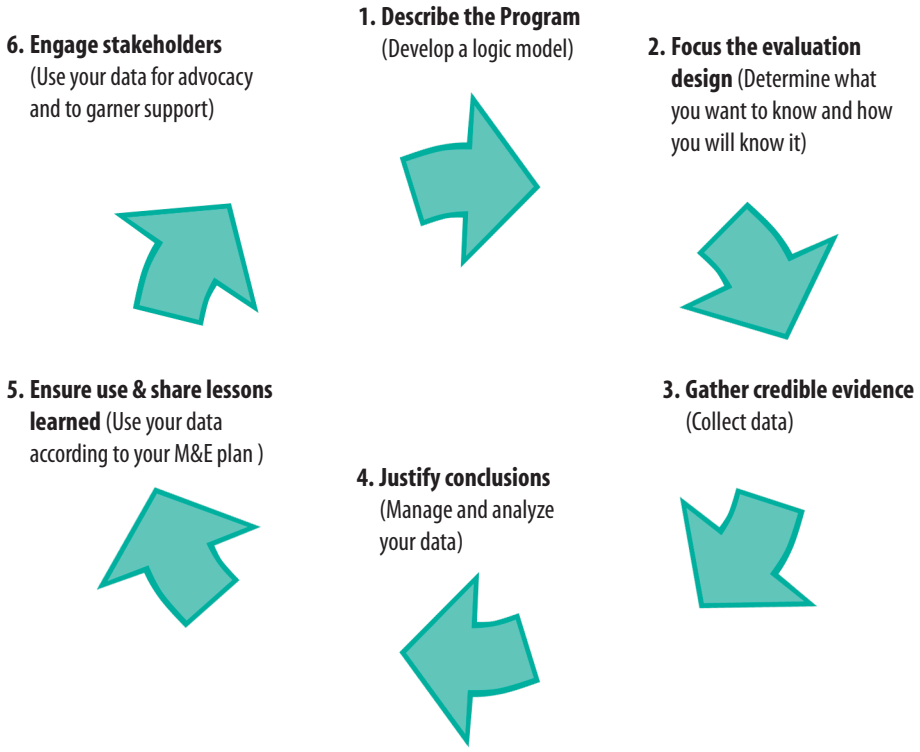
The Monitoring & Evaluation Process

This Guide will take you through the following steps for developing your M&E plan:

- **Step 1: Develop a logic model**
- **Step 2: Determine what you want to know and how you will know it**
- **Step 3: Collect data**
- **Step 4: Manage and analyze your data**
- **Step 5: Use your data according to your M&E plan**
- **Step 6: Use your data for advocacy and to garner support**

These steps can be described as they relate to the CDC Framework for Program Evaluation in Public Health, which is listed under *Additional Resources* in Chapter 1 and illustrated below in adapted form.

Each step in the adapted CDC framework illustrated above appears in bold type and is followed by a corresponding step in the M&E process in parentheses. Each of these steps in the M&E process is described in this guide. A helpful resource for further information on each of the steps discussed in this guide is the *CDC Evaluation Capacity Building Manual*.



Approaches to RESPECT

Before beginning discussion of the steps it is important to think about how RESPECT fits into your agency. Although most Evidence Based Interventions (EBIs) are self-contained and are not designed to be integrated with other interventions, RESPECT can be integrated with other programs, and can also be provided as a stand-alone intervention.

There are three basic approaches to using RESPECT within an agency:

1. **Fully integrated programs:** Using RESPECT as the model for delivering counseling, testing, and referral (CTR) in conventional or rapid testing settings, or Comprehensive Risk Counseling and Services (CRCS) at all sites and with all clients.
2. **Partially integrated programs:** Using RESPECT with some CTR or CRCS clients. RESPECT might be used in only one of several clinic locations, for a few of the CRCS visits, or with a specific group of CTR clients (for example, with high-risk clients), while other clients receive standard counseling and testing.
3. **Stand-alone programs:** RESPECT is delivered on its own, without integration into an existing CTR or CRCS program. Any HIV testing included in RESPECT is done by referral only.

It is important to note that each of these models requires a slightly different approach to M&E.

Agencies with fully integrated programs may want to consider integrating the RESPECT evaluation questions into their overall program evaluation (of either CTR or CRCS) to avoid expending unnecessary resources and completing two sets of evaluations. For example, elements unique to the RESPECT counseling protocol can be included in an overall evaluation of your CTR/CRCS intervention.

Agencies with partially integrated programs may find that they are already doing some of the activities needed to monitor and evaluate RESPECT. They may need to add some additional M&E activities specific to the RESPECT model and objectives. They may also want to add some M&E activities that allow them to compare how well each of the models meets the needs of specific groups of clients and settings. If the plan is to diffuse RESPECT to all sites or client groups over time, they might need some evaluation questions about how best to disseminate the model within their agency.

Agencies with stand-alone programs that are providing HIV testing by referral will need to think about how they will track and follow up on the referrals made.

Even though RESPECT is essentially a client-centered counseling model and builds upon best practices for CTR, it has some unique characteristics that need to be monitored and evaluated specifically. Requirements of RESPECT that go beyond the client-centered counseling model are

- identification of a **specific, achievable risk reduction step**
- referral specifically to **facilitate risk reduction step**
- identification of social **support for risk reduction step**
- provider **observations and case** conferences as described in the RESPECT manual.

Evaluation questions must be designed to capture information on these distinct characteristics. See Core Elements and Key Characteristics of RESPECT in the box below.

RESPECT Core Elements

- **Conduct one-on-one counseling, using RESPECT protocol prompts.**
- **Utilize a "teachable moment" to motivate clients to change risk-taking behaviors.**
- **Explore circumstances and context of a recent risk behavior to increase perception of susceptibility.**
- **Negotiate an achievable step that supports the larger risk-reduction goal.**
- **Implement and maintain quality assurance procedures.**

RESPECT Key Characteristics

- **Conduct sessions using open-ended questions, prompting the client to engage actively in the discussion.**
- **Allow the client to identify an achievable risk-reduction step.**
- **Engage in role-plays with the client to increase the client's self-efficacy to engage in risk-reduction behaviors.**
- **Provide referrals based on the client's self-identified needs.**
- **Modify the time needed to complete all of the protocol components, taking cues from client needs and agency requirements.**
- **Provide on-site conventional HIV testing, which will allow the client to attempt to implement the risk-reduction step between sessions. When implemented in non-HIV testing settings, it is recommended that a second session be scheduled for purposes of following up on the attempt to implement a plan.**

Any adaptations to the RESPECT model will need to be captured in the M&E plan. For example, if the Session 1 and Session 2 protocols are to be covered in one single session (such as a rapid testing session), it will not be possible to identify whether the client has undertaken the agreed-upon risk reduction step, and M&E materials will need to reflect this fact. Or, for example, if RESPECT is offered in a setting where clients come back multiple times and the session protocol can be covered numerous times with the same client, the evaluation questions will need to reflect this. **It is important that any adaptations you make to the model are documented.**

Remember that you cannot adapt or change any of the core elements of RESPECT. Otherwise, there is the potential that RESPECT may not be implemented as intended and therefore may not prove to be as effective. **Consult with your PO if you want to make changes in Key Characteristics**. If key characteristics are changed with your Project Officer's approval, you'll want to make sure those changes are reflected in the logic model you develop and in all your M&E materials.

TIME-SAVER

The Monitoring and Evaluation Task List (Tool 1) lists the tasks associated with development of an M&E plan. You can use this tool to create a work plan that identifies the responsible person(s) and timeline for each task, and to track your progress as you develop and implement your M&E plan.

Chapter 2 Summary

In this chapter we have introduced

- the Components of a Monitoring and Evaluation Plan
- the CDC Framework for Evaluation
- steps of a Monitoring and Evaluation Plan, which correspond to the CDC Framework for Evaluation
- the Core Elements and Key Characteristics of RESPECT.

3

Describe the Program: RESPECT Logic Model

The first step in preparing your RESPECT monitoring and evaluation (M&E) plan is development of a logic model. A logic model provides a visual description of an intervention or program and drives the development of the M&E plan. It helps describe the problem the intervention is addressing, guides the development of your evaluation questions, and helps you identify the key activities you need to track.

> ***A Logic Model is: "a tool used to visually describe the main elements of an intervention and illustrate the linkages between the components.***
>
> —CDC EVALUATION CAPACITY BUILDING MANUAL

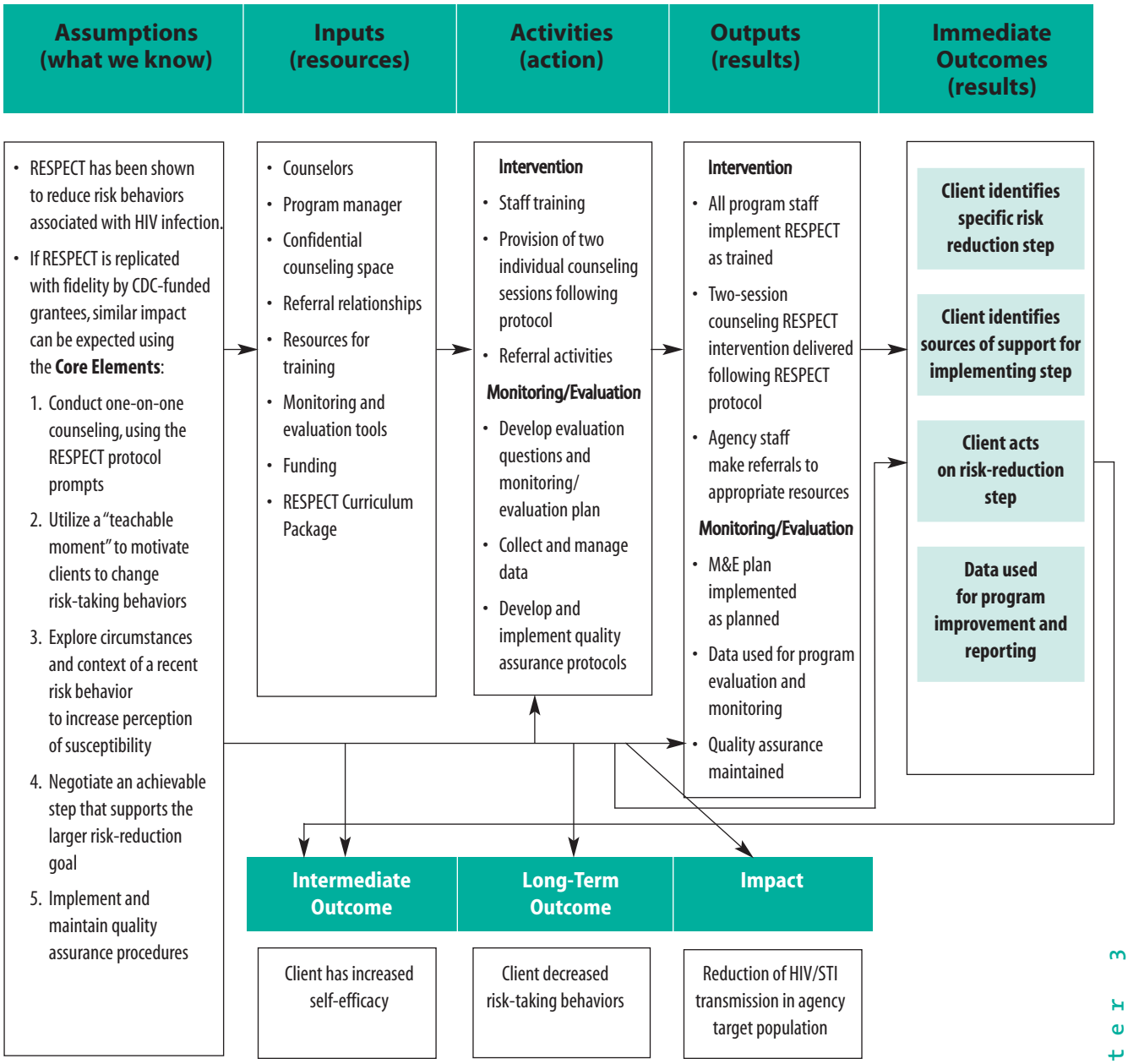
A logic model for RESPECT will provide a common language and understanding of the RESPECT intervention for staff in your agency. It identifies the critical assumptions, inputs, and outputs of the RESPECT intervention. It is based on the RESPECT training curriculum and the research that has been conducted to date on the intervention. The logic model depicts the "logical" pathway through which the RESPECT intervention leads to accomplishing the intended long-term outcome of a reduction in HIV transmission. Your logic model will describe how you are implementing RESPECT for your client population and agency. It will reflect the program implementation model that your agency has chosen.

✓ RECOMMENDED ACTIVITY

Review the sample Logic Model below and included in the Appendix (Tool 2). This model illustrates how RESPECT might be conceptualized in the field, and the M&E components that are part of implementation.

TOOL 2: SAMPLE RESPECT LOGIC MODEL

This logic model illustrates implementation of the RESPECT model with clients and components of an M&E plan. Be sure to tailor this to reflect your approach to implementing RESPECT



Tailor the logic model as needed to fit:

- your agency
- the community you serve
- the specific characteristics of the client population that will receive RESPECT
- your agency's implementation model for RESPECT

Be sure to consider the following:

1. **What specific group or sub-group of clients participates in RESPECT? For example, your agency may serve men who have sex with men (MSM) but you may choose to target young men who have sex with men (YMSM) so that only they receive the RESPECT intervention.**
2. **How does your agency provide HIV testing for RESPECT clients? What variations to the RESPECT model are used? Some examples of variations include:**
   - **Completion of the HIV test during Session 1 of RESPECT.**
   - **Referral outside the agency for HIV testing.**
   - **Implementation of RESPECT without a testing component. For example, if you are integrating the RESPECT counseling protocol into a risk reduction program for those who are HIV+ you do not need to include a testing component as part of the intervention.**
3. **Is RESPECT combined with counseling, testing, and referral (CTR) or Comprehensive Risk Counseling and Services (CRCS)? If so, you need to consider how they are integrated.**
4. **Which staff provide RESPECT? For example, if you are implementing RESPECT as a counseling protocol within CTR or CRCS, do all providers and sites use RESPECT? Or do only some providers and sites implement RESPECT?**

TIME-SAVER

The sample Logic Model for RESPECT included above is also included in the Appendix (Tool 2). It should be tailored for your agency considering the items listed above, as well as the resources available to you to implement RESPECT.

Chapter 3 Summary

In this chapter we have introduced

- how to develop and tailor a logic model
- a sample logic model for RESPECT.

4

Focus the Evaluation Design: The Evaluation Plan

STEP 2: DETERMINE WHAT YOU WANT TO KNOW AND HOW YOU WILL KNOW IT.

This step includes the following activities:

- **Identify the evaluation questions you want to answer.**
- **Develop SMART (Specific, Measurable, Achievable, Realistic, Time-phased) objectives based on your evaluation questions.**
- **Begin to develop a data planning matrix.**
- **Identify measures and data collection methods or sources for evaluation questions and SMART objectives.**

Identify the evaluation questions you want to answer

Your RESPECT logic model provides the conceptual framework for identifying evaluation questions. These questions should focus on who you serve and how the program is being implemented (**process**), and on what changes (**outcomes**) occur for clients who participate in RESPECT.

Process monitoring and evaluation
The evaluation questions related to process come from the "Activities" column of the logic model.

> ***Process monitoring** is the routine documentation and review of program activities, populations served, services provided, or resources used in order to inform program improvement and process evaluation.*
>
> —CDC Evaluation Capacity Building Manual

> ***Process evaluation** assesses planned versus actual program performance over a period of time for the purpose of program improvement and future planning.*
>
> —CDC Evaluation Capacity Building Manual

Questions addressing **process monitoring and evaluation** (M&E) may include:

- Have we developed our implementation plan?
- Are staff members appropriately trained?
- Was RESPECT implemented as planned?
- Are we reaching the number of clients we expected to?
- Are we reaching our intended target population?
- Do clients who start RESPECT complete the intervention?
- Are clients participating in the intervention as intended?
- Are testing and referral activities occurring as we would expect under our model (integrated or by referral)?
- Have we identified problems we're having with implementation of RESPECT?
- Are we addressing the problems we have identified?
- Are we completing the required quality assurance activities?
- Are providers following the protocol for delivery of RESPECT?
- Are clients satisfied with RESPECT services?

Outcome monitoring

The evaluation questions related to outcomes come from the "Outputs" and "Outcomes" columns of the logic model.

> ***Outcome monitoring** involves the routine documentation and review of program-associated outcomes (e.g., individual-level knowledge, attitudes and behaviors or access to services; service delivery; community or structural factors) in order to determine the extent to which program goals and objectives are being met.*
>
> —CDC Evaluation Capacity Building Manual

Questions addressing **outcome monitoring** may include:

- Are clients more aware of their own risk-taking behaviors?
- Do clients returning for a second session report that they completed the risk-reduction step(s) that they identified in the first session?
- Are clients who are referred to a service, accessing it?

You'll also want to include the questions related to CDC's required Performance Indicators, your agency's internal objectives, and those required by or of interest to any other funding sources.

There may be additional questions your agency wants to answer about RESPECT, and those should be included as well. For example, if you are implementing RESPECT with only one segment of your client population, you may want to ask whether clients receiving RESPECT are more likely to identify risk reduction steps than clients who do not receive RESPECT.

Process M&E activities will help you ensure that you are delivering the intervention as intended. Through outcome monitoring you will assess whether RESPECT is helping clients identify and implement a risk reduction step, identify sources of support or act on the risk-reduction step.

RECOMMENDED ACTIVITY

Write out your evaluation questions. This will help you begin to think about the data elements that will be needed to answer the questions, and your plan for gathering data.

TIME-SAVER

The RESPECT Data Analysis Tool (Tool 3 in the Appendix) outlines data required for CDC Performance Indicators, data that are required to monitor RESPECT, and additional (optional) data elements that are important for counseling, testing, and referral (CTR) programs to gather. Remember that you can always augment the tools to suit your agency's needs. You can add additional elements to the RESPECT Data Analysis Tool as needed.

Develop SMART objectives based on your evaluation questions

SMART objectives help you determine the answers to your evaluation questions. Each evaluation question should have one or more related SMART objectives. SMART stands for Specific, Measurable, Appropriate, Realistic, and Time-Phased. Objectives that don't have all of these characteristics can be difficult to monitor.

Your M&E plan will focus on collecting data related to process objectives and immediate outcome objectives. While the initial RESPECT research included intermediate outcome objectives related to decreased STD infection and increased condom use, tracking of intermediate or long-term outcomes is not part of the RESPECT intervention, and would require considerable additional resources.

TIME-SAVER

- **To assist you in writing your own SMART objectives there is a SMART Table in the Appendix (Tool 4) which breaks down the components of the objectives and suggests words and phrases to use.**
- **Tool 5 in the Appendix provides sample SMART objectives for RESPECT. Remember to tailor your SMART objectives to meet your agency's implementation of RESPECT.**

Begin to develop a data planning matrix

A data planning matrix, described in the CDC Evaluation Capacity Building Manual, can help you organize your evaluation questions, SMART objectives, and the information needed to complete your evaluation plan.

TIME-SAVER

Tool 6 in the Appendix is a Sample Data Planning Matrix illustrating an evaluation approach. The Data Planning Matrix is organized in two sections; one for process monitoring and one for outcome monitoring. Tool 7 is a blank Data Planning Matrix that you can use for your own plan.

Using content from the Sample Data Planning Matrix (Tool 6) as examples, the rest of this chapter will take you through the process of developing your own matrix.

At this point you will want to enter your evaluation questions and their related SMART objectives into your Data Planning Matrix. As you continue to develop your plan, you'll complete the rest of the columns in the matrix, entering information about how you will measure progress toward your objectives.

Following is an example of how the process evaluation question "Do clients who start RESPECT complete the intervention?" would be presented in the data planning matrix. A SMART process objective (Objective #8 from the Sample Data Planning Matrix) can be entered in the matrix.

