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ABSTRACT
South Africa urgently needs HIV prevention interventions that can be disseminated for use in clinical and community settings. A brief theory-based HIV risk reduction counselling intervention originally developed in the USA has recently been adapted for use in a South African sexually transmitted infection clinic. The 60-minute risk reduction counselling intervention was grounded in the Information-Motivation-Behavioural Skills (IMB) model of HIV preventive behaviour change, adapted through a series of interdisciplinary collaborative workshops. This paper reports the process of developing and culturally adapting the brief risk reduction counselling intervention. The processes used for adapting the HIV risk reduction counselling for South Africa provides a potential model for conducting technology transfer activities with other HIV prevention interventions. Several lessons learned from this process may help guide future efforts to transfer HIV prevention technologies.

Keywords: HIV/AIDS prevention counselling, HIV/AIDS risk reduction, clinic-based intervention, South Africa.

RÉSUMÉ
L’Afrique du Sud a un besoin urgent des interventions préventives du VIH qui pourraient être répandues utilisées dans des centres médicaux et des communautés. Une brève intervention théorie-basée de réduction de risque du VIH par consultation qui a été développée aux États-Unis fut récemment adaptée pour usage dans des centres médicaux sud-africains des infections sexuellement transmises. L’intervention par consultation de réduction de risque qui dure 60 minutes a bien été fondée sur le modèle Information-Motivation-Compétence Comportementales (IMB) du changement de comportement préventive du VIH, adaptée à travers une série des ateliers de collaborations interdisciplinaires. Cette communication présente un rapport du processus de développer et d’adaptation culturelle de la brève intervention par consultation de réduction de risque. Le processus utilisé afin d’adapter la consultation de réduction de risque du VIH pour l’Afrique du Sud pourvoit un modèle potentiel pour mener les activités de transfert de technologie avec d’autres interventions de prévention du VIH. Les nombreuses leçons tirées de ce processus pourraient diriger les futurs efforts de transférer les technologies de prévention du VIH.

Mots clés: développement, consultation de réduction de risque de VIH, centres médicaux des infections sexuellement transmises, l’Afrique du Sud.

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In the Republic of South Africa, where as many as one in five people in urban and peri-urban areas are infected with HIV, there have been few empirically tested HIV prevention efforts directed at adults (Shisana & Simbayi, 2002). HIV prevention interventions are most often developed for adolescents in schools, such as life skills and peer education programmes. AIDS prevention messages have also been delivered to the masses in South Africa by way of large- and small-scale media campaigns such as loveLife, Soul City and Khomanani. Intensive behaviour change HIV risk reduction interventions are therefore needed to reach adults and out-of-school youth who are at highest risk for HIV transmission.

The risk reduction counselling intervention described here showed promising effects when tested for potential efficacy in a randomised trial (Simbayi et al., 2004). The content and process of the risk reduction counselling, as well as its cultural tailoring and local adaptation, have not yet been described. The goal of this paper is to provide a detailed account of the development of a potentially effective HIV risk reduction counselling intervention adapted for use in South African clinics. First, we review the public health rationale for brief individual risk reduction counselling for HIV prevention. We then describe the developmental process, content, and implementation strategies for the adapted and tested risk reduction counselling intervention. We conclude by discussing lessons learned from our experience in this research.

Rationale for brief HIV risk reduction counselling interventions

Carefully controlled randomised clinical trials (RCT) have demonstrated that relatively brief and concentrated HIV risk reduction counselling interventions can reduce HIV-related risk behaviours and sexually transmitted infections (Kalichman, DiFonzo, Kyomugisha, Simpson, Presser, & Bjordstrom, 2001; National Institutes of Health Panel, 1997). Among the most convincing studies in support of brief HIV risk reduction counselling was the US Centers for Disease Control and Prevention’s (CDC’s) Project Respect that showed that participants in the brief two- session risk reduction counselling intervention had a 30% reduction in new STIs over 6 months’ follow-up and a 20% reduction over 12 months’ follow-up, compared with participants receiving clinician delivered didactic information messages. Studies of risk reduction counselling in the context of HIV testing have also shown positive outcomes in Africa (Allen, Tice, Van de Perre, Serufilira, Hudes, Nsengumuremyi et al., 1992; VCT Efficacy Study Group, 2000).

Unfortunately, in South Africa only one in five HIV infected persons has been tested for HIV (Shisana & Simbayi, 2002) and as many as half of STI clinic patients do not accept HIV counselling and testing (Kalichman & Simbayi, 2003). Similar results have recently been found in a national population-based survey of South African youth (Pettifor, Rees, Steffenson, Hlongwa-Madkizedla, Macphail, Vermaak et al., 2004). To reach those at highest risk for HIV infection and HIV transmission, including individuals who are HIV-positive but have not been tested, risk reduction counselling should be available to people at risk regardless of whether they accept an HIV antibody test.

In a test of a brief HIV risk reduction counselling intervention delivered independent of HIV testing in the USA, Belcher, Kalichman, Topping, Smith, Emshoff, Norris et al. (1998) showed that a single 2-hour risk reduction counselling session effectively reduced high-risk sexual practices among women at risk for HIV and other STIs. Women recruited from an inner-city neighbourhood in Atlanta, Georgia (USA) were screened for high-risk behaviour and randomly assigned to one of two conditions: (a) a 2-hour HIV risk reduction counselling session, or (b) a 2-hour contact matched HIV information education session. The HIV risk reduction counselling was based on cognitive and behavioural skills training models for HIV risk reduction and the comparison intervention delivered information about HIV without the motivational and skills building components. Outcomes from this study showed that women in the HIV risk reduction counselling condition...
demonstrated significantly less unprotected vaginal intercourse and greater condom use than women in the comparison condition. Condom use increased from 22% of vaginal intercourse occasions protected at baseline to 66% at the 3-month follow-up for women in the HIV counselling condition, compared with an increase of 27 - 43% for women in the control condition. This study demonstrated significant effects of a single 2-hour session HIV risk reduction counselling intervention with effect sizes comparable with those found in interventions of much greater duration, participant and resource burden, and expense.

Another study has experimentally evaluated the components of a brief HIV risk reduction counselling project conducted in a US city STI clinic. Based on the Information-Motivation-Behavioural Skills (IMB) model of risk behaviour change (Fisher & Fisher, 1992; 2000), the study was designed to deconstruct the independent and interactive effects of prevention education, motivational enhancement, and risk reduction behavioural skills (Kalichman et al., 2005). Men and women receiving STI clinic services were randomly assigned to one of four 90-minute HIV risk reduction counselling interventions: information-educational counselling; information-education counselling + motivational enhancement counselling; information-education + behavioural skills training; or information-education, motivational enhancement, and behavioural skills training combined. Results showed that the full IMB risk reduction counselling model reduced rates of unprotected intercourse, increased use of risk reduction behavioural strategies, and reduced rates of new STIs over 1 year among men relative to the men in the other three intervention conditions. For women, however, the information-motivational enhancement counselling session demonstrated lower rates of unprotected intercourse and greater use of risk reduction strategies over the follow-up period. These findings support the potential effects of brief theory-based risk reduction counselling in STI clinic contexts.

The risk reduction intervention project described in this article was initiated to meet the need for a brief risk reduction counselling intervention for use with people who may or may not refuse HIV VCT in South African STI clinics. We first conducted preliminary intervention development activities to formulate a theoretical model from which a risk reduction counselling session could be derived. Our objective was to develop a theory-based HIV risk reduction intervention for South African men and women who are receiving STI diagnostic and treatment services. The intervention was based on a model of HIV prevention that was derived from the IMB model of health behaviour change integrated with contextual factors identified as relevant in South Africa.