Evaluation Question: Do clients who start RESPECT complete the intervention?

Process Objective	Measure(s)	Data Collection Method / Source	Who will Collect/ Enter the Data?	Timeframe For Analysis
8. X percent of RESPECT clients completing the first session will receive the second session. (CDC HE/RR Performance Indicator)				

Be sure to modify the examples from the Sample Data Planning Matrix to reflect the specific questions you have identified and the specific way your agency is implementing RESPECT. For example, if you are implementing RESPECT within an existing program (CTR or Comprehensive Risk Counseling and Services), you'll want to consider the way the integration is happening. If you are not including HIV testing in the model, you'll need to change or eliminate the questions related to HIV testing to reflect your approach.

Identify measures and data collection methods or sources for evaluation questions and SMART objectives

Each SMART objective should have a corresponding "measure of success." These measures of success can be either qualitative or quantitative in nature.

Quantitative measures

Quantitative measures generally describe ***how often*** something is happening. They are numeric and can be calculated. Quantitative data include counts, proportions, and averages, to name a few.

The following example of a quantitative measure is a proportion. It was developed to address SMART objective #8 in the example: "X percent of RESPECT clients completing the first session will receive the second session." This process example from the Sample Data Planning Matrix focuses on the first three columns of the Data Planning Matrix: Objectives, Measures, and Data Collection Methods/Source.

Evaluation Question: Do clients who start RESPECT complete the intervention?

Process Objective	Measure(s)	Data Collection Method (s)/Source
X percent of RESPECT clients completing the first session will receive the second session. (CDC HE/RR Performance Indicator)	Total number of clients who complete 2nd session/total number of clients completing 1st session	Tally records for sessions 1 and 2/ Session record forms

The "measure of success" in this example is the ***proportion*** of clients who complete RESPECT (receive both Session 1 and Session 2).

Qualitative measures

Qualitative measures describe ***what is happening*** or ***why something is happening*** and are usually a documentation of observations, perceptions, and opinions. Examples of qualitative data are notes taken during counselor observations, narratives from focus groups, or answers to open-ended questions.

The following example of a qualitative measure is an observation. It addresses the process evaluation question "Are we reaching our intended target population?" and measures achievement of the process objective listed as #6 in the Sample Data Planning Matrix. As with the quantitative measure example above, this example focuses on the first three columns of the Data Planning Matrix: Objectives, Measures, and Data Collection Methods/Sources.

Evaluation Question: Are we reaching our intended target population?

Process Objective	Measure(s)	Data Collection Method (s)/Source
6. By month three of the intervention, obtain feedback from staff to assess facilitators and barriers to reaching and serving the target population.	Frequency of facilitators/barriers identified by staff	Documentation of staff feedback/ Notes from meetings, key informant interviews, focus groups, etc.

In this example, staff discussion about barriers provides qualitative information about ways to better support the staff and/or target population during the intervention.

Both quantitative and qualitative data are important to understand whether you are reaching your service goals.

In addition to the data used to measure your SMART objectives, you will need to include additional data required by funding agencies, and the NHM&E Data set. Be sure to incorporate these variables into the data collection plan.

RECOMMENDED ACTIVITY

Identify how each evaluation question and SMART objective will be measured.

TIME-SAVER

- **The Sample Data Planning Matrix (Tool 6) has measures for each evaluation question and its corresponding SMART objective. Use these as appropriate for your agency's implementation of RESPECT.**
- **The Sample Data Analysis Tool (Tool 3) has a list of suggested quantitative variables ("Data Element" column) that will help answer SMART objectives as well as RESPECT-specific objectives. The tool also contains other data variables that you may find helpful for your own purposes.**

Chapter 4 Summary

In this Chapter we have discussed

- developing Evaluation Questions
- process and Outcome Monitoring
- writing SMART Objectives
- developing a Data Planning Matrix
- qualitative and Quantitative Data.

5 Gather Credible Evidence: Collecting Your Data

STEP 3: COLLECT DATA

Now that you have organized your evaluation questions and objectives and identified the measures and data collection sources needed to address them, the next step is to develop a plan for collecting the data. You need to identify which tools to use for data collection and who in your agency will collect the data.

Planning for data collection includes the following activities:

- **Identify the forms that will be used to collect the data.**
- **Develop or revise data collection tools as needed.**
- **Develop a process for using data collection tools.**
- **Pilot test data collection tools if tools have been adopted or revised.**
- **Train staff on how to use data collection tools.**

Identify the forms that will be used to collect the data

- Consider what data needs to be captured on the forms.
- If you are implementing RESPECT as part of counseling, testing, and referral (CTR) or Comprehensive Risk Counseling and Services (CRCS), are there already existing forms that could be used or revised, such as the CDC HIV test form. (See Appendix 4)
- Can all the data be collected on one form, or will multiple forms be necessary?
- How will the data collected on the forms be analyzed? If the agency wants to see a breakdown of the data by client age, the forms should include client age or date of birth. Or perhaps, capturing where the service took place is important to your agency's monitoring and evaluation (M&E) plan. Then it is important to include a clinic identification number on the data collection forms.

If a database will be used to collect or compile data, whether it is PEMS or another type of database, there are two steps to data collection: data capture and data entry. Data capture is the act of taking the information about the client or the session and filling out a paper form, while data entry is the process of entering the data from a paper form into the database.

TIP

Consider your staffing capacity and staff work patterns.

- **What are the current staffing roles? Do staff members have the appropriate training and time to carry out their M&E roles? For example, with the current caseload that providers have, can they also be expected to fill out a session record form AND enter it into a database? If not, is there another staff person who can be trained to enter the data into a database? Or are there ways the agency can reduce caseloads to accommodate the new emphasis on M&E?**
- **Based on staff workloads, what is the amount of data your agency can reasonably collect? If your data collection goals are too broad for your staff capacity, revise your evaluation questions and SMART objectives.**

TIME-SAVER

- **The Sample Data Planning Matrix (Tool 6) can help organize your data collection plan. It includes columns for entering a "Measure" for each SMART objective, and for entering the methods and forms to use for data collection ("Data Collection Method(s)/Sources,") as well as the responsible person and timeframe.**
- **The RESPECT Data Analysis Tool (Tool 3) calculates program performance variables for monitoring and evaluating RESPECT.**
- **Sample data collection forms in the Appendix include:**
  - **A Sample RESPECT Session Record (Tool 8) and a blank RESPECT Session Record Form (Tool 9) for your own use**
  - **The Quality Assurance Fidelity checklist (Tool 10)**
  - **The Quality Assurance Tool Supplemental Form (Tool 11)**
  - **The Counselor Training and Development Worksheet (Tool 12)**
  - **A Sample Client Satisfaction Survey Tool (Tool 13)**

Develop or revise data collection forms as needed

When drafting or tailoring data collection tools, be sure that they include required data variables. Data collection tools should include: the National HIV Prevention and Monitoring Data Set, variables you need to calculate the required CDC Performance Indicators, data required to monitor RESPECT, and/or any other data required by other funding sources. If you are combining RESPECT with CTR or CRCS, you may be able to add a few RESPECT variables to an already existing form.

Remember that this guide includes data collection tools that you can tailor to your agency's data collection needs.

Before a form is created, it is important to think about its purpose and how it fits into the flow of serving clients. Before implementing a form, you should:

- Identify the purpose of the form.
- Determine at what point in the intervention the form will be used (for example, at intake, at the end of the session, etc.).
- Decide who will fill out the form and who will enter the data from the form into your database.
- Make sure that the database that is used corresponds to the forms; the database should contain data fields to match the fields on the form.
- Determine the process that you will use to collect, manage, and analyze your data.

Develop a process for using data collection tools

The process for using each data collection tool should include all the steps from obtaining the form to destroying it. It should include how the form will be used in the agency, who will use the form, and how it will get from one person to another. The process should include information about

- where the user will obtain the form
- who will fill out the form and how often
- how and where the completed form is or will be stored. (This is especially important if the form contains confidential client information.)
- who should have access to the form
- how the form will be transported from place to place, if needed. (Does it need to be sent to the state health department or to a central office for data entry?)
- who will enter data from the form into a database and how often

- how long the form will be stored after data entry
- what security procedures are in place to protect the data
- when and how the form will be destroyed

TIME-SAVER

The Sample Data Management Plan (Tool 14) describes how, by whom, and how often data are collected, managed, and analyzed. It is based on a fictitious agency and should be changed to reflect your agency's data management plan.

Pilot test data collection tools

Before implementing the data collection tools, it is important to test them. This can be done in a number of ways. You could have a few providers familiar with RESPECT review the forms. Or you could pilot the forms during three to five client sessions, being sure to track how well the form works from its origin through its disposal. Another technique is to hold focus groups in which the clients or providers who will use the forms provide feedback on them. You may want to use a combination of these methods. It is important to pilot test all tools developed. This step helps to ensure that they suitable for your particular agency and client base. Some of the things to check for are:

- Are the form instructions clear?
- Are the questions on the form clear?
- Is there enough space to document the information?
- Is the form too long for the amount of time given to fill it out?
- Is any information missing from the form?

Train staff on how to use the data collection tools

All staff using a data collection tool, whether for data capture or data entry, should be trained on use of the form. They should receive training on all the definitions for each field on the form. Even for fields that seem obvious, it is important that everyone understand the definition to avoid mistakes in data capture. For example, if the form asks for "client's identified risks," in keeping with the key characteristics of RESPECT, training should specify that documentation should be limited to risks the client identifies, and not include the risks that the counselor perceives the client to have.

All staff should be trained on your agency's policies for maintaining client

confidentiality and each staff person's role in implementing the agency's security procedures should be identified.

Summary of Chapter 5

In this Chapter we have discussed

- developing data collection forms
- testing data collection forms
- developing a process for using data collection forms
- training staff to use data collection forms.

6 Justify Conclusions: Analyzing Your Data

STEP 4: MANAGE AND ANALYZE YOUR DATA

After you have developed data collection tools, the next thing to think about is how to manage the data that have been collected. The major components of data management are:

- **data compilation**
- **data analysis**

Data compilation

Data compilation refers to the process of gathering and counting up data from individual data collection forms in order to combine them into a total aggregate count.

✓ RECOMMENDED ACTIVITY

Choose a database to store and compile data.

Many agencies will have access to the CDC Program Evaluation Monitoring System (PEMS) for data entry and reporting. Data collected in your PEMS database can be compiled by running pre-programmed reports or extracting the data into an Excel spreadsheet. If your agency is using a database other than PEMS, it is important to make sure that the database meets your data management needs. It should

- capture necessary data elements
- have specifications/requirements and field limitations for each data element that minimize data entry mistakes
- have a mechanism for compiling or extracting data for data analysis.

TIP

Data Entry Rules

It is important to think through the instructions staff will need to be consistent and accurate in their data entry over time. Some things to consider are:

- **How will missing data on forms be handled?**
- **Are there details in the chart that will be denoted differently across counselors but should be entered consistently? For example: Risk Reduction Step might be written, "RR," "Risk Red.," Risk Red. Step," etc., but should be entered one way by all staff for consistency.**

TIP

Not Using a Database?

It is generally accepted that using a database or spreadsheet is more efficient than hand-tallying data. However, it may be more feasible for an agency to hand-tally data if staff are unfamiliar with data systems and/or the agency does not have access to a database or spreadsheet program. If data will be hand- tallied, it is a good idea to write a description of how the data are tallied to ensure uniformity of the process over time and across staff.

As you develop your M&E plan, you should consider if it is really more time-efficient to hand-tally data or if training staff up front to use PEMS (or another database) would be worth the investment. Generally, compiling data from a database is not only more time-efficient, it is usually more accurate.

Data cleaning

A key component of data compilation is cleaning. Data cleaning means ensuring no data was omitted, that data was entered correctly into the database, and that data values are within expected ranges. One focus of data cleaning is to identify data missing from forms and the database. Efforts should be made to identify and fill in missing information. Data cleaning can start by checking that forms are filled out completely before entering them into a database. A second way to clean data is to have a second person check the database entry of another and correct any mistakes that were found. This is usually done for a small percentage of the overall data. Another way to clean data is to compare variables that have clear relationships. For example, if the data show that a man is pregnant, the data should be double-checked and corrected.

Data compilation is usually done on a monthly basis to ensure that all data are clean and available for data analysis.

RECOMMENDED ACTIVITY

Identify staff resources to compile data.

- **Do staff have the necessary training to carry out their role?**
- **Have staff been trained on the agency's policies and procedures for maintaining client confidentiality?**
- **If there is not enough staff capacity to compile the data, do you need an outside evaluator or quality assurance monitor?**

TIME-SAVER

- **The Monitoring and Evaluation Task List (Tool 1) can be used to make sure that all the steps leading up to data analysis are completed.**

Data analysis

Data analysis is the process of calculating quantitative data and summarizing and organizing qualitative data. The aim of data analysis is to answer evaluation questions, identify trends in service delivery (e.g., very few clients show up for appointments scheduled for 8 a.m. or earlier), and identify gaps in data (e.g., are there questions the data do not answer?).

Data analysis does not have to involve complicated statistics. It can mean calculating the measurements you identified for the evaluation questions and SMART objectives.

In the **qualitative** measurement example presented in Chapter 4, we wanted to answer the process evaluation question *"Are we reaching our intended target population?"* Following the related process objective (#6 in the Sample Data Planning Matrix), by the third month of the intervention we would "…obtain feedback from staff to assess facilitators and barriers to reaching and serving the target population." If a discussion was held at a case-conference meeting and a list of ideas were compiled, the data might be analyzed by counting the ideas that were repeated the most often, or simply identifying which ideas were the most feasible.

In the **quantitative** measurement example discussed in Chapter 4, *"Do clients who start RESPECT complete the intervention?"* we identified the need to calculate the proportion of clients who completed both RESPECT sessions. The measures we identified in the Sample Data Planning Matrix (Tool 6) for Process Objective #8 were:

- Total number of clients who completed the second session of RESPECT
- Total number of clients who were enrolled in RESPECT

To analyze this data we would divide the total number of clients who completed the second session of RESPECT by the total number of clients who were enrolled in RESPECT during the identified time frame. (Note: The RESPECT Data Analysis Tool (Tool 3) can be used to automate this calculation)

Analyzing data may also mean organizing data in multiple ways to compare different populations. For example, data can be organized to show services delivered by age of clients, by client gender, or by location of service. If such geographic or demographic information is important to your agency, it must be captured on the data collection tools

An example of this is looking at the data according to age group. Your agency may want to know whether its young (13-to-24-year-old) male clients are completing the RESPECT intervention as often as other clients. The data in our quantitative example could be organized by age and gender.

First, we would identify all male clients ages 13 to 24 years enrolled in RESPECT. Our numerator would be the total number of male clients between the ages of 13 and 24 who completed the second RESPECT session; and our denominator would be the total number of male clients between the ages of 13 and 24 who completed the first RESPECT session. We can compare the resulting proportion to the proportion for our overall client population to see if the young male population is completing the RESPECT sessions as often as our overall RESPECT population.

RECOMMENDED ACTIVITY

Identify staff resources to analyze data.

- **Does the agency have the expertise on staff to carry out data analysis?**
- **If not, what training will staff need?**
- **Do you need an outside evaluator, and if so, in what capacity?**

RECOMMENDED ACTIVITY

Develop a plan for how often data will be analyzed.

- **What are your reporting requirements? Does your plan for analyzing data correspond to reporting deadlines?**
- **How often do you want to analyze data to consider program improvements? If it is your first year implementing the program, you will want to analyze data for feedback on service delivery more often than during your fifth year implementing the project.**

Minimally, data should be analyzed and interpreted often enough to make program improvements and meet reporting requirements. A good rule of thumb is to compile and analyze data once a month.

TIME-SAVER

- **The RESPECT Data Analysis Tool (Tool 3) is an Excel spreadsheet that can be used to capture program performance variables. "Raw" data can be entered into the tool, and the measures will be calculated automatically.**
- **The Quality Assurance Fidelity Checklist (Tool 10) is an Excel spreadsheet designed to calculate the average score for each of the providers for each observed session and the overall average of all the providers.**

- **The Data Management Plan (Tool 14) outlines the methods and the responsible party for collecting, entering, storing, and analyzing data and conducting quality assurance. In addition to the data management plan you will need to establish policies and procedures for storing, transporting, and/or disposing of data; to ensure confidentiality; and to ensure ongoing data quality.**
- **The Counselor Training and Development Worksheet (Tool 12) is an Excel spreadsheet designed to calculate the proportion of observations that were made according to the RESPECT QA Observation schedule described in the *2-Session RESPECT HIV Prevention Counseling Manual.***

Once the data analysis is complete, data are ready to be utilized for reporting, program improvement, and feedback to staff and clients.

Remember, it is important to share successes!

Summary Chapter 6

In this chapter we discussed

- storing and compiling data
- data cleaning
- data analysis.

7

Using Your Data: Inform Program Planning and Implementation, Share Lessons Learned, Engage Stakeholders

STEP 5: USE YOUR DATA ACCORDING TO YOUR MONITORING AND EVALUATION PLAN

Now that you have put in place the systems to capture and analyze your data, it is time to use it!

This chapter covers how to use the data you have gathered for

- **program monitoring**
- **program improvement**
- **program planning**
- **reporting to funders and others**
- **program advocacy and support.**

Your M&E plan will help ensure that you are maximizing your resources and obtaining the results you want. While one person, likely the program manager, may have overall responsibility for the M&E plan, stakeholders should also be involved, from planning to determining the use of data for program improvement. The data analysis you conduct will help you identify trends, limitations, and gaps in your program implementation. Your agency's plan for collecting, managing, and analyzing data should describe how often you will use the results of your analysis to make changes and who will be involved in the program planning and improvement activities that result from the data analysis.

TIME-SAVER

The Monitoring and Evaluation Task List (Tool 1) can be helpful to remind you of the steps involved in planning and carrying out your M&E plan.

Use data for program monitoring

Your **process objectives** form the basis for identifying whether or not you are implementing your program as planned.

Your agency's own Data Planning Matrix (Tool 7) will provide you with the numerators and denominators you want to track related to each evaluation question you are measuring. The RESPECT Data Analysis Tool (Tool 3) will provide data elements and formulas to assist you in calculating the program performance measures.

✓ RECOMMENDED ACTIVITY

During the first several months of implementing the RESPECT intervention and M&E plan, you should review data frequently (perhaps weekly or bi-weekly) to identify any challenges that need to be addressed. Once your program is established you can review your data less frequently (monthly or quarterly, depending on the data element).

Through analysis of your data you can determine if an objective was met and what helped or held back progress toward the objective.

If an objective was met, you need to understand what is contributing to the success so you can keep doing it. You may need additional information to understand what is working well.

If an objective was not met, you should ask what information will help you understand what to change. You may already have an idea of what information you need and have ready access to that information. Or you might have to ask staff, clients, or other stakeholders to help you identify what is keeping you from succeeding.

If you find that you don't have the information to determine whether or not you reached the objective, you'll need to figure out why the information is missing and address the reason it is missing.

Here is an **example** of what this might look like for RESPECT, following our quantitative evaluation question "Do clients who start RESPECT complete the intervention?" This example is adapted from the CDC Evaluation Capacity Building Manual referenced in Chapter 1.