The Phaphama risk reduction counselling intervention

In the research described here, we designed a single 60-minute risk reduction counselling session for use in South African STI clinics. The intervention was named Phaphama, a Xhosa word meaning ‘be wise’. Following its development (described in the sections that follow), we conducted a randomised trial to test the potential efficacy of the Phaphama risk reduction counselling intervention (see Simbayi et al., 2004 for the complete study outcomes).

The Phaphama risk reduction counselling intervention development was guided by the Information-Motivation-Behavioural Skills (IMB) model of AIDS preventive behaviour (Fisher & Fisher, 1992; 2000). The IMB model states that information about HIV transmission is a necessary precursor to risk reduction. Motivation to change, however, also directly affects whether one acts on information about risk and risk reduction. Finally, the IMB model holds that behavioural skills related to preventive actions represent a final common pathway for information and motivation to result in AIDS preventive behaviour change. The IMB model proposes that information and motivation activate behavioural skills to ultimately engage in risk reduction behaviours. Behavioural skills become increasingly important when preventive actions require complex skills, such as condom use, communicating about risk and risk reduction with a partner, or refusing unprotected intercourse. The IMB model is flexible and allows for the integration of risk reduction components with contextual and population-specific factors, such as gender attitudes and internalised stigmas. In addition, there is strong empirical evidence in support of the IMB model, particularly as a heuristic for HIV risk reduction interventions (Fisher & Fisher, 2000).

It is, of course, implausible to transplant HIV risk reduction models, including the IMB model, that have
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been demonstrated useful in the US and Europe for use in South Africa. Traditional and contemporary representations of health and illness in South Africa differ markedly from Western perspectives. Gender power differentials also create a different risk context in South Africa as do AIDS stigmas and poverty. In South Africa, HIV prevention efforts occur in a context of 11 - 20% population HIV prevalence. The history of apartheid also creates a unique context for HIV/AIDS, as prevention activities must be adapted to multiple racial groups living in communities that remain relatively isolated from each other. For these and other reasons, it is essential that theory-based HIV risk reduction models be reconstructed and culturally translated for South Africa.

Our approach to adapting the IMB model for use in South Africa was first to conduct formative research with members of targeted communities. We then formed an interdisciplinary collaborative working group to develop the intervention content. Counselors were then trained for implementing the intervention within the context of a randomised study design.

**Formative research activities**

At the start of the formative research, the primary collaborators met with 24 community health workers at a township community centre in Cape Town. Participants in this community meeting were all actively involved in AIDS-related community services. The community health workers were concerned about increases in sexual violence and substance use as well as increases in AIDS cases. We learned that young adults in the township are at considerable risk for HIV, including early age of first intercourse and serial sexual relationships. HIV risk behaviours occur in a context of poverty, co-occurring STIs and HIV prevalence of 20%. The community workers were very enthusiastic about potential interventions to reduce HIV risk behaviours. They saw risk reduction counselling as an important service and believed that counselling offers opportunities for HIV prevention. The health workers and advocates who participated in the community meeting offered their views of the IMB constructs and how they could be interpreted in South Africa, as well as ideas about HIV risk factors that were integrated into our intervention development process.

**Collaborative intervention development workshops**

The collaborative working group for developing the risk reduction intervention was composed of three US researchers, two South African researchers, two South African HIV counselling and testing programme developers and three counsellor trainers, two counsellors, two STI clinic directors, and two field staff. After initial planning, we conducted a series of eight working group meetings (workshops), in South Africa and the US. The first series of four workshops was held in Cape Town over a 1-week period. It soon became apparent that although South African and US workshop participants used the same prevention terminology, cultural translations held different meanings. The collaborators became engaged in activities for identifying various terms used in the scope of HIV prevention and describing the terms when used in their respective work. This activity proved valuable in helping the interdisciplinary team achieve congruency, especially in developing the intervention. We learned that some terms held the same meaning regardless of the different cultures such as ‘prevention’ or ‘intervention’. Terms such as ‘community’, however held different contextual meanings (e.g. specific geographic location, specific population or class of people, specific level of work). Finally, there were times when we thought we were describing the same thing such as ‘peer counsellor’ or ‘lay counsellor’, yet the cultural connotations were different. Our initial step was therefore to develop a common language for defining the parameters of HIV risk reduction counselling.

To form a starting place for the counselling intervention itself, the US and South African collaborators presented risk reduction counselling models that had demonstrated promise in their respective countries. The South African team presented a counselling model that has been extensively used in VCT in South Africa and was not grounded in any particular theory of behaviour change. The presentation included a discussion on the model’s concepts followed by a role-play mock demonstration of the model. The US team presented a model designed as an HIV prevention intervention that was implemented in a US STI clinic and was grounded in the IMB model of health behaviour change (Kalichman et al., 2005). The presentation of the US approach followed the same format as the presentation of the South African model. Discussions following the presentations identified the relevant information, motivational enhancement, and behavioural skills components and confirmed our belief that developing an intervention using the IMB
model would be viable. For each of the intervention components defined by consensus, we outlined the necessary information to include for an intervention in the cultural context of Cape Town, paying particular attention to linking the components to specified outcomes. The outline was then chronologically ordered to ensure the most effective information flow of individual components. It was determined that the intervention would be delivered in a single 60-minute session using an illustrated desktop flipchart as a patient education tool. Fig. 1 shows the patient education flipchart as situated in a risk reduction counselling session.

The second series of four workshops was held 2 weeks later in Atlanta, Georgia in the US. All of the participants in the South African workshops attended the second series of workshops in the US. The first draft of the flipchart and other intervention materials were presented and the group held discussions and made recommendations for changes to materials before final versions were processed. The intervention was then examined for clarity, continuity and flow by conducting role-play mock demonstrations using people not previously involved in any part of the intervention development as mock participants.

Training counsellors in the Phaphama risk reduction counselling
Two full-time counsellors and one backup counsellor were used to deliver the Phaphama risk reduction counselling intervention. The counsellors had backgrounds in psychology and had attended counselling or psychotherapy courses. One male counsellor and two female counsellors fluent in English and Xhosa were trained to deliver the intervention. Before training to deliver the Phaphama counselling intervention, the counsellors first underwent HIV VCT training at the Western Cape AIDS Training, Information and Counselling Centre (ATICC). ATICC is a part of the province’s Department of Health and trains health care providers (both professional and lay) to respond to the HIV/AIDS epidemic in the Western Cape Province. During their month-long training at ATICC, they attended lectures that gave them an initial understanding of HIV/AIDS and how it affects their communities. They were also intensely trained in how to conduct HIV VCT with patients who come to seek HIV testing services. The approach focused on providing information and mental health support within the HIV testing context. The ATICC training equipped the counsellors with HIV counselling techniques that enabled them to effectively perform...
HIV risk reduction counselling included in the Phaphama risk reduction intervention.

Training for Phaphama risk reduction counselling itself occurred over an additional 2-week period. The counsellors were first introduced to the adapted IMB model described above. The counselling trainers demonstrated a mock counselling session to introduce the counsellors to the intervention. Then the 60-minute intervention was broken down into sections so the counsellors could initially learn each component before moving on to the next element. For each intervention component, the counsellor trainers facilitated a discussion that encompassed the component’s purpose and process. Each counsellor then had the opportunity to role-play the component as a means to gain experience in conducting each component. When the counsellors had learned each component, the different sections were pieced together and role-played as a unified risk reduction counselling session. The counsellors also familiarized themselves with using the flipchart and other patient education materials to guide the intervention session. The counsellors practised in mock sessions to become familiar with the intervention and prepare for a variety of clients using several risk scenarios. Counselling techniques were refined during feedback sessions with the counsellor trainers. After the initiation of the project, the counsellors met weekly with a trained psychologist for supervision and counselling debriefing.