Evaluation Question: **Do clients who start RESPECT complete the intervention?**

Evaluation Objective: **90% of RESPECT clients completing the first sesion will receive the second session**

Evaluation Findings	Implications (additional data that may be needed)	Potential ways to gain insight
Scenario One: **objective met:** 92% of RESPECT clients completing the first session completed the second session.	Is there something specific we're doing that helps us achieve a second session? What contributes to completion of the second session? What are we doing that reinforces attendance at the second session?	Review of processes for scheduling the second session; client or counselor surveys; case conference conversation with providers about how the second session is introduced/reinforced. Analysis of session records for clients completing the second session compared to those not completing the second session. Brief surveys of clients who completed a second session.
Scenario Two: **objective not met:** 70% of RESPECT clients completing the first session completed the second session.	Are providers appropriately introducing/scheduling the second session? Is there any difference between the clients who complete a second session and those who don't? Do some providers have higher rates of completion than others?	Supervisor observations about how the second session is introduced. Comparison of client demographic and/or risk profiles for those completing the second session versus those not completing the second session. Comparison of second session completion rates by counselor. Client surveys about the second session.
Scenario Three: **do not know if objective was met:** Data was not compiled.	Were session record forms completed? Were session record forms entered into the data collection system (PEMS or other)? If not, what inhibited completion/entry? If so, why wasn't the data compiled?	Review of a sample of session record forms and/or a sample of records in the data collection system. Report from PEMS on incomplete records. Survey or conversation with data entry staff and/or provider staff about barriers to form completion and/or data entry.

Use data for program improvement

Of course, there is no use in monitoring how you are doing if you don't use the information you garner to improve your program.

RECOMMENDED ACTIVITY

Over the first few months of implementation the program manager should examine all of the process objectives outlined in the agency's Data Planning Matrix and RESPECT Data Analysis Tool, if used, and identify any areas where they are not being met. If you aren't on track to meeting your goals, barriers to meeting them should be identified and corrected.

For example, you may find that you are enrolling many more clients than you expected, but that they aren't from the population you most wanted to serve with RESPECT. You'll want to figure out why you aren't successfully enrolling eligible clients and whether outreach, staff training, or some other effort is needed to correct that.

RECOMMENDED ACTIVITY

Sharing the results of the analysis with providers and supervisors or with other staff who influence the RESPECT intervention (such as scheduling or data entry staff) can heighten awareness of any shortfalls that need to be addressed and identify adjustments that will allow your agency to better meet its implementation goals.

Your data can also tell you whether the outcomes you are achieving are what you expected. You may be carrying out RESPECT largely as you planned but find that clients aren't attaining the outcome objectives you expected. In that case you'll need to consider whether you need additional information about your client population, and if you need to modify your implementation to better meet your client needs.

Use data for program planning

✓ RECOMMENDED ACTIVITY

At least annually or semi-annually you'll want to look at your data as you plan your strategies and resource allocations for your next implementation period. Your data (both process and outcome) will allow you to identify strengths that you may want to build on and areas that you want to focus on improving. For example, the data can be used to assess the extent to which your agency is addressing the needs and satisfaction of its constituents, both clients and staff. It can also help you identify significant changes you need to make in your implementation plans.

Your M&E data may also help you budget the resources you need for your next intervention cycle. For example, you may discover a need for staff training on the RESPECT protocol that will require training or travel dollars. Or you may want to increase the available time of a supervisor who seems most capable of helping providers increase their effectiveness.

Your data can also help you allocate existing resources. If you find that you are having trouble enrolling one of your target populations in RESPECT, you can plan to increase your outreach to that population or plan to employ an alternative enrollment strategy. Or if you don't know how to address the problem, you might plan to track some additional indicators that will provide you with the information you need.

If you are implementing RESPECT with a subset of your counseling and testing clients, your data will help you decide whether and how to extend the approach to other client groups.

✓ RECOMMENDED ACTIVITY

At regular intervals (after your first few months of implementation and then at least annually) you'll need to review your evaluation documents to incorporate what you have learned. It may be that they need only minor changes. Or it could be that your evaluation caused you to change some basic assumptions and you need to make significant changes.

Be sure to review your

- **logic model**
- **evaluation questions**
- **SMART objectives**
- **data planning matrix.**

STEP 6: USE YOUR DATA FOR ADVOCACY AND TO GARNER SUPPORT

The most immediate use of your M&E data is to report to your funders and organizational leaders that you have achieved what you committed to in your grant application. Or, if you haven't achieved your goals, to help you develop some realistic steps for improvement.

Your data can be used to report on CDC Performance Indicators and to report within your agency on services provided.

However, there are other ways your data can help you with advocacy and support:

- Identification of trends or changes in client characteristics (such as risk factors) may help you build a case for additonal funding from a new source.
- Sharing with stakeholders how you used program data to make improvements can lead to increased credibility for your agency in the community and with funders.
- Data about goals met can be shared in your agency's marketing materials and in subsequent grant proposals. Data can be used to develop a profile of your typical client and to "paint a picture" of what your program allows clients to achieve.
- Data about client needs can be used to forge partnerships with other organizations, or to renegotiate existing partnerships.
- Data about program achievements can be shared with staff to increase morale and retention.

Chapter 7 Summary

In this chapter we discussed using data to inform

- program monitoring
- program improvement
- program planning
- reporting to funders and others
- program advocacy and support.

8

CDC's National HIV Prevention Monitoring and Evaluation Plan: Use of PEMS Software for RESPECT Monitoring and Evaluation

Introduction

CDC has undertaken significant efforts to ensure that the HIV prevention programs it funds are effective in preventing the spread of HIV (Thomas, Smith, & Wright-DeAgüero, 2006). One strategy employed by CDC to strengthen HIV prevention is improving organizational capacity to monitor and evaluate prevention programs (CDC, 2007). The National HIV Prevention Program Monitoring and Evaluation Data Set (NHM&E DS) is a major component of this strategy.

The NHM&E DS is the complete set of CDC's HIV prevention monitoring and evaluation (M&E) variables, including required variables for reporting to CDC and optional variables specific to an intervention or for local M&E. Implementation of NHM&E DS makes it possible for CDC to answer critical national questions about the following

- demographic and risk behavior of clients being served by its grantees
- resources used to provide these services
- effectiveness of these services in preventing HIV infection and transmission.

DISCLAIMER: The reporting requirements for the National HIV Prevention Program Monitoring and Evaluation Data Set presented in this document are current as of September 2008. Please refer to the PEMS Web site (https://team.cdc.gov) for the most current reporting requirements.

Implementation of the NHM&E Plan makes it possible for CDC, at the national level, and its funded grantees, locally, to answer such questions as:

- How many people are being served by various HIV prevention interventions?
- What populations are participating in HIV prevention interventions?
- What services have been planned for and subsequently provided?

- What resources have been allocated for HIV prevention programs?
- Have the anticipated outcomes been achieved?
- What are the demographics, risk behaviors, and risk characteristics of clients served by RESPECT?

Using Program Evaluation and Monitoring System (PEMS) software

PEMS is an optional, secure, browser-based software that allows for data management and reporting. PEMS includes all required and optional NHM&E DS variables (CDC, 2008c). A **PEMS User Manual** is also available to assist with software utilization. This how-to manual describes the functionality within the application and provides step-by-step instructions for each module within the Web-based software tool. Screenshots, example extracts of data, and reports are used to illustrate key features included in the PEMS software. You can download this manual at the PEMS Web site (http://team.cdc.gov) under Trainings/PEMS User Manual (CDC, 2008c).

DISCLAIMER: The reporting requirements for the National HIV Prevention Program Monitoring and Evaluation Data Set presented in this document are current as of September 2008. Please refer to the PEMS Web site (*https://team.cdc.gov*) for the most current reporting requirements. .

Implementation of NHM&E at your agency will help you conduct activities associated with your M&E plan for RESPECT. Collection of the required variables will help you answer your evaluation questions, provide data for tracking of process and outcome monitoring, assess the status of your SMART objectives, and generate data you can use to calculate CDC Performance Indicators for RESPECT.

Note: It may be necessary to use complementary data collection systems for other aspects of your M&E plan such as RESPECT session information and quality assurance activities that cannot be captured in the PEMS software.

Preparing for NHM&E Implementation

There are a variety of things you should have in place at your agency for implementation of NHM&E. Someone on staff should be designated as the Implementation Coordinator. This individual is responsible for coordinating all aspects of activities associated with NHM&E, including establishment of a NHM&E implementation team.

Members of the NHM&E team will have responsibility for such activities as:

- Review of the NHM&E data set, the required variables
- Modification and/or creation of data collection forms to make sure the program is capturing required variables
- Training of prevention staff on collection of required variables
- Training of staff who will be users of the PEMS software
- Ensuring staff have access to the correct hardware, software, and internet connections
- Working with prevention program staff on reporting and utilization of the NHM&E data set to support ongoing M&E activities

Here are some tips for getting ready to implement NHM&E data collection for RESPECT.

- If your agency already receives HIV prevention funds from CDC, find out who in your agency is serving as the NHM&E Implementation Coordinator. This individual can work with you to plan for integration of RESPECT into all aspects of NHM&E activities.
- If this is the first time you are receiving funds from CDC for HIV prevention, contact your Project Officer, who will help you identify your technical assistance provider. Your technical assistance provider will begin by giving you an overview and orientation to the NHM&E Plan; making sure you have all relevant PEMS materials; developing a training plan to meet your needs; and assisting you in getting access to the PEMS software.

National HIV Prevention M&E Data Set

The NHM&E DS is organized in a series of data tables. The PEMS software captures these variables in different modules, or components, of the PEMS software according to categories, such as information about your agency, your HIV prevention programs, and the clients you serve. The NHM&E DS document should be available from the NHM&E Implementation Coordinator in your agency, or from your Project Officer. The Data Variable Set provides the number, name, definition, instructions, value choices, and codes for each variable.

- There is a minimum set of variables that all grantees are required to report to CDC.
- There are additional variables included in the software that may be useful to your agency, but are not required.
- There are "local variables" that can be used when you enter client information to capture data not otherwise reflected in the NHM&E data set.

RECOMMENDED ACTIVITY

Review your client intake and session record forms to ensure you are gathering all the required variables.

In this chapter we will discuss in detail only those tables and associated modules you will use to enter information specific to RESPECT.

Agency Information Module in PEMS

The following tables in the Agency Information Module apply to all interventions including RESPECT, and should be updated annually under the direction of your NHM&E Implementation Coordinator:

- Table A: General Agency Information
- Table B: CDC Program Announcement Award Information
- Table C: Contractor Information (including any agencies you contract with to implement RESPECT)

The Agency Information module in the PEMS software also describes the infrastructure, including delivery sites, network agencies, and workers (e.g., counselors) that will be used to deliver RESPECT. Correct set-up of this information before program implementation will facilitate entry of client-level data, as well as the generation of reports helpful for program M&E and progress reports.

- Table S: Site Information (*Agency Information Module, Sites Sub-module*). Each service delivery site (i.e., location) where the RESPECT intervention is delivered should be entered into PEMS. This will allow indication of the site where the RESPECT session was delivered when client level data are entered.
- Table N: Network Agencies (*Agency Information Module, Network Agency Sub-module*). The variables in this table are not required. However, use of this table will help with tracking and verification of client referrals to services outside of your organization. Referrals to other programs within your agency, known as internal referrals, can also be tracked here. Because referral outcomes are important process measures for RESPECT, use of this table is recommended.

- Table P: Worker Information (*Agency Information Module, Worker Sub-module*). The variables in this table are not required. However, use of this table will allow you to identify the number of sessions provided by each RESPECT counselor, as well as whether or not they provided certain components of the intervention as planned.

Program Information Module

The Program Information Module in the PEMS software is where information is captured on how RESPECT will be implemented, including where it fits into the overall structure of your agency, the target population to be served, and the activities to be included in RESPECT sessions. Correct set-up of this information before program implementation is essential to the accurate capturing of client-level data, as well as the generation of reports helpful for program M&E and progress reports. The PEMS Information Module includes the following tables:

Table E1: Program Model and Budget (Planning)

Table F: Intervention Plan Characteristics

Programs in PEMS are identified in terms of the *Program Name* (the overall name your agency uses for the program of which RESPECT is a part), the *Program Model*, which identifies the evidence base (scientific or operational basis for a program), and the *Intervention Plan* (how the intervention is delivered as part of the program model). An intervention may have multiple sessions, as in the case of RESPECT. If your agency is delivering RESPECT to two distinct target populations that you want to track separately, you can create two distinct interventions under the RESPECT program model, each with unique names.

Within the Program Information Module, PEMS allows you to select the activities that are part of each RESPECT session. Because the NHM&E variables were designed to be used for a variety of HIV prevention interventions, they do not cover all activities that are part of all interventions. PEMS does not, for example, have specific value choices for the following activities that are part of each RESPECT session:

- Client identification of his/her own specific risk factor for HIV
- Client expression of intent to implement risk reduction step
- Client identification of a source of support for risk reduction step
- Client report of implementation of risk reduction step

PEMS does, however, have an activity value choice for "risk reduction discussion," which could be used to indicate that some or all of the RESPECT components listed above were completed.

If you wish to capture the specific activities that are not part of the existing value list, PEMS allows you to define your own local variables and value choices, which can be entered into PEMS when information is entered about a client session that was delivered. Your NHM&E technical assistance provider can provide more information about how to do this.

Client Information Module

The Client Information Module includes:

Table G1: Client Characteristics- Demographics

For every client who receives the RESPECT intervention, a demographic profile must be included. The profile includes some required variables (including race, gender, and year of birth, among others), and a number of optional variables.

Table G2 Client Characteristics – Risk Profile

Risk profile information is also captured in this module, and again can include both optional and required variables. Risk profile information can be linked to the RESPECT intervention, and can be captured for every session if desired.

When client information is entered, it is linked to the program, program model, and intervention that was created as described above. Risk profile information for every session can also be captured.

Session Information

Table H: Client Intervention Characteristics

Once a client has participated in a RESPECT session, information about that session will be entered into PEMS. Once the client and RESPECT program are chosen, PEMS will prompt for entry of which worker led the session, where and how the session was delivered, and what activities were included in the session. PEMS will generate a list of the planned activities, allow choice of those that were completed, as well as any activities that were entered as delivered but not originally planned for the session. If a referral is made, a referral activity can be chosen and referral details, including the outcome, tracked.

When session information is entered, there is also an option to enter an updated risk profile for the client.

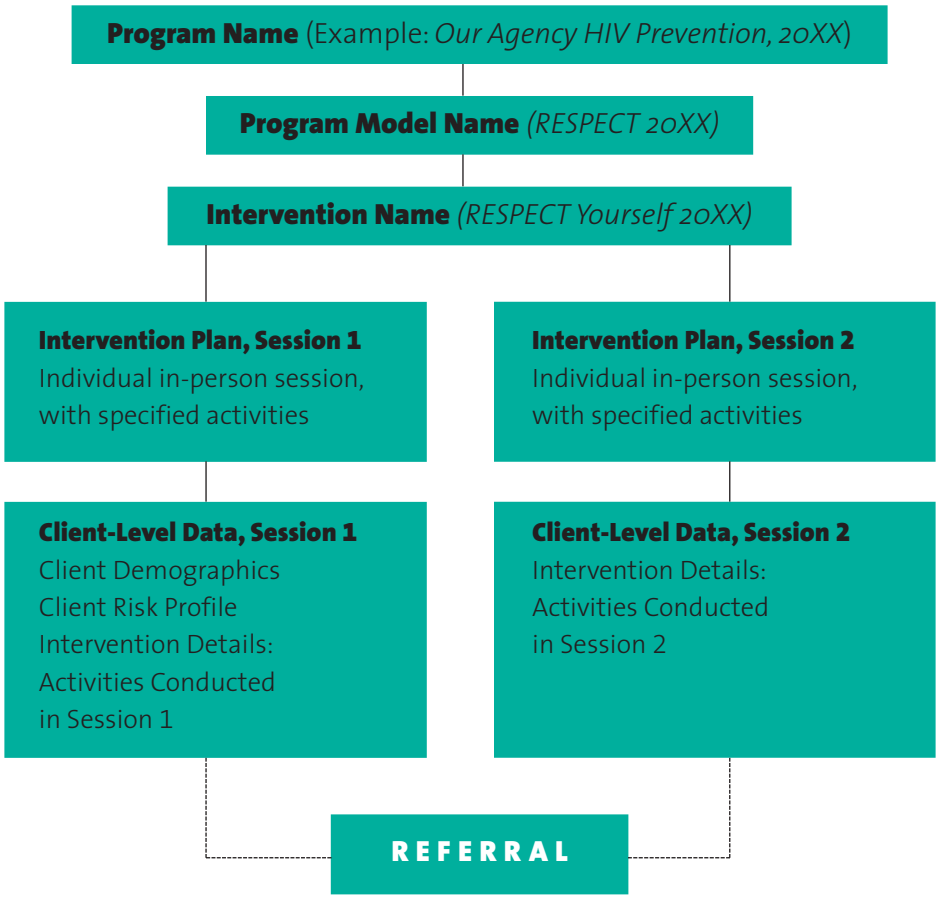
In addition, there is an opportunity to enter information on up to 32 local variables for which you define the variable and the value choices. PEMS does not include activity variables for the following components of RESPECT sessions:

- Client identification of his/her own specific risk factor for HIV
- Client expression of intent to implement risk reduction step
- Client identification of a source of support for risk reduction step
- Client report of implementation of risk reduction step

Tracking of these components is not part of the required NHM&E variables or CDC Performance Indicators, but is an important part of local M&E. These components could be captured through the PEMS local variables or through a complementary tracking database.

Sample PEMS Set Up

The following diagram illustrates how RESPECT may be set up as a PEMS program.



RESPECT Integrated with Counseling, Testing, and Referral

Because RESPECT and Counseling, Testing, and Referral (CTR) have different evidence bases, the two components of an integrated RESPECT program must be captured separately. A client is entered into PEMS, and the activities of the RESPECT session captured, including an internal referral to testing, but no information about the test itself. Information about the test and the risk assessment conducted as part of the test are then captured on an HIV test form and entered for the client in the HIV test form sub-module.

In the Program Information Module a program model will be set up for both CTR and RESPECT. These might both fall under one program (CTR), or they might each be under a different program, depending on how you conceptualize HIV prevention efforts in your agency.

Program Monitoring via PEMS

Reports can be run on client level data that allow you to see how many RESPECT clients have completed both RESPECT sessions, which program activities they have engaged in, and how their risk profile has changed over time.

It is critical that the intake form and the session record form used to collect client and session data include the NHM&E data variables.

RESPECT Components Not Captured in PEMS

The following RESPECT quality assurance activities will need to be captured outside of PEMS:

- Staff training on RESPECT
- Counselor observations according to the schedule described in the 2-Session RESPECT HIV Prevention Counseling Manual (RESPECT manual)
- Case conferences, as described in the RESPECT manual

Obtaining Data from PEMS

Data can be obtained from PEMS in two ways:

- A data extract may be used to obtain all data points in a particular PEMS table or set of tables. The data can be imported into a spreadsheet or database for further analysis.
- Pre-defined PEMS reports can be generated on specific data elements such as
  - The characteristics of RESPECT clients
  - The characteristics of RESPECT sessions
  - Details on referrals made and their outcomes
  - RESPECT sessions with incomplete information in PEMS
  - Client risk behaviors.

The tables in Tool 15, the NHM&E DS for RESPECT, provide guidance on completing the required program and client level variables in PEMS, as well as optional values that can assist in M&E.

Chapter 8 Summary

In this chapter we discussed

- the National HIV Prevention Program Monitoring and Evaluation Data Set (NHM&E DS)
- implementing NHM&E at your agency
- entering the RESPECT intervention into PEMS.
- using data from PEMS to inform your M&E activities.

9

Tools: Overview and Summary

A variety of tools are included in the Appendix to assist you in developing and implementing your Monitoring and Evaluation (M&E) Plan. Following is a brief summary of each of these tools. As you review what is here, you can choose those tools that work best for you. They should be modified to reflect the unique features of RESPECT in your agency and can be used alone or to supplement tools you are currently using for M&E. Use of these tools is not a requirement. It is our hope that including them in this M&E Field Guide will address one of the most frequent requests providers of evaluation technical assistance receive from community-based organizations: assistance with development of data collection tools for program evaluation.