**Delivering the Phaphama risk reduction counselling intervention**

The intervention components and the content-related counselling activities for the Phaphama counselling session are shown in Table 1. The first 5 minutes of each counselling session were dedicated to creating a climate marked by mutual respect, emotional affinity, comfort, openness and positive affirmation of the participant. This was achieved by communicating counselling goals such as the overall aims of the programme, an overview of the session, respect for confidentiality, getting acquainted with the participant and acknowledging initial participant feelings such as anxiety, mistrust, or embarrassment. The Phaphama counselling session included all of the information, motivational enhancement, and behavioural skills building components.

**TABLE 1. INTERVENTION COMPONENTS AND SESSION CONTENT FOR THE PHAPHAMA RISK REDUCTION COUNSELLING INTERVENTION**

| Component                         | Content                                                                                     |
|-----------------------------------|--------------------------------------------------------------------------------------------|
| Introduction and rapport building | (5 minutes)                                                                                  |
| Information                       | (15 minutes)                                                                                 |
| • Description of local HIV prevalence |
| • Review of modes of HIV transmission |
| • Dispelling HIV transmission myths and correcting misinformation |
| Motivational enhancement          | (15 minutes)                                                                                 |
| • Activity to examine a continuum of risk behaviours |
| • Personalised feedback on risk behaviours |
| • AIDS destigmatisation           |
| • Risk reduction values clarification |
| • Risk reduction goal setting      |
| • Decisional balance exercise     |
| Behavioural skills building       | (25 minutes)                                                                                 |
| • Functional analysis of personal behaviours |
| • Examination of personal risk situations |
| • Identifying risk antecedents     |
| • Sexual communication skills      |
| • Condom skills building exercises |

**Information**

According to the adapted intervention, information about modes of STI and HIV transmission and preventive measures necessary to reduce risk were reviewed. The information section was predominantly didactic in that information pertaining to STIs was shared with participants. This included a discussion of common STIs such as syphilis, gonorrhoea, genital herpes and genital warts. HIV was introduced as one of the STIs in that context. However, points of dissimilarity between other STIs and HIV were highlighted. For example, it was explained that unlike most STIs, HIV is an incurable condition. Following this discussion, information on the local prevalence of HIV in Cape Town was presented. Given the tendency to defend oneself from HIV/AIDS by minimising the implications of statistics, it was important to ‘localise’ the HIV prevalence. For example, the translation of the estimated prevalence of 23% in the targeted communities was conveyed graphically as one in five people in parts of Cape Town are living with HIV/AIDS. This simplification of statistics undermined the tendency to distance the epidemic and heightened the appreciation of the gravity of HIV/AIDS. On another level, communicating statistics in this way signalled a more inclusive discourse, allowing the counsellor and participant to engage in a discussion of the local HIV epidemic.
Having set the tone for the discussion of HIV/AIDS, the next segment of the risk reduction counselling session focused on basic HIV/AIDS information such as answering the questions ‘What is HIV and AIDS?’, ‘How is HIV transmitted?’, ‘What is HIV testing and its significance?’, and ‘What is the chronic nature of HIV/AIDS?’. Given the pervasiveness of HIV/AIDS myths in the targeted communities, it was also important to dispel common myths. Some of the myths included that HIV can be contracted through kissing, touching, using the same toilets and sharing utensils and that HIV can be cured by having sex with a virgin. To this end, there was a sharp focus on de-stigmatising HIV/AIDS and people living with HIV/AIDS. For the de-stigmatising component, the desktop flipchart included images of notable public figures who were both HIV-negative and HIV-positive. These images were used as a springboard for the discussion of HIV/AIDS de-stigmatisation.

Motivation

The next component of the risk reduction session introduced the concept of personal risk. This concept was achieved by introducing a continuum of risk where participants were required to consider the risk levels of various sexual practices. The risk levels were conceptualised on a continuum from low risk on one end to high risk on the other. Fig. 2 shows the risk continuum activity as it was presented in the counselling session. Sexual practices that were included in the risk continuum activity were vaginal sex with and without a condom, oral sex with and without a condom, anal sex with and without a condom, sex during menses, thigh sex, kissing, mutual masturbation. The risk continuum became a medium for participants to redefine their notions of risk. Having identified the risk level of each of the sexual practices along the risk continuum, each participant was requested to identify sexual behaviour he or she had practised. This activity served to assist the participant and counsellor in identifying the participant’s personal risk profile.

To personalise the discussion for each participant, the counsellor guided the participant in identifying a risk situation from their past. Part of this discussion included the significance of reducing risk behaviour. Participants were also guided to identify possible factors that could increase their potential for engaging in risk behaviours. Personalised risk factors were referred to as triggers and were classified into four...
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categories: people/partner, moods/feelings, places and substances. During this segment of the session great care was taken to ensure that participants understood risk in the context of other STIs as well as HIV. Moving the discussion of risk behaviour from the general to the specific helped participants to formulate a personal risk profile. Each participant was then assisted to state risk reduction goals. For example, if a participant had multiple partners and did not always use condoms, his or her risk reduction plan could involve consistent condom use.

Also integrated into the motivational component of the session was the individual's perceived 'importance' and 'confidence' regarding engaging in less risky behaviour. This was achieved by using significance and confidence ladders as images for the participant to represent their motivation and confidence for change. Fig. 3 presents the motivational ladders used in the intervention. Participants indicated their level of importance and confidence regarding reducing their STI and HIV risks and then discussed these ratings with the counsellor. Participants were given a copy of the ladders to take with them as part of their personal risk reduction plan. These techniques were adapted from risk reduction interventions in the US that have incorporated motivational enhancement techniques innovated in the field of substance abuse counselling (Miller & Sanchez, 1994; Miller, Zweban, DiClemente & Rychtarik, 1992).

**Behavioural Skills**

For the behavioural skills building component, participants were instructed in behavioural self-management skills and sexual communication skills related to avoiding HIV transmission risks within the gender-tailored context of the individualised session. Counsellors engaged the participant in a functional analysis of their risk behaviours using story telling to examine sexual scripts and sexual scenarios. Participants discussed personal behaviours and cues related to sexual risk situations and were asked to think of ways to manage factors that may contribute to their personal risks. Identity as a man or woman in his or her relationships was related to enacting skills such as redirecting sexual activities toward lower risk alternatives, managing sexually coercive situations, carrying condoms, and avoiding sex after drinking. There was also a focus on identifying barriers to lowering risks in sexual relations, such as cultural expectations of men and women, and barriers to risk reduction. Male and female condom use was demonstrated to desensitise and reduce condom aversion, modelling condom use on anatomical models and allowing participants to practise condom application with corrective feedback from the counsellor. Condoms were discussed in relation to main and outside partners and the meaning of condoms in different relationships. For women, there was an emphasis on strategies for getting men to use condoms and for alternative safer sex practices to avoid unprotected vaginal and anal intercourse.

Given that some condom failures are linked to oil-based condom lubricants such as vaseline and elite advanced cream, a discussion of latex degrading lubricants was included. The behavioural skills intervention elements also focused on the role of communication skills including gender sensitivity and empathy to reduce risk for sexual violence as well as HIV transmission. For sexual communication skills, participants were instructed in strategies for negotiating safer sex, initiating condom use and refusing unprotected sex.