- **Monitoring & Evaluation Task List (Tool 1)** - The M&E task list provides an overview and summary of all tasks associated with your M&E plan. It can be used to create a work plan to track implementation of the M&E plan. Periodic review of this task list will allow you to track progress as you proceed through each of the steps of your M&E plan. **FOR USE BY: Program Manager**
- **Sample RESPECT Logic Model (Tool 2)** - This sample logic model illustrates implementation of the RESPECT model with clients and includes components of an M&E plan. Be sure to tailor this model to reflect your approach to delivery of RESPECT. **FOR USE BY: Program Manager**
- **RESPECT Data Analysis Tool (Tool 3)** - This tool facilitates calculation of program performance measures. Variables specific to RESPECT are highlighted in purple.

  The tool also provides formulas to assist you in calculating the outcomes for your program (in a 'percentage' format). For example, the percentage of clients served who are from the target population you are trying to reach and engage in RESPECT. Likewise, the number of RESPECT clients who completed the intended number of sessions, identified a risk reduction step, and so forth. This tool is formatted as an Excel spread sheet for ease of use. **FOR USE BY: Program Manager**

- **SMART Table (Tool 4)** - This table is designed to assist you in writing your own SMART objectives. The SMART Table provides suggestions of words and phrases to use for each component of a SMART objective.
  FOR USE BY: Program Manager
- **Sample SMART Objectives for RESPECT (Tool 5)** - Your M&E plan will focus on collecting process objectives and short-term outcomes. Sample SMART objectives for RESPECT are presented in this tool for your reference. These should be tailored to meet your agency's implementation of RESPECT. **FOR USE BY: Program Manager**; useful overview to share with staff as part of training on evaluation.
- **Sample Data Planning Matrix (Tool 6) and blank Data Planning Matrix (Tool 7)** - The Sample Data Planning Matrix links sample SMART objectives with evaluation questions. The blank Data Planning Matrix is included for use in your agency. The matrix can be completed to document the SMART objectives, measures, and data sources you will use to answer each evaluation question you develop. You can also include the person responsible for collection of the data and the time frame for data collection. **FOR USE BY: Program Manager**; useful overview to share with staff as part of training on evaluation.
- **Sample RESPECT Session Record Form (Tool 8)** and blank RESPECT Session Record Form (Tool 9) - The sample form is completed for a fictional RESPECT session. The blank form is provided for use in your agency. It includes fields for recording key data variables specific to RESPECT, as well as information regarding referrals and HIV testing. It can be used by the counselor to capture critical information after each counseling session and can serve as the client's counseling record. It may also be used by data entry staff to capture information about the session in PEMS (or in the agency's own data system) and for quality assurance activities such as chart reviews. **FOR USE BY: RESPECT providers, data entry staff, supervisors.**
- **Quality Assurance Fidelity Check List (Tool 10)** - The QA check list has been formatted as an Excel spread-sheet. Upon completion, it will automatically calculate the percent of RESPECT counseling components that have been implemented by providers in each RESPECT session. This summary tool makes it possible for supervisors to identify QA trends that can be addressed with individual providers or staff as a whole. To the extent to which consistent session components are not completed, training and supervision can be designed to improve the quality of counseling sessions. **FOR USE BY: Supervisors.**
- **RESPECT Quality Assurance Tool Supplemental Form (Tool 11)** - This form has been developed for use by supervisors to assist in supervisory sessions with providers following observations. It includes a series of questions to guide discussion about the observation with the counselor. This can be used as an adjunct to the RESPECT Quality Assurance tool (QA Check List) included with the RESPECT implementation manual. **FOR USE BY: Supervisors.**

- **Provider Training and Development Worksheet (Tool 12)** - This form (formatted as an excel spreadsheet) can be used to track implementation of provider observations for each counselor. Upon completion, it will automatically calculate the % of observations conducted so that supervisors can assess the extent to which they are following the required observation protocol detailed in the RESPECT implementation manual. **FOR USE BY: Supervisors.**
- **Sample Client Satisfaction Survey (Tool 13)** - This sample form can be tailored as needed for your agency and client base to elicit feedback from clients on their experience in the program. **FOR USE BY: Clients and Program Manager**
- **Sample Data Management Plan (Tool 14)** - A data management plan describes your methods for collecting, entering, and storing data, conducting quality assurance, and analyzing the data. It also describes who is responsible for each of these steps. This sample plan is for a fictitious agency. The plan must be adapted to fit your agency, describing steps staff will take to complete forms you are using for documenting implementation of RESPECT, such as intake forms, session notes, HIV test forms, and quality assurance forms. It should also describe how data will be cleaned and forms assessed for completeness, and how data will be used for reporting and program improvement purposes. **FOR USE BY: Program Manager and as a training tool for project staff.**
- National HIV Prevention and Monitoring Data Set (NHM&E DS) **for RESPECT (Tool 15)** - This tool lists the variables that are required to be collected for RESPECT, as well as optional variables which may be helpful for M&E. The tool provides the name and number for each variable, indicates the PEMS software module and sub-module where each variable is found, and provides guidance for the variable. **FOR USE BY: Program Manager**

Chapter 9 Summary

In this chapter we have introduced a variety of tools designed to assist you in developing and implementing your Monitoring and Evaluation (M&E) Plan.

APPENDICES

APPENDIX I: RELATED RESOURCE

1. Centers for Disease Control and Prevention (2008a). "Evaluation Capacity Building Guide." Draft in preparation. Developed for the Centers for Disease Control and Prevention under contract number 200-2006-18987. Atlanta, GA: Author.
2. Centers for Disease Control and Prevention. (2008d). National HIV Prevention Program Monitoring and Evaluation Data Set."
3. Centers for Disease Control and Prevention (2008c). "Program Evaluation and Monitoring System (PEMS) User Manual."
4. Framework for Program Evaluation in Public Health. Centers for Disease Control and Prevention. MMWR 1999; 48 (no. RR-11). 1-42.
5. 2 Session Respect HIV Prevention Counseling Manual.
6. CDC 'At a Glance"-Revised HIV Prevention Program Indicators, HIV Surveillance Measures, and Program context Questions, by Domain.
7. Kamb, ML et al. (1998) "Efficacy of Risk Reduction Counseling to Prevent Human Immunodeficiency Virus and Sexually Transmitted Diseases". Journal of the American Medical Association. Vol. 280, No. 13
8. Bolu, Omoayo Oet al. (2004) "Is Sexually Transmitted Disease Prevention Counseling Effective Among Vulnerable Populations" Sexually Transmitted Diseases, Vol. 31, No. 8.
9. Carol Roye et al. (2006)" A Brief, Low-Cost, Theory-Based Intervention to Promote Dual Method Use by Black and Latina Female Adolescents: A Randomized Clinical Trial." Health Education & Behavior, Vol. (): 1-14

APPENDIX 2: SUMMARY OF NATIONAL HIV PREVENTION MONITORING AND EVALUATION REQUIRED VARIABLES

This document provides a summary of the variable requirements for the January 1 and July 1, 2008 data collection periods, excluding variable requirements for HIV Testing and Partner Counseling and Referral Services (PCRS). HIV Testing variable requirements are currently specified in the HIV Testing Form and Variables Manual and the CDC HIV Testing Variables Data Dictionary. Requirements for PCRS will be released later in 2008. Since this document only provides a summary of the requirements, please refer to the PEMS DVS for a more detailed description of definitions and value choices.

VARIABLE NUMBER	VARIABLE NAME	HD & CBO REPORTED REQUIRED
	GENERAL AGENCY INFORMATION (TABLE A)	
A01	Agency Name	Required
A01a	PEMS Agency ID	Required
A02	Community Plan Jurisdiction	Required
A03	Employer Identification Number (EIN)	Required
A04	Street Address 1	Required
A06	City	Required
A08	State	Required
A09	Zip Code	Required
A10	Agency Website	Required
A11	Agency DUNS Number	Required
A12	Agency Type	Required
A13	Faith-based	Required
A14	Race/Ethnicity Minority Focused	Required
A18	Directly Funded Agency	Required
A21	Agency Contact Last Name	Required
A22	Agency Contact First Name	Required
A23	Agency Contact Title	Required
A24	Agency Contact Phone	Required
A25	Agency Contact Fax	Required
A26	Agency Contact Email	Required

CDC PROGRAM ANNOUNCEMENT AWARD INFORMATION (TABLE B)		
B01	CDC HIV Prevention PA Number	Required
B02	CDC HIV Prevention PA Budget Start Date	Required
B03	CDC HIV Prevention PA Budget End Date	Required
B04	CDC HIV Prevention PA Award Number	Required
B06	Total CDC HIV Prevention Award Amount	Required
B06a	Annual CDC HIV Prevention Award Amount Expended	Required
B07	Amount Allocated for Community Planning	Required
B08	Amount Allocated for Prevention Services	Required
B09	Amount Allocated for Evaluation	Required
B10A	mount Allocated for Capacity Building	Required

CONTRACTOR INFORMATION (TABLE C)		
C01	Agency Name	Required
C04	City	Required
C06	State	Required
C07	Zip Code	Required
C13	Employer Identification Number (EIN)	Required
C14	DUNS Number	Required
C15	Agency Type	Required
C16	Agency Activities	Required
C17	Faith-based	Required
C18	Race/Ethnicity Minority Focused	Required
C19	Contract Start Date-Month	Required
C20	Contract Start Date-Year	Required
C21	Contract End Date- Month	Required
C22	Contract End Date- Year	Required
C23	Total Contract Amount Awarded	Required
C25	CDC HIV Prevention Program Announcement Number	Required
C26	CDC HIV Prevention PA Budget Start Date	Required
C27	CDC HIV Prevention PA Budget End Date	Required

SITE INFORMATION (TABLE S)		
S01	Site ID	Required
S03	Site Name	Required
S04	Site Type	Required
S08	County	Required
S09	State	Required
S10	Zip Code	Required
S16	Use of Mobile Unit	Required

PROGRAM NAME - PLANNING (TABLE D)		
D01	Program Name	Required
D02	Community Planning Jurisdiction	Required
D03	Community Planning Year	Required

PROGRAM MODEL AND BUDGET - PLANNING (TABLE E1)		
E101	Program Model Name	Required
E102	Evidence Base	Required
E103	CDC Recommended Guidelines	Required
E104	Other Basis for Program Model	Required
E104-1	Specify Other Basis for Program Model	Required
E105	Target Population	Required
E107	Program Model Start Date	Required
E108	Program Model End Date	Required
E109	Proposed Annual Budget	Required

INTERVENTION PLAN CHARACTERISTICS (TABLE F)		
F01Intervention Type	Required	
F02Intervention ID	Required	
F02a	Intervention Name	Required
F03HIV+ Intervention	Required	

F04Perinatal Intervention	Required	
F05Total Number of Clients	Required	
F06Sub-Total Target Population	Required	
F07Planned Number of Cycles	Required	
F08Number of Sessions	Required	
F09Unit of Delivery	Required	
F11Delivery Method	Required	
F14Level of Data Collection	Required	
CLIENT CHARACTERISTICS (TABLE G)		
G101	Date Collected	Required
G102	PEMS Client Unique Key	Required
G112	Date of Birth - Year	Required
G113	Calculated Age (System Generated)	Required
G114	Ethnicity	Required
G116	Race	Required
G120	State/Territory of Residence	Required
G123	Assigned Sex at Birth	Required
G124	Current Gender	Required
G200	Date Collected	Required
G204	Previous HIV Test	Required
G205	Self Reported HIV Test Result	Required
G208	In HIV Medical Care/Treatment (only if HIV+)	Required
G209	Pregnant (only if female)	Required
G210	In Prenatal Care (only if pregnant)	Required
G211	Client Risk Factors ***	Required
G212	Additional Client Risk Factors ^^^	Required
G213	Recent STD (Not HIV)	Required

***Note: The recall period for client risk factors is 12 months.

^^^ Note: Additional value choices for risk factors added:
Sex without using a condom
Sharing drug injection equipment

CLIENT INTERVENTION CHARACTERTICS (TABLE H)		
H01	Intervention ID	Required
H01a	Intervention Name	Required
H03Cyce	Required	
H04a	Form ID (Counseling & Testing Only)	Required
H05	Session Number	Required
H06	Session Date	Required
H10	Site Name/ID	Required
H13	Recruitment Source	Required
H18	Recruitment Source - Service/Intervention Type	Required
H21	Incentive Provided	Required
H22	Unit of Delivery	Required
H23	Delivery Method	Required

REFERRAL (TABLE X7)		
X702	Referral Date	Required
X702a	Reason Client Not Refrerred to Medical Care	Required
X703	Referral Service Type	Required
X706	Referral Outcome	Required
X710	Referral Close Date	Required
X712	HIV Test Performed	Required
X713	HIV Test Result	Required
X714	Confirmatory Test	Required
X714a	HIV Test Result Provided	Required

AGGREGATE HE/RR AND OUTREACH (TABLE AG)		
AG00	Intervention Name/ID	Required
AG01	Session Number	Required
AG02	Date of Event/Session	Required
AG03	Duration of Event/Session	Required

AG04	Number of Client Contacts	Required
AG05a	Delivery Method	Required
AG05c	Incentive Provided	Required
AG06	Site Name/ID	Required
AG08a	Client Primary Risk - MSM	Required
AG08b	Client Primary Risk - IDU	Required
AG08c	Client Primary Risk - MSM/IDU	Required
AG08d	Client Primary Risk - Sex Involving Transgender	Required
AG08e	Client Primary Risk - Heterosexual Contact	Required
AG08f	Client Primary Risk - Other/Risk Not Identified	Required
AG09a	Client Gender - Male	Required
AG09b	Client Gender - Female	Required
AG09c	Client Gender - Transgender MTF	Required
AG09d	Client Gender - Transgender FTM	Required
AG10a	Client Ethnicity - Hispanic or Latino	Required
AG10b	Client Ethnicity - Not Hispanic or Latino	Required
AG11a	Client Race - American Indian or Alaska Native	Required
AG11b	Client Race - Asian	Required
AG11c	Client Race - Black or African American	Required
AG11d	Client Race - Native Hawaiian or Other Pacific Islander	Required
AG11e	Client Race - White	Required
AG11f	Client Race - Multiracial	Required
AG12a	Client Age - Under 13 years	Required
AG12b	Client Age - 13 - 18 years	Required
AG12c	Client Age - 19-24 years	Required
AG12d	Client Age - 25 - 34 years	Required
AG12e	Client Age - 35 - 44 years	Required
AG12f	Client Age - 45 years and over	Required
AG14a	Materials Distributed - Male Condoms	Required
AG14b	Materials Distributed - Female Condoms	Required

AG14c	Materials Distributed - Bleach or Safer Injection Kits	Required
AG14d	Materials Distributed - Education Materials	Required
AG14e	Materials Distributed - Safe Sex Kits	Required
AG14f	Materials Distributed - Referral list	Required
AG14g	Materials Distributed - Role Model Stories	Required
AG14h	Materials Distributed - Other (specify)	Required
AG15	Aggregate Data Collection Method	Required
HEALTH COMMUNICATION / PUBLIC INFORMATION (TABLE HC)		
HC01	Intervention Name/ID	Required
HC02	HC/PI Delivery Method	Required
HC05	Event Start Date	Required
HC06	Event End Date	Required
HC07	Total Number of Airings	Required
HC08	Estimated total Exposures	Required
HC09	Number of Materials Distributed	Required
HC10	Total Number of Web Hits	Required
HC11	Total Number of Attendees	Required
HC12	Number of Callers	Required
HC13	Number of Callers Referred	Required
HC14	Distribution - Male condoms	Required
HC15	Distribution - Female condoms	Required
HC16	Distribution - Lubricants	Required
HC17	Distribution - Bleach or Safer Injection Kits	Required
HC18	Distribution - Referral Lists	Required
HC19	Distribution - Safe sex kits	Required
HC20	Distribution - Other	Required
HC21	Site Name/ID	Required

COMMUNITY PLANNING LEVEL (TABLE CP-A/B/C)		
CP-A01	Name of HIV Prevention CPG	HD only
CP-A02	Community Plan Year	HD only
CP-B01	Priority Population	HD only
CP-B02	Rank	HD only
CP-B03	Age	HD only
CP-B04	Gender	HD only
CP-B05	Ethnicity	HD only
CP-B06	Race	HD only
CP-B07	HIV Status	HD only
CP-B08	Geo Location	HD only
CP-B09	Transmission Risk	HD only
CP-C01	Name of the Prevention Activity/Intervention	HD only
CP-C02	Prevention Activity/Intervention Type	HD only
CP-C04	Evidence Based	HD only
CP-C05	CDC Recommended Guidelines	HD only
CP-C06	Other Basis for Intervention	HD only
CP-C07	Activity	HD only

GENERAL INSTRUCTIONS FOR COMPLETING THE HIV TEST FORM

- This form is designed to be read by an Optical Character Recognition (OCR) scanner. The legibility of this form depends on the quality of the hand-written and selected information.
- Carefully separate the sheets at the perforations. If the form tears, it may not be readable by the scanner or operator.
- Each part has a top sheet and a bottom carbonless copy. The top copy (white) is the only sheet that should be scanned. The bottom copy (yellow) should **NOT** be scanned; rather it should be used for record keeping purposes.
- **DO NOT** use red ink. Blue or black ink is preferred.
- **DO NOT** fold, staple, wrinkle or tear form(s).
- **DO NOT USE WHITE OUT**. White out sometimes will cause a mis-read by the scanning software.
- **DO NOT** mark on the bar codes of the Form ID numbers. Marking on the Form ID numbers (barcode) may cause the wrong number to be scanned.
- **DO NOT** make any stray marks on the form(s), particularly in the fields where answers will appear.
- Part 1 is the only form with a pre-printed code. You must attach a form identification sticker (barcode) located on the back of the carbonless copy (yellow) to Part 2 and/or Part 3 in order to link a client's information.
    - Part 1 should be used for all testing events
    - Part 2 should be used to record referral data on **confirmed HIV positive** clients
    - Part 3 is used by jurisdictions funded to collect HIV Incidence data.

RESPONSE FORMATS

There are three different response formats on the form that you will use to record data: (1) text boxes, (2) check boxes, and (3) radio buttons. Instructions for each one of these formats are listed below.

Text boxes

Text boxes are used to record handwritten information (e.g., codes, dates). When writing letters or numbers in the boxes:

- use all capital letters and write neatly in your best penmanship. **DO NOT** use cursive.
- put only 1 letter or number per box and **DO NOT** have any part of the letter or number touch the edges of the box.

Here are examples of how to write letters and numbers:

LETTERS

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z

NUMBERS

0	1	2	3	4	5	6	7	8	9

Check boxes

Check boxes are used to select all options that apply. For example, check boxes are used to record information about "Race."

- use an "X" instead of a check mark because the tail of the check mark might run over into another box.
- keep the "X" within the edges of the box.

Radio buttons

Radio buttons are ovals used to select only one option from among two or more options. For example, radio buttons are used to select "Current Gender." When selecting an option using a radio button:

- fill in the oval completely.
- **DO NOT** mark over area of the oval.

Printed Barcode

HIV TEST FORM

PART 1

Form Approved: OMB No. 0920-0696, Exp. Date: 08/31/2010

CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

Agency

Session Date (MMDDYYYY) | Unique Agency ID Number | Intervention ID

Site ID | Site Type (See codes on reverse) | Site Zip Code

Client

Client ID | Date of Birth (MMDDYYYY) | State | County | Zip Code

Ethnicity
- Hispanic or Latino
- Not Hispanic or Latino
- Don't know
- Declined

Race — *Check all that apply*
- American Ind./AK Native
- Asian
- Black/African American
- Native HI/Pac. Islander
- White
- Don't know
- Declined

Current Gender
- Male
- Female
- Transgender – M2F
- Transgender – F2M

Previous HIV Test?
- Yes
- No
- Don't know
- Declined
- Not asked

Self-Reported Result
- Positive
- Negative
- Prelim. Pos.
- Indeterminate
- Don't know
- Declined
- Not asked

Provide date of last test (MMYYYY)

HIV Test Information

	HIV TEST 1	HIV TEST 2	HIV TEST 3
Sample Date (MMDDYYYY)			
Worker ID			
Test Election	Tested anonymously; Tested confidentially; Declined testing	Tested anonymously; Tested confidentially; Declined testing	Tested anonymously; Tested confidentially; Declined testing
Test Technology	Conventional; Rapid; Other	Conventional; Rapid; Other	Conventional; Rapid; Other
Specimen Type	Blood: finger stick; Blood: venipuncture; Blood spot; Oral mucosal transudate; Urine	Blood: finger stick; Blood: venipuncture; Blood spot; Oral mucosal transudate; Urine	Blood: finger stick; Blood: venipuncture; Blood spot; Oral mucosal transudate; Urine
Test Result	Positive/Reactive; NAAT-pos; Negative; Indeterminate; Invalid; No result	Positive/Reactive; NAAT-pos; Negative; Indeterminate; Invalid; No result	Positive/Reactive; NAAT-pos; Negative; Indeterminate; Invalid; No result
Result Provided	Yes; No	Yes; No	Yes; No
Date Provided (MMDDYYYY)			
If results not provided, why?	Declined notification; Did not return/Could not locate; Obtained results from another agency	Declined notification; Did not return/Could not locate; Obtained results from another agency	Declined notification; Did not return/Could not locate; Obtained results from another agency
If rapid reactive, did client provide confirmatory sample?	Yes; Client declined confirmatory test; Did not return/Could not locate; Referred to another agency; Other	Yes; Client declined confirmatory test; Did not return/Could not locate; Referred to another agency; Other	Yes; Client declined confirmatory test; Did not return/Could not locate; Referred to another agency; Other

Risk Factors

Choose one if: Client was not asked about risk factors; Client was asked, but no risk was identified; Client declined to discuss risk factors

If client risk factor information was discussed, please mark all that apply:

In past 12 months has client had:
- ...without using a condom?
- ...with person who is an IDU?
- ...with person who is MSM? (Female Only)
- ...with person who is HIV positive?

Vaginal or Anal Sex / Oral Sex: With Male; With Female

Injection Drug Use (IDU)

Has client used injection drugs in past 12 months? *if marked* → Did client share drug injection equipment?

Other Risk Factor(s) (see codes on reverse)

Session Activity

During this visit, was a risk reduction plan developed for the client? Yes No

Other Session Activities (see codes on reverse)

Local Use Fields

L1 | L2

CDC Use Fields

C1 | C2

WHITE COPY = Scan YELLOW COPY = Record Keeping CDC 50.135a (E), 10/2007

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HIV TEST FORM
PART 1

Form Approved: OMB No. 0920-0696, Exp. Date: 08/31/2010

CDC Centers for Disease Control and Prevention

Agency

Session Date (MMDDYYYY) | Unique Agency ID Number | Intervention ID

Site ID | Site Type (See codes on reverse) | Site Zip Code

Client

Client ID | Date of Birth (MMDDYYYY) | State | County | Zip Code

Ethnicity	Race — *Check all that apply*	Current Gender	Previous HIV Test?	Self-Reported Result
Hispanic or Latino	American Ind./AK Native	Male	Yes	Positive
Not Hispanic or Latino	Asian	Female	No	Negative
Don't know	Black/African American	Transgender – M2F	Don't know	Prelim. Pos.
Declined	Native HI/Pac. Islander	Transgender – F2M	Declined	Indeterminate
	White		Not asked	Don't know
	Don't know / Declined			Declined
				Not asked

Provide date of last test (MMYYYY)

HIV Test Information

	HIV TEST 1	HIV TEST 2	HIV TEST 3
Sample Date (MMDDYYYY)			
Worker ID			
Test Election	Tested anonymously / Tested confidentially / Declined testing	Tested anonymously / Tested confidentially / Declined testing	Tested anonymously / Tested confidentially / Declined testing
Test Technology	Conventional / Rapid / Other	Conventional / Rapid / Other	Conventional / Rapid / Other
Specimen Type	Blood: finger stick / Blood: venipuncture / Blood spot / Oral mucosal transudate / Urine	Blood: finger stick / Blood: venipuncture / Blood spot / Oral mucosal transudate / Urine	Blood: finger stick / Blood: venipuncture / Blood spot / Oral mucosal transudate / Urine
Test Result	Positive/Reactive / NAAT-pos / Negative / Indeterminate / Invalid / No result	Positive/Reactive / NAAT-pos / Negative / Indeterminate / Invalid / No result	Positive/Reactive / NAAT-pos / Negative / Indeterminate / Invalid / No result
Result Provided	Yes / No	Yes / No	Yes / No
Date Provided (MMDDYYYY)			
If results not provided, why?	Declined notification / Did not return/Could not locate / Obtained results from another agency	Declined notification / Did not return/Could not locate / Obtained results from another agency	Declined notification / Did not return/Could not locate / Obtained results from another agency
If rapid reactive, did client provide confirmatory sample?	Yes / Client declined confirmatory test / Did not return/Could not locate / Referred to another agency / Other	Yes / Client declined confirmatory test / Did not return/Could not locate / Referred to another agency / Other	Yes / Client declined confirmatory test / Did not return/Could not locate / Referred to another agency / Other

Risk Factors

Choose one if: Client was not asked about risk factors / Client was asked, but no risk was identified / Client declined to discuss risk factors

If client risk factor information was discussed, please mark all that apply:

In past 12 months has client had:

	Vaginal or Anal Sex	Oral Sex
With Male		
With Female		

...without using a condom?

...with person who is an IDU?

...with person who is MSM?

...with person who is HIV positive?

Injection Drug Use (IDU)

Has client used injection drugs in past 12 months? *if marked* Did client share drug injection equipment?

Other Risk Factor(s) (see codes on reverse)

Session Activity

During this visit, was a risk reduction plan developed for the client? Yes / No

Other Session Activities (see codes on reverse)

Local Use Fields

L1

L2

CDC Use Fields

C1

C2

WHITE COPY = Scan YELLOW COPY = Record Keeping CDC 50.135a (E), 10/2007

Client Identifying Data (Optional)

Name: _____

Address: _____

Phone: _____ Other: _____

Codes for Site Type

F01	Inpatient Facility
F01.01	Inpatient Hospital
F01.50	Inpatient- Drug / Alcohol Treatment
F01.88	In patient Facility- Other
F01.99	Inpatient Facility- Unknown
F02	Outpatient facility
F02.03	Outpatient- Private Medical Practice
F02.04	Outpatient- HIV Specialty Clinic
F02.10	Outpatient- Prenatal/ OBGYN Clinic
F02.12	Outpatient- TB Clinic
F02.12	Outpatient- Drug / Alcohol Treatment Clinic
F02.19	Outpatient- Family Planning
F02.20	Outpatient- Community Mental Health
F02.30	Outpatient- Community Health Clinic
F02.58	Outpatient- School/University Clinic
F02.60	Outpatient- Health Department/Public Health Clinic
F02.61	Outpatient- Health Department/Public Health Clinic-HIV
F02.62	Outpatient- Health Department/Public Health Clinic-STD
F02.88	Outpatient Facility- Other
F02.99	Outpatient Facility- Unknown
F03	Emergency Room
F04.01	Blood Bank, Plasma Center
F04.05	HIV Counseling and Testing Site
F06	Community Setting
F06.01	Community Setting – AIDS Service Organization – non clinical
F06.02	Community Setting – School/Education Facility
F06.03	Community Setting – Church/Mosque/Synagogue/Temple
F06.04	Community Setting – Shelter/Transitional housing
F06.05	Community Setting – Commercial
F06.06	Community Setting – Residential
F06.07	Community Setting – Bar/Club/Adult Entertainment
F06.08	Community Setting – Public Area
F06.09	Community Setting – Workplace
F06.10	Community Setting – Community Center
F06.88	Community Setting – Other
F07	Correctional Facility
F88	Facility – Other

Codes for Other Risk factor(s)

01	Exchange sex for drugs/money/or something they need
02	While intoxicated and/or high on drugs
05	With person of unknown HIV status
06	With person who exchanges sex for drugs/money
08	With anonymous partner
09	With person who has hemophilia or transfusion/transplant recipient
11	Sex with transgender

Codes for Other Session Activities

03.00	HIV Testing
04.00	Referral
05.00	Personalized Risk assessment
06.00	Elicit Partners
07.00	Notification of exposure
08.01	Information – HIV/AIDS transmission
08.02	Information-Abstinence/postpone sexual activity
08.03	Information-Other sexually transmitted diseases
08.04	Information-Viral hepatitis
08.05	Information – Availability of HIV/STD counseling and testing
08.06	Information-Availability of partner notification and referral services
08.07	Information – Living with HIV/AIDS
08.08	Information – Availability of social services
08.09	Information – Availability of medical services
08.10	Information – Sexual risk reduction
08.11	Information – IDU risk reduction
08.12	Information – IDU risk free behavior
08.13	Information – Condom/barrier use
08.14	Information – Negotiation / Communication
08.15	Information – Decision making
08.16	Information – Disclosure of HIV status
08.17	Information – Providing prevention services
08.18	Information – HIV testing
08.19	Information – Partner notification
08.20	Information – HIV medication therapy adherence
08.21	Information – Alcohol and drug use prevention
08.22	Information – Sexual health
08.23	Information – TB testing
08.66	Information – Other
09.01	Demonstration – Condom/barrier use
09.02	Demonstration – IDU risk reduction
09.03	Demonstration – Negotiation / Communication
09.04	Demonstration – Decision making
09.05	Demonstration – Disclosure of HIV status
09.06	Demonstration – Providing prevention services
09.07	Demonstration – Partner notification
09.66	Demonstration – Other
10.01	Practice – Condom/barrier use
10.02	Practice – IDU risk reduction
10.03	Practice – Negotiation / Communication
10.04	Practice – Decision making
10.05	Practice – Disclosure of HIV status
10.06	Practice – Providing prevention services
10.07	Practice – Partner notification
10.66	Practice – Other
11.01	Discussion – Sexual risk reduction
11.02	Discussion – IDU risk reduction
11.03	Discussion – HIV testing
11.04	Discussion – Other sexually transmitted diseases
11.05	Discussion – Disclosure of HIV status
11.06	Discussion – Partner notification
11.07	Discussion – HIV medication therapy adherence
11.08	Discussion – Abstinence/postpone sexual activity
11.09	Discussion – IDU risk free behavior
11.10	Discussion – HIV/AIDS transmission
11.11	Discussion – Viral hepatitis
11.12	Discussion – Living with HIV/AIDS
11.13	Discussion – Availability of HIV/AIDS counseling testing
11.14	Discussion – Availability of partner notification and referral services
11.15	Discussion – Availability of social services
11.16	Discussion – Availability of medical services
11.17	Discussion – Condom/barrier use
11.18	Discussion – Negotiation / Communication
11.19	Discussion – Decision making
11.20	Discussion – Providing prevention services
11.21	Discussion – Alcohol and drug use prevention
11.22	Discussion – Sexual health
11.23	Discussion – TB testing
11.66	Discussion – Other
12.01	Other testing – Pregnancy
12.02	Other testing – STD
12.03	Other testing – Viral hepatitis
12.04	Other testing – TB
13.01	Distribution – Male condoms
13.02	Distribution – Female condoms
13.03	Distribution – Safe sex kits
13.04	Distribution – Safer injection / bleach kits
13.05	Distribution – Lubricants
13.06	Distribution – Education materials
13.07	Distribution – Referral lists
13.08	Distribution – Role model stories
13.66	Distribution – Other
14.01	Post-intervention follow up
14.02	Post-intervention booster session
15.00	HIV Testing History Survey
88	Other

Form ID stickers
(n=8)

Form ID Series Affected
1000000000 - 1000950000

Codes for Site Type

F01	Inpatient Facility
F01.01	Inpatient Hospital
F01.50	Inpatient- Drug / Alcohol Treatment
F01.88	In patient Facility- Other
F01.99	Inpatient Facility- Unknown
F02	Outpatient facility
F02.03	Outpatient- Private Medical Practice
F02.04	Outpatient- HIV Specialty Clinic
F02.10	Outpatient- Prenatal/ OBGYN Clinic
F02.12	Outpatient- TB Clinic
F02.19	Outpatient- Drug / Alcohol Treatment Clinic
F02.20	Outpatient- Family Planning
F02.30	Outpatient- Community Mental Health
F02.51	Outpatient- Community Health Clinic
F02.58	Outpatient- School/University Clinic
F02.60	Outpatient- Health Department/Public Health Clinic
F02.61	Outpatient- Health Department/Public Health Clinic-HIV
F02.62	Outpatient- Health Department/Public Health Clinic-STD
F02.88	Outpatient Facility- Other
F02.99	Outpatient Facility- Unknown
F03	Emergency Room
F04.01	Blood Bank, Plasma Center
F04.05	HIV Counseling and Testing Site
F06	Community Setting
F06.01	Community Setting – AIDS Service Organization – non clinic
F06.02	Community Setting – School/Education Facility
F06.03	Community Setting – Church/Mosque/Synagogue/Temple
F06.04	Community Setting – Shelter/Transitional housing
F06.05	Community Setting – Commercial
F06.06	Community Setting – Residential
F06.07	Community Setting – Bar/Club/Adult Entertainment
F06.08	Community Setting – Public Area
F06.09	Community Setting – Workplace
F06.10	Community Setting – Community Center
F06.12	Individual Residence
F06.88	Community Setting – Other
F07	Correctional Facility
F88	Facility – Other

Please refer to this site type list when completing Part 1 until further notice!

Place Barcode Sticker Here

HIV TEST FORM

PART 2

Form Approved: OMB No. 0920-0696, Exp. Date 08/31/2010

CDC requires the following information on **confirmed positives**

Referrals

Was client referred to medical care?

- ○ Yes → If yes, did client attend the first appointment?
  - ○ Yes
  - ○ No
  - ○ Don't know
- ○ No → If no, why?
  - ○ Client already in care
  - ○ Client declined care

Was client referred to HIV Prevention services?

- ○ Yes
- ○ No

Was client referred to PCRS?

- ○ Yes
- ○ No

If female, is client pregnant?

- ○ Yes → If yes, in prenatal care?
  - ○ Yes
  - ○ No → If no, was client referred for prenatal care?
    - ○ Yes → If yes, did client attend first prenatal care appointment?
      - ○ Yes
      - ○ No
      - ○ Don't know
    - ○ No
  - ○ Don't know
  - ○ Declined
  - ○ Not asked
- ○ No
- ○ Don't know
- ○ Declined
- ○ Not asked

Local Use Fields

L3		L8		L13	
L4		L9		L14	
L5		L10		L15	
L6		L11		L16	
L7		L12		L17	

CDC Use Fields

C3		C6	
C4		C7	
C5		C8	

Notes (Print Only)

Public reporting burden of this collection of information is estimated to average 8 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-79, Atlanta, Georgia 30333; ATTN: PRA 0920-0696.

WHITE COPY = Scan YELLOW COPY = Record Keeping CDC 50.135b (E), 10/2007

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HIV TEST FORM

PART 2

Form Approved: OMB No. 0920-0696, Exp. Date 08/31/2010

CDC requires the following information on **confirmed positives**

Referrals

Was client referred to medical care?

- ⬭ Yes → If yes, did client attend the first appointment?
  - ⬭ Yes
  - ⬭ No
  - ⬭ Don't know
- ⬭ No → If no, why?
  - ⬭ Client already in care
  - ⬭ Client declined care

Was client referred to HIV Prevention services?

- ⬭ Yes
- ⬭ No

Was client referred to PCRS?

- ⬭ Yes
- ⬭ No

If female, is client pregnant?

- ⬭ Yes → If yes, in prenatal care?
  - ⬭ Yes
  - ⬭ No → If no, was client referred for prenatal care?
    - ⬭ Yes → If yes, did client attend first prenatal care appointment?
      - ⬭ Yes
      - ⬭ No
      - ⬭ Don't know
    - ⬭ No
  - ⬭ Don't know
  - ⬭ Declined
  - ⬭ Not asked
- ⬭ No
- ⬭ Don't know
- ⬭ Declined
- ⬭ Not asked

Local Use Fields

L3		L8		L13	
L4		L9		L14	
L5		L10		L15	
L6		L11		L16	
L7		L12		L17	

CDC Use Fields

C3		C6	
C4		C7	
C5		C8	

Notes (Print Only)

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HIV TEST FORM

PART 3

Form Approved: OMB No. 0920-0696, Exp. Date: 08/31/2010

CDC Centers for Disease Control and Prevention

HIV Incidence

Date information collected? (MMDDYYYY)

Date first positive HIV test: (MMDDYYYY)

Has client ever tested negative?
- Yes
- No
- Don't know
- Declined

Date last negative HIV test: (MMDDYYYY)

Number of tests in the two years before the current (or first positive) test. Include the current (or first positive) test.

1 (Current (or 1st positive) test) + [ ] (# of tests in the 2 years before the current (or 1st positive) test) = [ ]

Has client used or is client currently using antiretroviral medication (ARV)?
- Yes → If yes, specify antiretroviral medication? → [ ] [ ] [ ] [ ]
- No
- Don't know
- Declined

(See codes on reverse)

Date ARV began? (MMDDYYYY)

Date of last ARV use? (MMDDYYYY)

Public reporting burden of this collection of information is estimated to average 8 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-79, Atlanta, Georgia 30333; ATTN: PRA 0920-0696.

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HIV TEST FORM

PART 3

Form Approved: OMB No. 0920-0696, Exp. Date: 08/31/2010

CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

HIV Incidence

Date information collected? (MMDDYYYY)

Date first positive HIV test: (MMDDYYYY)

Has client ever tested negative?
- Yes
- No
- Don't know
- Declined

Date last negative HIV test: (MMDDYYYY)

Number of tests in the two years before the current (or first positive) test. Include the current (or first positive) test.