To reinforce the newly acquired skills, participants rehearsed the communication skills by role-playing a risk situation from the participant's past. The counsellor, playing the role of the participant's partner, aided the participant to enact new, safer responses to a previous risk situation. Role-plays provided opportunities for interpersonal and communication skills practice and development. Skills building offered the opportunity for experiencing another person's perspective. The session concluded by asking the participant to summarise their risk reduction goals, processes for reaching their goals, barriers to reaching goals and problem solving those barriers.
Illustrative case
The following case illustrates some of the features that study participants found most useful about the counselling. The reactions were in response to exit interviews that followed the counselling session. A 26-year-old indigenous African man who was a tertiary school student in Cape Town was recruited during his clinic visit where he was being treated for symptoms of urethral infection. This client frankly discussed issues of risk during the Phaphama counselling session. He was quite open in explaining details about his sexual relationships with his three current sex partners. He knew which of his partners had infected him and he also believed this partner was his ‘best’ sex partner and did not want to change their relationship in any way. He was also concerned about the potential risks from sexual contact during menstruation because his primary girlfriend does not inform him when she is menstruating and sex during menstruation is common in their relationship.

This client seemed to benefit from the interactive aspects of the session. In particular, he became quite engaged in the risk continuum activity and in identifying risk-related triggers and behaviour change barriers. He said he had been in several other counselling sessions for various problems but none of them were interactive with regard to interpersonal activities. The client stated that the role play activities were particularly helpful because they prepared him to discuss risk reduction with his partners, particularly issues related to sex during menstruation. Another aspect of HIV risk reduction that he found particularly useful was identifying alcohol use as a trigger to risk and a barrier to risk reduction. The client stated that he felt he was at greater risk after drinking alcohol but had not previously realised the connection between alcohol and risk. His risk reduction plan therefore reflected these newly realised risk-related factors and included a plan to reduce his number of sex partners down to one and to avoid drinking before sex.

Conclusions
The intervention development team successfully demonstrated the cultural translation of an HIV prevention counselling session for use in South Africa. The process for translating a Western HIV risk reduction counselling session for use in South Africa may provide a model for future prevention technology transfer efforts. Along the way, we learned some valuable lessons that could be useful to future researchers in transferring HIV prevention interventions to South Africa. Below is a brief summary of the lessons learned in three areas: building collaborations, effective planning, and delivering the intervention.

Building strong and equal partnerships
- It takes time to develop a collaborative partnership. There are no shortcuts but teams must work hard on this for the relationship to be a fruitful one.
- Mutual respect and trust of differences in research culture and practices is critical. Neither team nor team leaders should take each other for granted as both teams need each other for the collaboration to be effective.
- Team leaders must correspond consistently via e-mail, telephonically on a monthly basis and through visits to each other’s institutions each year.
- There must be perceived fairness in the distribution of research funds from joint grant applications by both partners.

Adequate planning
- Strong links with clinics at which interventions will take place must be nurtured. Where possible, staff from clinics must be part of the team that develops the interventions. Networking with other critical role players is also very important. For example, ATICC was co-opted because of their experience with training of VCT counsellors. Such collaboration allows for buying into the research being conducted in clinics.
- Intervention tools need to be contextualised and presented in appropriate language based on formative research that employs both qualitative and quantitative methods.
- The initial intervention must be contextualised by learning from those with experience working on the ground in the country concerned. Where possible, a hybrid intervention should be adopted following looking at both international and local interventions.

Counselling
- Guaranteeing and emphasising confidentiality at the outset of the project encouraged people to participate. Participants generally trusted the confidentiality of the study because it was
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Condom use was a challenge to many participants, particularly older men and women. Although aware of condoms, many had never used a condom and many people who had used condoms had experienced breaks and tears, reducing their interest and trust in condoms.

We found that some women were not comfortable having a man as their risk reduction counsellor. Although the discomfort subsided for most women when assigned the male counsellor, a few requested a transfer to a female counsellor. Male participants were counselled by male and female counsellors without apparent preference.

It is often very difficult for women to get their partners to begin to use condoms. At the end of counselling, some women asked the counsellor for a letter stating why a condom should be used so that they could provide it as a resource to give to their partners.

Participants had sometimes thought that the risk reduction counselling was to promote VCT and some stated that they thought they would be coerced or even tricked into getting tested.

Participants frequently requested brochures and pamphlets that would summarise the intervention session that they could keep with them. Future interventions may expand on the information resources that participants can take with them from the session.

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