1 (Current (or 1st positive) test) + [ ] (# of tests in the 2 years before the current (or 1st positive) test) = [ ]

Has client used or is client currently using antiretroviral medication (ARV)?
- Yes → If yes, specify antiretroviral medication? → [ ] [ ] [ ] [ ] (See codes on reverse)
- No
- Don't know
- Declined

Date ARV began? (MMDDYYYY)

Date of last ARV use? (MMDDYYYY)

WHITE COPY = Scan YELLOW COPY = Record Keeping CDC 50.135c (E), 10/2007

Codes for Antiretroviral (ARV) medication(s)

22 Agenerase (amprenavir)
30 Aptivus (tipranavir, TPV)
32 Atripla (efavirenz/emtricitabine/tenofovir DF)
24 Combivir (lamivudine/ zidovudine, 3TC/AZT)
06 Crixivan (indinavir, IDV)
11 Emtriva (emtricitabine, FTC)
03 Epivir (lamivudine, 3TC)
28 Epzicom (abacavir/lamivudine, ABC/3TC)
25 Fortovase (saquinavir, SQV)
10 Fuzeon (enfuvirtide, T20)
19 Hepsera (adefovir)
02 Hivid (zalcitabine, ddC)
23 Hydroxyurea
18 Invirase (saquinavir, SQV)
16 Kaletra (lopinavir/ ritonavir)
31 Lexiva (fosamprenavir, 908)
07 Norvir (ritonavir, RTV)
33 Prezista (darunavir, DRV)
09 Rescriptor (delavirdine, DLV)
26 Retrovir (zidovudine, ZDV, AZT)
15 Reyataz (atazanavir, ATV)
08 Saquinavir (Fortavase, Invirase)
21 Sustiva (efavirenz, EFV)
13 Trizivir (abacavir/lamivudine/zidovudine, ABC/3TC,AZT)
27 Truvada (tenofovir DF/emtricitabine, TDF/FTC)
01 Videx (didanosine, ddl)
14 Videx EC (didanosine, ddl)
17 Viracept (nelfinavir, NFV)
05 Viramune (nevirapine, NVP)
12 Viread (tenofovir DF, TDF)
04 Zerit (stavudine, d4T)
21 Ziagen (abacavir, ABC)

88 Other
99 Unspecified

APPENDIX 4: SAMPLE TOOLS FOR RESPECT MONITORING AND EVALUATION

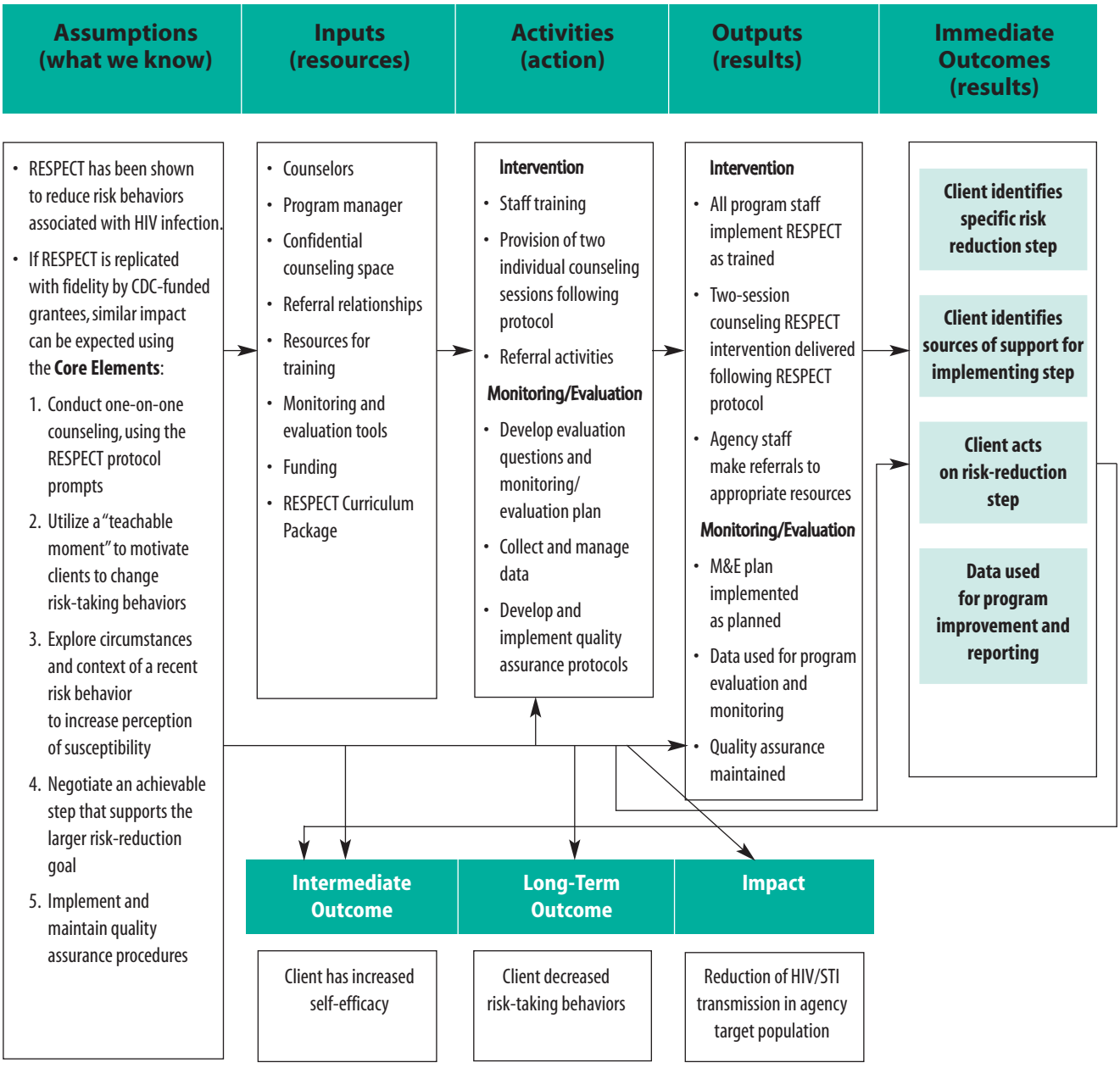
TOOL 1: MONITORING AND EVALUATION TASK LIST

Activity	Responsible Staff Person	Timeline	Achieved
DEVELOPING A MONITORING AND EVALUATION PLAN			
Develop a logic model (see Tool 2*)			Yes/No/NA
Develop evaluation questions			Yes/No/NA
Write SMART objectives (see Tools 4 & 5*)			Yes/No/NA
Complete a data planning matrix with your evaluation questions, objectives, measures, etc., including QA			Yes/No/NA
activities required for RESPECT (see Tools 6 & 7*)			Yes/No/NA
Develop and/or revise data collection forms (see Tool 8 & 9*)			Yes/No/NA
Develop a data management plan to guide data entry, cleaning and generation of reports (see Tool 11*)			Yes/No/NA
Develop data analysis plan (determine who will analyze the data, and what the frequency of data analysis will be). (see Tool 3*)			Yes/No/NA
IMPLEMENTING A MONITORING AND EVALUATION PLAN			
Complete session records (see Tools 8, 9 and 13			Yes/No/NA
Enter session records into PEMS or other database (see Tool 15)			Yes/No/NA
Monitor completion of counselor training and development (see Tools 10 and 12)*			Yes/No/NA
Conduct chart review			Yes/No/NA
Conduct client satisfaction survey (see Tool 14*)			Yes/No/NA
Compile data			Yes/No/NA
Conduct data analysis (see Tool 3*)			Yes/No/NA
Use data for program improvement			Yes/No/NA
Use data for reporting (see Tool 3)			Yes/No/NA

* A tool to assist with this task is available in this appendix. Please note that additional tools may be needed, or that you may need to modify the tool to fit your needs.

TOOL 2: SAMPLE RESPECT LOGIC MODEL

This logic model illustrates implementation of the RESPECT model with clients and components of an M&E plan. Be sure to tailor this to reflect your approach to implementing RESPECT



TOOL 3: RESPECT DATA ANALYSIS TOOL

This tool is a Microsoft Excel spreadsheet which summarizes the data variables you will need to collect for the following CDC reporting requirements: CDC Performance Indicators (highlighted in yellow) specific to an individual-level intervention and RESPECT-specific variables (highlighted in purple). It also includes data variables you can choose to collect that may be useful for local program monitoring and/or for those programs integrating RESPECT into a counseling, testing, and referral (CTR) program.

The tool also provides formulas to assist you in calculating the outcomes for your program (in a 'percentage' format). For example, you will report on the percentage of clients served who are from the target population you are trying to reach and engage in RESPECT. Likewise, you will report on the number of RESPECT clients who completed the intended number of sessions, identified a risk reduction step, and so forth. This tool is formatted as an Excel spread sheet for ease of use, and is designed for use by the Program Manager.

Because it is an Excel spreadsheet, **this tool does not lend itself to presentation in this document, and is included in the disk that was provided to you with this document**. Detailed instructions on use of the tool are provided at the top of the document.

TOOL 4: SMART TABLE

The table below contains a number of prompts that will assist you in developing SMART objectives. The list of terms shown in each column is not exhaustive. The last column shows some terms related to results or outcomes common to counseling interventions such as RESPECT.

1	2	3	4	5
Specific	**Measurable**	**Appropriate** Ask yourself the following questions:	**Realistic** Ask yourself the following questions:	**Time-phased**
• Provide • Recruit • Train • Deliver • Refer • Increase • Improve • Implement • Observe • Enhance • Raise • Develop • Revise • Complete • Decrease • Obtain	• Number • Average • Percentage (proportion) • Change over time _____ of _____ • Sessions • Referrals • Risk reduction steps • Perceived personal risk • Knowledge of HIV status • Tests • Program improvement • Counselor skill	• Is this objective related to the intervention goals? • Is this objective congruent with the target population's characteristics? • Is this objective in line with the core elements and key characteristics of RESPECT?	• Do your staff have the skill set/training to carry out the objective? • Do you have the resources to attain the objective? • Have you set achievable goals (reasonably high, but not impossible)? • Have other programs attained similar results? • Is your network of service providers adequate to support attaining this objective?	By the beginning/end of • the ____ session • the ____ week • the ____ month • the ____ quarter • the ____ year

Instructions: Use phrases from the table above to help you develop your SMART objectives and complete your data planning matrix.

Examples:
- 10 counselors will complete the RESPECT training by the end of the first quarter of this year.
- 95 percent of clients who complete session one of RESPECT will identify a risk reduction step by the end of the session.

TOOL 5: SAMPLE SMART OBJECTIVES FOR RESPECT

This tool provides sample SMART objectives specific to RESPECT. The samples below should be tailored to meet your agency's implementation of RESPECT.

ASSUMPTIONS

- The implementing agency has already assessed that RESPECT is appropriate for their setting/population.
- Core elements will be retained.
- Using formative evaluation methods, the RESPECT team has already identified key characteristic that need to be adapted to reflect target population, setting and resources, and sought Project Officer approval as needed.
- RESPECT can be implemented in one of three approaches, and objectives will need to be tailored accordingly by implementing agencies:
  - Fully integrated into counseling, testing and referral (CTR) or Comprehensive Risk Counseling and Services (CRCS), meaning CTR or CRCS are delivered to all clients using the RESPECT protocol;
  - Partially integrated into CTR or CRCS, meaning CTR or CRCS are delivered to a subset of clients and/or by a subset of counselors using the RESPECT protocol;
  - Stand-alone: RESPECT is implemented outside of a CTR or CRCS intervention.

PROCESS OBJECTIVES

Pre-Implementation Objectives

Developing a roll-out plan

1. By (date) an implementation plan for enrolling X proportion of eligible clients (as determined during implementation/planning stage above) will be developed.

Developing quality assurance, monitoring, and evaluation plan and systems

2. By (date), the RESPECT team will develop a monitoring and evaluation plan.

Planning Staff Training

3. By (date), X number of supervisors and X number of prevention staff will attend the RESPECT training.
4. By the end of the first year all counselors requiring continuing education in HIV counseling and testing will attend the needed training.

Full Implementation Objectives

Goal: Implement RESPECT with fidelity to the model, and in a manner appropriate for the agency's resources, community, and target population

Client Participation

5. At the end of each quarter the program manager will compare total eligible clients served by RESPECT to projected eligible clients.
6. By month three of the intervention, obtain feedback from clients and staff to assess barriers to reaching and serving the target population.
7. By (date) X percent of projected clients will be enrolled in RESPECT and meet the established eligibility criteria
8. X percent of RESPECT clients enrolled in RESPECT receive the second session.

8a. X percent of RESPECT HIV+ clients enrolled in RESPECT receive the second session.

Client Response to RESPECT Intervention/ Risk-Reduction Step

9. X percent of RESPECT clients will identify their own specific risk factor(s) for HIV by the end of the first session.
10. X percent of RESPECT clients will identify at least one achievable risk reduction step by the end of the first session.
11. X percent of RESPECT clients will identify a source of support during Session 1 or 2 for their stated risk reduction step

Testing (if not component of program)

12. X percent of RESPECT clients who are HIV-negative or status unknown and have reported not having an HIV test in the previous 3 months will receive a referral to CTR during the first RESPECT session.

Related Process Monitoring Evaluation Questions

- *Are we reaching the number of clients we expected to?*
- *Do clients who start RESPECT complete the intervention?*
- *Are testing and referral activities occurring as would be expected under our model?*
- *Are we reaching our intended target population?*
- *Are staff appropriately trained and supported to implement RESPECT?*
- *Are counselors following the protocol for delivery of RESPECT?*
- *Are we completing the required quality assurance activities?*
- *Are we addressing any problems we are having with implementation?*

Referral (for services other than testing)

13. X percent of clients participating in RESPECT who receive a positive HIV test result will be referred to an HIV care and treatment facility during the session in which the test result is delivered.
14. X percent of pregnant clients participating in RESPECT who receive a positive HIV test result will be referred to prenatal care during the session in which the test result is delivered.

Feedback

15. Input on needed improvements will be gathered from key staff and stakeholders within the first three months of project implementation.
16. By month four of the intervention the project team will make necessary changes/ enhancements to implementation based on data gathered from key staff and stakeholders.
17. At the end of each quarter the RESPECT team will identify needed changes to RESPECT implementation.

Quality Assurance

18. X percent of session observations required by the RESPECT observation schedule will be completed by the supervisor by the end of each quarter.
19. X percent of records reviewed as indicated in the RESPECT record review schedule will be completed by the program manager by the end of each quarter.
20. Case conferences will be held at least monthly, with an average of X percent of the RESPECT team staff in attendance each month.
21. X percent of new and X percent of experienced counselors will implement (on average) at least X percent of the RESPECT components during sessions observed each quarter.

IMMEDIATE OUTCOME OBJECTIVES

RESPECT Specific Outcome

1. X percent of RESPECT clients who report implementation of risk-reduction step at the second session.

Referral and Testing Outcomes

2. X percent of RESPECT clients referred for an HIV test during calendar year XXXX will receive an HIV test within X days of the RESPECT session in which the referral occurred. Note: Applies where tests are delivered by referral.
3. X percent of RESPECT clients will receive an HIV test during or immediately following the first RESPECT session. Note: Applies where tests are delivered directly.
4. X percent of RESPECT clients who receive an HIV test will receive their results within X days of the test being performed.

5. X percent of all HIV tests provided in calendar year XXXX will be newly identified, confirmed HIV-positive.
6. X percent of RESPECT clients with newly identified, confirmed HIV-positive tests during calendar year XXXX will be provided HIV test results within X days of the test being performed.
7. X percent of newly identified, confirmed HIV-positive RESPECT clients will access referral to HIV medical care within X days of the referral.
8. X percent of pregnant HIV-positive RESPECT clients will access referral to prenatal care within X days of referral.

TOOL 6: SAMPLE DATA PLANNING MATRIX

The data planning matrix links your SMART objectives with the evaluation questions in your monitoring and evaluation plan. For each evaluation question you have developed, the matrix can be completed to identify the measures and data sources you will use to answer each question, the person responsible for collecting the data, and the time frame for collection and analysis.

Note: Objectives in this Sample Data Planning Matrix are appropriate for RESPECT implemented alone, with counseling, testing, and referral (CTR), and with Comprehensive Risk Counseling and Services (CRCS), unless otherwise noted. All objectives are written as SMART objectives and can be found on Tool 5, Sample SMART Objectives for RESPECT.

DATA PLANNING MATRIX

Evaluation Question: ***Have we developed our implementation plan?***

Process Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data[1]	Timeframe for Collection/ Analysis
1. By (date) an implementation plan for enrolling X proportion of eligible clients (as determined during implementation/planning stage) will be developed.	Is plan developed? _____ Yes _____ No	Document review/ Copy of the plan	Project Manager	First month/First month/
2. By (date), the RESPECT team will develop a monitoring and evaluation plan.	Is M&E plan developed? _____ Yes _____ No	Document review/ Copy of the plan	Project Manager	First month/First month/

[1] The person who collects the data may or may not be the same person who enters the data into a database. If there are staff dedicated to data entry, this column can be split to reflect who will collect the data and who will enter the data. This SAMPLE matrix assumes that the Program Manager will be responsible for analyzing all data, and therefore doesn't specify who will analyze the data. If responsibility for analysis will vary by objective, this column could be modified to indicate both who will collect the data and who will analyze it.

Evaluation Question: ***Are staff appropriately trained?***

Process Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data	Timeframe for Collection/ Analysis
3. By (date) X number of supervisors and X number of prevention staff will attend the RESPECT training.	Staff attending RESPECT training	Document review/ Copy of the plan	Program Manager	At the end of first quarter. Afterwards, annually or quarterly after new staff are hired/ At the end of first quarter. Afterwards, annually or quarterly after new staff are hired.
4. By the end of the first year all counselors requiring continuing education in HIV counseling and testing attended the needed training.	Attendance by staff needing training at continuing education classes.	Document review/List of staff needing training, and staff training records	Program Manager	At the end of first quarter. Afterwards, annually or quarterly after new staff are hired/ At the end of first quarter. Afterwards, annually, or quarterly after new staff are hired.

Evaluation Question: ***Are we reaching the number of eligible clients we expected to?***

Process Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data	Timeframe for Collection/ Analysis
5. At the end of each quarter the program manager will compare total eligible clients served by RESPECT to projected eligible clients at the end of each quarter.	Total number of clients served and projected number of clients served.	Compare projected numbers to actual/Grant proposal and completed session record.	Program Manager	Ongoing (completion of session record forms)/ Quarterly.

Evaluation Question: ***Are we reaching our intended target population?***

Process Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data	Timeframe for Collection/ Analysis
6. By month three of the intervention, obtain feedback from staff to assess facilitators and barriers to reaching and serving the target population.	Frequency of facilitators/ barriers identified by staff.	Documentation of staff feedback/ Notes from meetings, key informant interviews, focus groups, etc.	Program Manager	Month three of each quarter/ End of first quarter, then annually
7. By (date) X percent of projected clients will be enrolled in RESPECT and meet the established eligibility criteria.	Projected clients /Total number of clients enrolled who meet eligigility criteria.	Document review / Grant proposal and intake/session record form or, if RESPECT integrated with testing, test form.	RESPECT Counselor	At the beginning of each session/Quarterly and annually

Evaluation Question: ***Do clients who start RESPECT complete the intervention?***

Process Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data	Timeframe for Collection/ Analysis
8. X RESPECT clients enrolled in RESPECT receive the second session.	Total number of clients who complete 2nd session/Total number of clients enrolled.	Tally records for enrollment and session completion/ Intake and Session Record forms.	RESPECT Counselor or Program Manager	Ongoing/Quarterly [2]
8a. By (date) X percent of projected clients will be enrolled in RESPECT and meet the established eligibility criteria.	Total number of HIV positive clients who complete 2nd session/Total number of HIV positive clients enrolled.	Tally records for enrollment and session completion/ Intake and Session record forms.	RESPECT Counselor or Program Manager	Ongoing/Quarterly [3]

[2] When quarterly reporting is done, it will be necessary to choose a cutoff date for data collection. For example, if your fiscal year is from July-June, you may want to report data from July 1-September 30 for the first quarter. When considering data cutoff dates, it is necessary to decide a priori which data will be included in the data set. For example, if the time period between Session 1 and Session 2 is one week, you may not want to include any Session 1 data for the last week in September because the data for Session 2 will be left out of the data set even though it may have been completed.

[3] When quarterly reporting is done, it will be necessary to choose a cutoff date for data collection. For example, if your fiscal year is from July-June, you may want to report data from July 1-September 30 for the first quarter. When considering data cutoff dates, it is necessary to decide a priori which data will be included in the data set. For example, if the time period between Session 1 and Session 2 is one week, you may not want to include any Session 1 data for the last week in September because the data for Session 2 will be left out of the data set even though it may have been completed.

Evaluation Question: ***Are clients participating in the intervention as intended?***

Outcome Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data	Timeframe for Collection/ Analysis
9. Percent of RESPECT clients who identify their own specific risk factor(s) for HIV by the end of the first session.	Number of clients who identified their own specific risk factor in first session/Total number of RESPECT clients receiving first session.	Review and tally of records for clients completing first session/Session Record forms.	RESPECT Counselor	Ongoing/Quarterly
10. X percent of RESPECT clients will identify at least one achievable risk reduction step by the end of the first session.	Number of clients who identified a risk reduction steps by end of the first session /Number of total RESPECT clients completing first session.	Review and tally records for clients completing first session/Session Record forms.	RESPECT Counselor or	Ongoing/Quarterly

Evaluation Question: ***Are clients participating in the intervention as intended?***

Outcome Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data	Timeframe for Collection/ Analysis
11. X percent of RESPECT clients who identify a risk reduction step by the end of the first session will report attempting the step by the second session.	Number of clients who identify a risk reduction step by the end of the first session/Number of clients who attempt the step by the second session.	Review and tally of records for clients completing second session/Session Record forms.	RESPECT Counselor	Ongoing/Quarterly
12. X percent of RESPECT clients will identify a source of support during Session 1 or 2 for their stated risk reduction step.	Number of clients who identify a source of support in Session 1 or 2/Total number clients who complete session 1.	Review and tally of records for clients completing first session/Session Record forms.	RESPECT Counselor	Ongoing/Quarterly

Evaluation Question: ***Are testing and referral activities occurring as would be expected under our model?***

Outcome Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data	Timeframe for Collection/ Analysis
13. X percent of RESPECT Session 1 clients who are HIV-negative or status unknown and have reported not having an HIV test in the previous 3 months will receive referral to CTR during the first RESPECT session. *Appropriate for: RESPECT alone, or RESPECT + CRCS (CRCS for negatives or unknown status.*	Total number of CTR referrals/ Total number of HIV-negative or status unknown clients who have reported not having an HIV test in the previous 3 months.	Review and tally of records for clients completing first session/ Session Record and/or intake and/or CTR forms (for internal referral).	RESPECT Counselor	Ongoing/Quarterly
14. X percent of clients participating in RESPECT who receive a positive HIV test result will be referred to an HIV care and treatment facility during the session in which the test result is delivered. *Appropriate for: RESPECT + CTR.*	Number of HIV-positive clients who received referral/Number of RESPECT clients with an HIV-positive test result.	Review and tally of records for clients with an HIV-positive test result/ Session Record and/or intake form.	RESPECT Counselor	Ongoing/Quarterly

Evaluation Question: ***Are testing and referral activities occurring as would be expected under our model?***

Outcome Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data	Timeframe for Collection/ Analysis
15. X percent of pregnant clients participating in RESPECT who receive a positive HIV test result will be referred to prenatal care during the session in which the test result is delivered. *Appropriate for: RESPECT +CTR.*	Total number of CTR referrals/ Total number of HIV-negative or status unknown clients who have reported not having an HIV test in the previous 3 months.	Review and tally of records for pregnant clients with an HIV-positive test result/ Session Record and/or intake form.	RESPECT Counselor	Ongoing/Quarterly

Evaluation Question: ***Are we addressing any problems we are having with implementation?***

Outcome Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data	Timeframe for Collection/ Analysis
16. Input on needed improvements will be gathered from key staff and stakeholders within the first three months of project implementation.	Input is gathered from key staff and stakeholders ___ Yes ___ No	Documentation of staff feedback/Notes from meetings, key informant interviews, focus groups, etc.	Program Manager	Month three/ Immediately following first quarter
17. By month four of the intervention, and quarterly thereafter, the RESPECT project team will make necessary changes/enhancements to RESPECT implementation based on data gathered from key staff and stakeholders.	Changes are made to RESPECT implementation based on feedback gathered.	List recommended changes and enhancements and changes made/Minutes from team meetings and/or Program Manager notes.	Program Manager	End of each quarter/ Immediately following end of each quarter

Evaluation Question: ***Are we completing the required quality assurance activities?***

Outcome Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data	Timeframe for Collection/ Analysis
18. X percent of session observations required by the RESPECT observation schedule will be completed by the end of each quarter.	Total number of session observations/Total number of recommended observations.	Document review/Staff training records.	Supervisor(s) & Program Manager	End of each quarter/ Immediately following end of each quarter
19. X percent of records reviewed as indicated in the RESPECT record review schedule will be completed by the Program Manager by the end of each quarter.	Total number of record reviews and frequency compared to schedule described in RESPECT curriculum.	Document review/ Calendar of record reviews.[4]	Program Manager	End of each quarter/ Immediately following end of each quarter

[4]Excel Workbook with pre-programmed formulas available in the Appendix.

Evaluation Question: ***Are we completing the required quality assurance activities? (cont.)***

Outcome Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data	Timeframe for Collection/ Analysis
20. Case conferences were held at least monthly, with an average of X percent of the RESPECT team staff in attendance each month. *Appropriate for: RESPECT alone, RESPECT + CTR, RESPECT + CRCS.*	Case conference requency and percent of staff in attendance.	Document review/ Case conference agenda and attendance records.	Program Manager	End of each quarter/ Immediately following end of each quarter

Evaluation Question: ***Are counselors following the protocol for delivery of RESPECT?***

Outcome Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data	Timeframe for Collection/ Analysis
21. X percent of new counselors will implement (on average) at least X percent of the RESPECT components during sessions observed each quarter.	Counselors are implementing X percent of RESPECT components by the time of their last observation.	Direct observation and record review and analysis [3]/ Session 1 and 2 Quality Assurance Form.	Counselors' Supervisor(s)	End of each quarter/ Immediately following end of each quarter
22. X percent of experienced counselors will implement (on average) at least X percent of the RESPECT components during sessions observed each quarter.	Counselors are implementing X percent of RESPECT components by the time of their last observation.	Direct observation and record review and analysis [3]/ Session 1 and 2 Quality Assurance Form.	Counselors' Supervisor(s)	End of each quarter/ Immediately following end of each quarter

Ooutcome Monitoring and Evaluation

DATA PLANNING MATRIX

Evaluation Question: ***Do clients returning for a second session report that they completed the risk-reduction step(s) that they identified in the first session?***

Outcome Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data	Timeframe for Collection/ Analysis
1. X percent of RESPECT clients report implementation of risk reduction step at the second session.	Number of RESPECT clients reporting implementation of the risk reduction step/ Total number of clients who completed Sessions 1 and 2.	Review and tally of records for second session/Session record form.	RESPECT Counselor	Ongoing/Quarterly

Evaluation Question: ***Are clients who are referred to a service, accessing it?***

Outcome Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data	Timeframe for Collection/ Analysis
2. X percent of RESPECT clients referred for an HIV test during calendar year XXXX will receive an HIV test within X days of the RESPECT session in which the referral occurred. *Appropriate for: RESPECT alone, or RESPECT + CRCS (CRCS for negatives or unknown status)*	Total number of clients who received test /Number of referred clients.	Review and tally of records for clients with HIV test/ Session Record form and referral records.	RESPECT Counselor	Ongoing/Quarterly
3. X percent of RESPECT clients will receive an HIV test during or immediately following the first RESPECT session. *Appropriate for: RESPECT + CTR.*	Total number of clients who received HIV test/Total number of RESPECT clients.	Review and tally of records for first session/CTR form, Session Record form.	RESPECT Counselor	Ongoing/Quarterly

Evaluation Question: ***Are clients who are referred to a service, accessing it?***

Outcome Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data	Timeframe for Collection/ Analysis
4. X percent of RESPECT clients who receive an HIV test will receive their results within X days of the test being performed. *Appropriate for: RESPECT + CTR.*	Number of clients who received results/Total number of clients tested.	Review and tally of records for clients with HIV test/ CTR form.	RESPECT Counselor	Ongoing/Quarterly
5. X percent of all HIV tests provided in the XXXX calendar year will be newly identified, confirmed HIV positive. *Appropriate for: RESPECT + CTR.*	Total number of confirmed HIV-positive tests among RESPECT clients/Total number of HIV tests provided to RESPECT clients.	Review and tally of records for clients with HIV tests/ CTR form.	RESPECT Counselor	Ongoing/Annually
6. X percent of RESPECT clients with a newly identified, confirmed HIV-positive test during the XXXX calendar year will receive their results within X days of the test being performed. *Appropriate for: RESPECT + CTR.*	Number of RESPECT clients who received confirmed positive test results/Total number of RESPECT clients with confirmed positive test.	Review and tally of records for clients with HIV tests/ CTR form.	Counselor	Ongoing/Annualy

Evaluation Question: ***Are clients who are referred to a service accessing it?***

Outcome Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data	Timeframe for Collection/ Analysis
7. X percent of newly identified, confirmed HIV-positive RESPECT clients that were referred to medical care who access care within X days of referral. *Appropriate for: RESPECT + CTR.*	Total number of HIV-positive clients who accessed medical care within X days of referral/ Total number of HIV-positive clients who were referred to care.	Review and tally of records for clients who are HIV positive/Session Record form or referral tracking form.	RESPECT Counselor	Ongoing/Quarterly
8. X percent of pregnant HIV-positive clients referred to prenatal care accessed care within X days of referral. *Appropriate for: RESPECT + CTR.*	Total number of HIV-positive clients who accessed medical care within X days of referral/ Total number of HIV-positive clients who were referred to care.	Review and tally of records for clients who are HIV positive and pregnant/ Session Record form or referral tracking form.	RESPECT Counselor	Ongoing/Quarterly

TOOL 7: BLANK DATA PLANNING MATRIX

The data planning matrix links your SMART objectives with the evaluation questions in your monitoring and evaluation plan. For each evaluation question you have developed, the matrix can be completed to identify the measures and data sources you will use to answer each question, the person responsible for collecting the data, and the timeframe for collection and analysis.

Instructions: All process and outcome objectives should be written as SMART objectives. Some evaluation questions will have more than one associated process or outcome objective. If there are not enough rows in this matrix, cut and paste the last blank row onto the table as many times as you need.

PROCESS MONITORING AND EVALUATION DATA PLANNING MATRIX				
Evaluation Question:				
Process Objective	**Measure(s)**	**Data Collection Method(s)/Source**	**Who Will Collect the Data[1]**	**Timeframe for Collection/ Analysis**
Evaluation Question:				
Process Objective	**Measure(s)**	**Data Collection Method(s)/Source**	**Who Will Collect the Data[1]**	**Timeframe for Collection/ Analysis**

[1] The person who collects the data may or may not be the same person who enters the data into a database. If there are staff dedicated to data entry, this column can be split to reflect who will collect the data and who will enter the data. This SAMPLE matrix assumes that the Program Manager will be responsible for analyzing all data, and therefore doesn't specify who will analyze the data. If responsibility for analysis will vary by objective, this column could be modified to indicate both who will collect the data and who will analyze it.

PROCESS MONITORING AND EVALUATION DATA PLANNING MATRIX

Evaluation Question:

Process Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data[1]	Timeframe for Collection/ Analysis

Evaluation Question:

Process Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data[1]	Timeframe for Collection/ Analysis

Evaluation Question:

Process Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data[1]	Timeframe for Collection/ Analysis

PROCESS MONITORING AND EVALUATION DATA PLANNING MATRIX

Evaluation Question:

Process Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data[1]	Timeframe for Collection/ Analysis

Evaluation Question:

Process Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data[1]	Timeframe for Collection/ Analysis

Evaluation Question:

Process Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data[1]	Timeframe for Collection/ Analysis

PROCESS MONITORING AND EVALUATION DATA PLANNING MATRIX

Evaluation Question:

Process Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data[1]	Timeframe for Collection/ Analysis

Evaluation Question:

Process Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data[1]	Timeframe for Collection/ Analysis

Evaluation Question:

Process Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data[1]	Timeframe for Collection/ Analysis

PROCESS MONITORING AND EVALUATION DATA PLANNING MATRIX

Evaluation Question:

Process Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data[1]	Timeframe for Collection/ Analysis

Evaluation Question:

Process Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data[1]	Timeframe for Collection/ Analysis

Evaluation Question:

Process Objective	Measure(s)	Data Collection Method(s)/Source	Who Will Collect the Data[1]	Timeframe for Collection/ Analysis

TOOL 8: SAMPLE RESPECT SESSION RECORD FORM

This tool provides an example of how the session record form would be completed for a fictional RESPECT session.

Client Unique ID: 1111

Counselor: *Betsy Smith*

RESPECT Target Group(s) to which client belongs: *women/heterosexual contact*

Session 1 Date: *March 27th, 2007*

Session 2 Date: *April 4th, 2007*

Indicate which **session stages** were completed:

SESSION 1	DONE (Y/N)	SESSION 2 NO TEST OR NEGATIVE TEST RESULT	DONE (Y/N)	SESSION 2 POSITIVE TEST RESULT	DONE (Y/N)
Introduce and orient client to the session	Y	Frame the session and orient the client	Y	Provide positive result	
Enhance the client's sense of self risk	Y	Give test result (if applicable)	Y	Identify sources of support and provide referrals	
Explore the most recent risk incident	Y	Review the risk-reduction step	Y	Address risk-reduction issues	
Review previous risk-reduction experience	Y	Revise the risk-reduction step	Y	Summarize	
Summarize risk incident & risk patterns	Y	Identify sources of support for the risk-reduction step	Y	Close the session	
Negotiate risk reduction stepp	Y	Provide referral	Y		
Identify sources of support & provide referrals	Y	Close the session	Y		
Close the session	Y				

Risk Reduction

Risk Behaviors (as client identified):
Meeting unknown men at clubs, parties, one night stands, unsafe sex; sex while high (cocaine and alcohol); minimal use of condoms - 1 out of 4 times; doesn't ask about either HIV status or request use of condoms.

Most Recent Risk Incident:
2 days earlier; sex with guy met at a club; didn't ask/use condoms; high.

Previous Risk Reduction Experiences:
Switch to more oral sex

Areas of Dissonance:
If knew partner had HIV would try to reduce risk, make different choices, yet isn't asking about status, use of condoms.

Issues Related to Risk Taking:
Use of drugs, club atmosphere makes her want to have sex
Uncomfortable with asking about condoms; lack of skills; "don't know what I'm supposed to do."

Agreed-Upon Risk-Reduction Step (Session 1): ***Talk to roommate about she handles guys/condoms; drinking less at the club; tell guy upfront about wanting to have safe sex; have condom with her and take out as a reminder.***

Source of Support for Risk-Reduction Step: **roommate**

Was Step Achieved (as reported in Session 2)? Yes **X** No
Talked with Lisa - found out she doesn't ask the guy to use, puts them on the guy herself; brought condoms with her; only made out with guy.

Revised Risk-Reduction Step (Session 2): ***Practice with condoms; asking Lisa for help with this; took condoms; consider seriously the referral for cocaine use after working on condom use.***

REFERRAL:

Date of referral: March 27, 2007 Referral Code: 1234

Referral to: Coke Anonymous

Accessed: Pending X _____ Yes _____ No _____

Date referral outcome confirmed: _____

TESTING:

In-House ___ X___ By Referral____

Test Outcome: Negative ____ X____ Positive ___ Indeterminate___

If Positive: Referred to HIV Medical Care? Yes___ No ___

Accessed: Pending ____ Yes ___ No____

Date referral outcome confirmed: _____

If positive and patient is female: Is patient pregnant? Yes ____ No ___

If yes, referred to prenatal care? Yes ___ No ___ Already in care ____

Accessed: Pending ___ Yes ___ No___

Date referral outcome confirmed: _____

* If using PEMS, these items should be captured using PEMS local variables.
All other information in the referral and testing sections of this form can be captured in PEMS using the referral activity or patient demographic screens.

TOOL 9: RESPECT SESSION RECORD FORM

The session record should be completed by RESPECT staff immediately following a RESPECT session. It captures which session stages and activities were achieved and will be helpful for documenting what was planned versus what was delivered. It can be kept in the client file for review prior to a subsequent session and used regularly as a data collection tool.

Client Unique ID: _____ Counselor: _____

RESPECT Target Group(s) to which client belongs: _____

Session 1 Date: _____ Session 2 Date: _____

Indicate which **session stages** were completed:

SESSION 1	DONE (Y/N)	SESSION 2 NO TEST OR NEGATIVE TEST RESULT	DONE (Y/N)	SESSION 2 POSITIVE TEST RESULT	DONE (Y/N)
Introduce and orient client to the session		Frame the session and orient the client		Provide positive result	
Enhance the client's sense of self risk		Give test result (if applicable)		Identify sources of support and provide referrals	
Explore the most recent risk incident		Review the risk-reduction step		Address risk-reduction issues	
Review previous risk-reduction experience		Revise the risk-reduction step		Summarize	
Summarize risk incident & risk patterns		Identify sources of support for the risk-reduction step		Close the session	
Negotiate risk reduction stepp		Provide referral			
Identify sources of support & provide referrals		Close the session			
Close the session					

Main Risk Behaviors (as client identified):
Most Recent Risk Incident:
Previous Risk Reduction Experiences:
Areas of Dissonance:
Issues Related to Risk Taking:

Agreed-Upon Risk Reduction step (Session 1):*_____

_____

Source of Support for Risk-Reduction Step:* _____

Was Step Achieved (as reported in Session 2)? * Yes ___ No___

Revised Risk-Reduction Step (Session 2): * _____

REFERRAL:

Date of referral: Referral Code:

Referral to:

Accessed: Pending Yes No

Date referral outcome confirmed:

TESTING:

In-House ___ ___ By Referral____

Test Outcome: Negative ____ ____ Positive ___ Indeterminate___

If Positive: Referred to HIV Medical Care? Yes___ No ___

Accessed: Pending ____ Yes ___ No____

Date referral outcome confirmed: _____

If positive and patient is female: Is patient pregnant? Yes ____ No ___

If yes, referred to prenatal care? Yes ___ No ___ Already in care ____

Accessed: Pending ___ Yes ___ No___

Date referral outcome confirmed: _____

* If using PEMS, these items should be captured using PEMS local variables.
All other information in the referral and testing sections of this form can be captured in PEMS using the referral activity or patient demographic screens.

TOOL 10: QUALITY ASSURANCE FIDELITY CHECKLIST

The QA check list has been formatted as an Excel spread-sheet. Upon completion, it will automatically calculate the % of RESPECT counseling components that have been implemented by providers in each RESPECT session. This summary tool makes it possible for supervisors to identify QA trends that can be addressed with individual providers or staff as a whole. To the extent to which consistent session components are not completed, training and supervision can be designed to improve the quality of counseling sessions. This tool is designed for use by supervisors.

Because it is an Excel spreadsheet, this tool does not lend itself to presentation in this document, and is included in the disk that was provided to you with this document. Detailed instructions on use of the tool are provided in the first sheet of this multi-sheet worksheet which is has yellow tab at the bottom labeled "Instructions."

TOOL 11: RESPECT QUALITY ASSURANCE TOOL

Supplemental Form

Counselor Name: _____ **Observer Name:** _____

Date of Observation: _____ **Client Number:** _____

Consider these questions immediately after the session and before meeting with the counselor, to assess what was achieved and determine main areas to discuss with the counselor.

Indicate the degree to which the counselor:

	ACCOMPLISHED FULLY	ACCOMPLISHED DURING MOST OF THE SESSION	ACCOMPLISHED DURING PART OF THE SESSION	NOT ACCOMPLISHED
Achieved all stages for this session				
Followed the correct sequence				
Used dissonance to support identification of risk reduction step				
Handled discomfort appropriately				
Used open and non-judgemental body language				

Explore jointly with the counselor:

- Aspects of the counseling session that were especially useful and reasons for their success, including specific strengths the counselor exhibited.
- Aspects of the counseling session that were challenging for the counselor and what made them challenging, as well as what might help the counselor address similar challenges in the future and alternative approaches that might have been used.
- Whether the counselor demonstrated different strengths and/or challenges in this session compared to past sessions. Are there any specific stages of the intervention which are more challenging for the counselor?
- What might facilitate covering all of the steps and stages, including:
  - Use of counselor cards
  - Client redirection
  - Exploring dissonance
  - Strengthening focus on the risk-reduction step (and limiting exploration of peripheral issues).
- One or two areas that the counselor can strengthen and a plan for doing so, such as additional one-on-one observation and coaching, more frequent observation, or additional opportunities for the counselor to observe more experienced counselors.
- Whether this session would be a good example for discussion during a case conference.

Encourage the counselor to:

- Identify a step or steps to continue building his/her knowledge and skills.

TOOL 12: PROVIDER TRAINING AND DEVELOPMENT WORKSHEET

This tool is formatted as an excel spreadsheet and can be used to track implementation of provider observations for each counselor. Upon completion, it will automatically calculate the percent of observations conducted so that supervisors can assess the extent to which they are following the required observation protocol detailed in the RESPECT implementation manual.

Because it is an Excel spreadsheet, this tool does not lend itself to presentation in this document, and is included in the disk that was provided to you with this document. Detailed instructions on use of the tool are provided in the first sheet of this multi-sheet worksheet which is has yellow tab at the bottom labeled "Instructions."

TOOL 13: SAMPLE CLIENT SATISFACTION SURVEY

Instructions: *This survey can be used to solicit feedback from clients on RESPECT, and specifically their experience with the counselor they saw. It should be adapted as needed for your agency and client base. It can be administered to each client at the end of each RESPECT session or on a periodic basis, such as several days or weeks out of each quarter.*

SURVEY INSTRUCTIONS: Please make an X in each row under the word that best describes your response to the statement on the left.

	STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE	NOT APPLICABLE
The administrative staff were courteous and answered any questions I had						
The counselor was clear about the objectives of the counseling session						
The counselor listened to the concerns I expressed						
The counselor I met with today treated me with respect						
The counselor avoided imposing his/her own values on me						
The counselor was sensitive to and accepting of my sexual orientation						
The counselor was sensitive to and accepting of my personal beliefs						
The session was conducted in the language I prefer speaking						
I found today's session to be useful						
The hours available for appointments were convenient						
I would recommend this counseling service to a friend						
I plan to return to meet with the counselor again						

TOOL 14: SAMPLE DATA MANAGEMENT PLAN

Instructions: ***This data management plan is for a fictitious agency.*** *This plan MUST be adapted to your agency. Your data management plan may also include a plan for formative evaluation, qualitative data, and/or client satisfaction data.*

This sample plan refers to forms that are part of the RESPECT intervention package (highlighted in green), forms included as tools in this guide (highlighted in pink), and other data management documents (highlighted in orange) that you may want to develop for your agency but that are not included in this guide.

Data Collection and Data Entry

Data collection of process and outcome variables: All clients will complete an intake form that will have a client Unique Identification (UID) number on it. The UID will be written on the **RESPECT Session Record** Form (Tool 9) that the counselor will use. The Intake Form will contain demographic information required for the NHM&E dataset, among other data. After the **Intake Form** is completed it will be entered into PEMS by data entry staff.

Each counselor will complete a **RESPECT Session Record Form** following a RESPECT session. Information from these forms will be entered into PEMS by data entry staff bi-weekly according to the organization's data entry rules.

Data collection of RESPECT quality assurance measures: Each supervisor will complete a **Quality Assurance Form** following a scheduled counselor observation. The supervisor will enter data into the **Quality Assurance Fidelity Checklist** (Tool 10), an Excel spreadsheet, to calculate the extent to which the RESPECT protocol is followed with fidelity. The date of each observation will be entered into the **Counselor Training and Development Worksheet** (Tool 12), an Excel spreadsheet, to calculate the extent to which the observation protocol is followed.

TIP

Data Management Plan and Data Management Protocols

A data management plan is one component of the data management protocols you'll need to put in place. The data management plan outlines the methods and the responsible party for collecting, entering, storing, and analyzing data and conducting quality assurance. In addition to the data management plan you will need to establish policies and procedures for storing, transporting, and/or disposing of data; to ensure confidentiality; and to ensure ongoing data quality. (See Data Management section in the *Evaluation Capacity Building Manual* for more information.)

Data Cleaning and Data Quality (QA) Measures

Data quality: All administrative staff, counselors, and data entry staff will be trained on how to use all data collection forms and the process for utilizing the forms. Intake staff will check the **Intake Form** for completeness and ask clients to complete any incomplete fields. Data entry staff will check the **Session Record Form** and HIV Test Form for missing data and confer with the appropriate counselor to fill in the data. Monthly QA reports will be run using PEMS reports function to identify missing data from the database and every effort will be made to enter missing data from completed forms. According to your RESPECT **data review protocol**, a designated percentage of all active charts in the previous week will be checked against data in PEMS.

Data Analysis

Data analysis plan: Monthly, the program manager will do data analysis. Data from the PEMS 'Planned vs. Delivered Report, PEMS Referrals Made Report, and the PEMS Data Extract for Client Session Information Local Variables will be hand-keyed in the **RESPECT Data Analysis Tool** (Tool 3) and calculated. Quality assurance data will be calculated in the **Quality Assurance Fidelity Checklist** (Tool 10) monthly by supervisors.

Reporting Data

Appropriate data from the **RESPECT Data Analysis Tool** and the **Quality Assurance Fidelity Checklist** will be included in the CDC Interim Progress Report and Annual Progress Report.

Data Utilization for Program Improvement

Monthly, data from the **RESPECT Data Analysis Tool** and the **Quality Assurance Fidelity Checklist** will be shared with all RESPECT staff. The data will answer the process monitoring questions. Staff will have the opportunity to recognize program objectives that have been met, identify any implementation issues, and discuss ways to improve program implementation during monthly staff meetings.

Storage and Destruction of Paper Forms

All forms containing client information will be stored in a locked file cabinet in a locked room. Counselors, supervisors, and data entry staff will all have key access to the room and file cabinet. Forms will be stored for a minimum of 5 years. After 5 years, they will be destroyed using a paper shredder and discarded.

TOOL 15: NHM&E VARIABLES FOR RESPECT

This tool describes the NHM&E variables that should be collected for RESPECT and indicates for each variable the PEMS software module and sub-module where it is found.

PROGRAM INFORMATION

PEMS SOFTWARE MODULE AND SUB-MODULE	NHM&E DS VARIABLE NUMBER	VARIABLE NAME	GUIDANCE
	TABLE D: PROGRAM NAME - PLANNING		
PROGRAM INFORMATION/ PROGRAM DETAILS	D01	Program Name	Enter the name your organization uses to identify the overarching program under which RESPECT resides. This may be your Counseling and Testing Program, or a program with multiple Health Education/Risk Reduction interventions, or RESPECT may be its own program. It is a good idea to add the year to the Program Name, since programs must be set up annually and you'll want to be able to distinguish them easily.
	D02	Community Planning Jurisdiction	Enter the CDC directly funded state, territory, or city health department Community Planning Jurisdiction in which RESPECT will be delivered.
	D03	Community Planning Year	Enter the calendar year within the Comprehensive HIV Prevention Community Plan for the Community Planning Jurisdiction that guides how RESPECT will be implemented. Usually this is the same year in which you begin program implementation.
	TABLE E1: PROGRAM MODEL AND BUDGET - PLANNING		
PROGRAM INFORMATION/ PROGRAM MODEL DETAILS	E101	Program Model Name	Enter the name your agency uses for the RESPECT intervention. It may be the same as the program name you entered for D01, Program Name, or different. **Note:** If you are implementing RESPECT within a Counseling, Testing, and Referral (CTR) program, with a subset of your target population, you might have one program (CTR) with two program models (CTR RESPECT and CTR).
	E102	Evidence Base	The evidence base is the research study that has proven an intervention is effective. For RESPECT, choose Code 2.02, Project RESPECT.
	E103	CDC Recommended Guidelines	In PEMS you choose between Evidence Base (E102), CDC Recommended Guidelines (E103), and Other Basis for Program model (E104). Because you have chosen RESPECT in E102, you will not select E103.
	E104	Other Basis for Program Model	In PEMS you choose between Evidence Base (E102), CDC Recommended Guidelines (E103), and Other Basis for Program model (E104). Because you have chosen RESPECT in E102, you will not select E104.
	E105	Target Population	Enter the population (or populations) you have decided will be eligible to receive RESPECT. Select from the list of priority populations that have been identified for your Community Planning Jurisdiction. If your eligible population is not represented in this list, you must add that target population through the "Additional Target Populations" sub-module before entering information into the Program Model Details sub-module.
	E107	Program Model Start Date	Enter the start date (month and year) of the annual funding period for this program model.
	E108	Program Model End Date	Enter the end date (month and year) of the annual funding period for this program model.
	E109	Proposed Annual Budget	Enter the annual budget for RESPECT using CDC/DHAP funds.

PEMS SOFTWARE MODULE AND SUB-MODULE	NHM&E DS VARIABLE NUMBER	VARIABLE NAME	GUIDANCE
	TABLE F: INTERVENTION PLAN CHARACTERISTICS		
PROGRAM INFORMATION/ PROGRAM DETAILS	D01	Program Name	Enter the name your organization uses to identify the overarching program under which RESPECT resides. This may be your Counseling and Testing Program, or a program with multiple Health Education/Risk Reduction interventions, or RESPECT may be its own program. It is a good idea to add the year to the Program Name, since programs must be set up annually and you'll want to be able to distinguish them easily.
	D02	Community Planning Jurisdiction	Enter the CDC directly funded state, territory, or city health department Community Planning Jurisdiction in which RESPECT will be delivered.
	D03	Community Planning Year	Enter the calendar year within the Comprehensive HIV Prevention Community Plan for the Community Planning Jurisdiction that guides how RESPECT will be implemented. Usually this is the same year in which you begin program implementation.
	E101	Program Model Name	Enter the name your agency uses for the RESPECT intervention. It may be the same as the program name you entered for D01, Program Name, or different. **Note:** If you are implementing RESPECT within a Counseling, Testing, and Referral (CTR) program, with a subset of your target population, you might have one program (CTR) with two program models (CTR RESPECT and CTR).
	E102	Evidence Base	The evidence base is the research study that has proven an intervention is effective. For RESPECT, choose Code 2.02, Project RESPECT.
	E103	CDC Recommended Guidelines	In PEMS you choose between Evidence Base (E102), CDC Recommended Guidelines (E103), and Other Basis for Program model (E104). Because you have chosen RESPECT in E102, you will not select E103.
	E104	Other Basis for Program Model	In PEMS you choose between Evidence Base (E102), CDC Recommended Guidelines (E103), and Other Basis for Program model (E104). Because you have chosen RESPECT in E102, you will not select E104.
	E105	Target Population	Enter the population (or populations) you have decided will be eligible to receive RESPECT. Select from the list of priority populations that have been identified for your Community Planning Jurisdiction. If your eligible population is not represented in this list, you must add that target population through the "Additional Target Populations" sub-module before entering information into the Program Model Details sub-module.
	E107	Program Model Start Date	Enter the start date (month and year) of the annual funding period for this program model.
	E108	Program Model End Date	Enter the end date (month and year) of the annual funding period for this program model.
	E109	Proposed Annual Budget	Enter the annual budget for RESPECT using CDC/DHAP funds.

PEMS SOFTWARE MODULE AND SUB-MODULE	NHM&E DS VARIABLE NUMBER	VARIABLE NAME	GUIDANCE
PROGRAM INFORMATION/ PROGRAM DETAILS	**TABLE F OPTIONAL VARIABLES**		
	F10	Activity	PEMS allows you to select actions or components that you plan as part of the RESPECT session. Some of the activities expected to be part of a RESPECT session, such as "identification of an achievable risk reduction step" are not included in the list. By including activities in the intervention characteristics you will be able to compare what you planned with what actually happens. The following activities could be included: **Session 1:** Code 04.00 Referral; Code 05.00 Personalized Risk Assessment; Code 10.03 Practice – Negotiation/Communication; Code 10.04 Practice – Decision Making; Code 11.18 discussion – Negotiation/Communication; Code 11.19 Discussion – Decision making; Code 88 – Other (specify) to indicate that a client identified an achievable risk reduction step. **Session 2:** The same activities might apply. **Note:** Review the full list in the NHM&E DS to determine which other activities should be included.
	F15	Duration of Intervention Cycle	If you know the total number of RESPECT cycles you plan to deliver and the time frame in which you expect the two sessions to be completed, indicate the total time you expect it to take to complete the cycle in months or days. **Note:** you cannot complete this variable if you chose "Ongoing" for F07 (Planned Number of Cycles).
	F16	Unit of Duration	Specify the time frame you expect it to take to complete the cycle in Month(s) or Day(s)

PEMS SOFTWARE MODULE AND SUB-MODULE	NHM&E DS VARIABLE NUMBER	VARIABLE NAME	GUIDANCE
	TABLE G: CLIENT CHARACTERISTICS - DEMOGRAPHIC		
CLIENT LEVEL SERVICES/ INTERVENTIONS	G101	Date Collected	Enter the date you collected client demographic data from the client – usually the date of intake.
	G102	PEMS Client Unique Key	EMS automatically generates a unique ID. If you use locally generated IDs you can enter them as well (Optional Variable G103).
	G112	Date of Birth - Year	Enter the year in which the client was born. Note that there are optional variables for the client's day and month of birth.
	G113	Calculated Age	This value does not have to be entered. It is calculated by the system.
	G114	Ethnicity	Enter the client's self-report of whether they are of Hispanic or Latino origin, using standard OMB codes. This variable is particularly important if ethnicity is an eligibility criterion for your RESPECT program.
	G116	Race	Enter the client's self-reported race, using standard OMB race codes for the value choices. More than one value can be selected. This variable is particularly important if race is an eligibility criterion for your RESPECT program.
	G120	State/Territory of Residence	Enter the state, territory, or district where the client is living at the time of intake.
	G123	Assigned Sex at Birth	Enter the biological sex assigned to the client at birth (i.e., noted on the birth certificate).
	G124	Current Gender	Enter the client's self-reported sexual identity.

PEMS SOFTWARE MODULE AND SUB-MODULE	NHM&E DS VARIABLE NUMBER	VARIABLE NAME	GUIDANCE
CLIENT LEVEL SERVICES/ INTERVENTIONS	**TABLE G OPTIONAL VARIABLES**		
	G103	Local Client Unique Key	This field may be used to enter client IDs you generate and utilize locally.
	G105 G106 G107 G108 G109	Last Name First Name Middle Initial Nick Name Aliases	These fields may be used to enter the client's name or nickname, to more readily identify the client.
	G110	Date of Birth - Month	Enter the calendar month in which the client was born.
	G111	Date of Birth - Day	Enter the calendar day in which the client was born.
	G128 G136	Locating Information	These variables can be used to capture the current address and phone number of the client.

PEMS SOFTWARE MODULE AND SUB-MODULE	NHM&E DS VARIABLE NUMBER	VARIABLE NAME	GUIDANCE
	TABLE G: CLIENT CHARACTERISTICS – RISK PROFILE		
SERVICES/ RISK PROFILE	G200	Date Collected	Enter the date client risk profile data are collected. For RESPECT, this could be the date of intake.
	G204	Previous HIV Test	Enter the client's self-report of whether or not he/she has had at least one HIV test before the day the risk profile data were collected.
	G205	Self-Reported HIV Test Result	If the client reports having a previous HIV test, enter the client's self-reported result.
	G208	In HIV Medical Care/Treatment (Only if HIV+)	If a client reports having tested HIV+, enter his/her self-report of whether or not he/she is receiving HIV medical care and treatment.
	G209	Pregnant (Only if female)	For female clients who have tested HIV+, this variable captures self-reported pregnancy status.
	G210	In Prenatal Care (Only if pregnant)	If a woman is pregnant and HIV+, enter her self-report of whether she is receiving regular health care during pregnancy.
	G211	Client Risk Factors	All of the activities the client has been involved in during the last year that could potentially put him/her at risk for HIV exposure and/or transmission can be entered here. These include injection drug use, sex with transgender, sex with female, sex with male, no risk identified, not asked, refused to answer, other (specify).
	G212	Additional Client Risk Factors	If a client's risk factors include sexual activity, this variable allows for entry of additional risk factors that can further describe the client's sexual risk for HIV exposure. There are 12 values to choose from.
	G213	Recent STD (Not HIV)	This variable capture's the client's self-reported or laboratory confirmed status of having been diagnosed with syphilis, gonorrhea, or Chlamydia.

PEMS SOFTWARE MODULE AND SUB-MODULE	NHM&E DS VARIABLE NUMBER	VARIABLE NAME	GUIDANCE
SERVICES/ RISK PROFILE	**TABLE G OPTIONAL VARIABLES**		
	G201	Incarcerated	This field may be used to enter client IDs you generate and utilize locally.This variable captures whether or not the client is or has been imprisoned (in jail or in a penitentiary).
	G202	Sex Worker	This variable indicates whether the client derived some or part of his/her income from engaging in sexual intercourse in the 90 days prior to data collection.
	G203	Housing Status	This variable captures the client's housing status in the 90 days prior to data collection.
	G210a	Local Recall Period	The default recall period (time that a client is asked to recall his/her risk behaviors) is 12 months. If a different recall period is used locally, that period can be indicated here and all of the risk indicators for both the default and local recall periods will be captured.
	G214	Injection Drugs/ Substances	This variable allows you to indicate which drugs/substances the client reports having injected during the recall period.

PEMS SOFTWARE MODULE AND SUB-MODULE	NHM&E DS VARIABLE NUMBER	VARIABLE NAME	GUIDANCE
	TABLE H: CLIENT INTERVENTION CHARACTERISTICS		
CLIENT LEVEL SERVICES/ INTERVENTIONS	H01	Intervention Name/ID	Select the intervention name that you created for RESPECT in the Program Information module (F02, Intervention Name/ID).
	H01a	Cycle	Because RESPECT has an ongoing number of cycles, do not complete this variable.
	H05	Session Number	Indicate whether the client is participating in Session 1 or Session 2 of RESPECT.
	H06	Session Date – Month	Enter the calendar month in which the session was delivered to the client.
	H07	Session Date – Day	Enter the calendar day in which the session was delivered to the client.
	H08	Session Date – Year	Enter the calendar year in which the session was delivered to the client.
	H10	Site Name/ID	Enter the official name of your agency's site where RESPECT was delivered.
	H13	Recruitment Source	This variable allows you to track how clients become aware of and enroll in RESPECT, including from agency referral, health information/public information campaigns, etc.
	H18	Recruitment Source - Service/ Intervention Type	If the client came to you via agency referral, this variable allows you to indicate the type of intervention the client was referred from, such as counseling and testing, outreach, etc.
	H21	Incentive Provided	This variable captures whether the client received any type of compensation for his/ her time and participation in the session.
	H22	Unit of Delivery	This variable captures whether the session was provided to one person at a time, to a couple, or to a group. For RESPECT, Code 01, Individual, should be selected.
	H 23	Delivery Method	This variable captures how the session was delivered. For RESPECT, Code 01.00, In Person, should be selected. Additional modes of delivery can also be selected.

PEMS SOFTWARE MODULE AND SUB-MODULE	NHM&E DS VARIABLE NUMBER	VARIABLE NAME	GUIDANCE
PROGRAM INFORMATION/ PROGRAM DETAILS	**TABLE H OPTIONAL VARIABLES**		
	H109	Worker ID	This variable allows you to choose from a list of workers to indicate the counselor who delivered the RESPECT session. Workers must be entered into the Agency Information module, Workers sub-module, to appear on the list. If this variable is completed you will be able to run reports by worker on how RESPECT is being implemented.
	H20	Activity	This variable allows you to capture the activities in which the client participated, and compare the activities provided to those planned. In addition to planned activities, you can choose activities which were provided but not planned to be delivered.
	LV01-LV32	Local Variables	Local Variables can be defined by each agency to capture client or session information not otherwise captured in PEMS. These variables are not entered as part of the program plan, but are captured at the time session information is recorded. For RESPECT, local variables could be used to capture information about whether or not a client: • Identified his/her own specific risk factor for HIV • Expressed intent to implement a risk reduction step • Identified a source of support for a risk reduction step • Reported implementation of a risk reduction step Information entered into the local variable fields may be alphabetic and/or numeric and may be up to 2000 characters per Local Variable.

PEMS SOFTWARE MODULE AND SUB-MODULE	NHM&E DS VARIABLE NUMBER	VARIABLE NAME	GUIDANCE
	TABLE X7: REFERRAL		
CLIENT LEVEL SERVICES/ REFERRALS	X701 or X701a	PEMS Referral Code or Local Referral Code	The PEMS system can be used to generate a unique referral code that will help to track internal client referrals and referrals to other agencies. This code facilitates tracking the outcome of the referral. A local referral code may also be used.
	X702	Referral Date	Enter the date on which the referral was made for the client, typically the date of the RESPECT session.
	X703	Referral Service Type	Select the service to which the client was referred. Internal or external referrals to HIV testing are tracked here, as are referrals to support the client's selected risk reduction step.
	X706	Referral Outcome	This variable captures the status of the referral and can be updated as more information is gathered. The system will automatically change the outcome to "lost to follow-up" if the referral status is "pending" more than 60 days after the referral date.
	X710	Referral Close Date	Enter the date when the outcome of the referral was confirmed or lost to follow-up. The system will automatically close the referral 60 days after the referral date.