

The 2005-2010 NYS Comprehensive HIV Prevention Plan



Submitted by the
NYS HIV Prevention Planning Group

to the
AIDS Institute
NYS Department of Health

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The New York State HIV Prevention Planning Group wishes to dedicate the 2005-2010 NYS Comprehensive HIV Prevention Plan to members of the Planning Group, colleagues, friends and family who have died as well as those who are courageously living with the struggle and those who support their struggle.

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PART A: Introduction to this Plan

HIV PREVENTION PLAN

The Center for Disease Control and Prevention's (CDC) *HIV Prevention Community Planning Guidance* indicates that "the primary task of the CPG is to develop a comprehensive HIV prevention plan that includes prioritized target populations and a set of prevention activities/interventions for each target population". However, a document merely providing prioritized populations and interventions would not provide the information needed to develop effective HIV prevention programs in a state like NYS, with a diverse population and mature epidemic.

This *2005-2010 NYS HIV Comprehensive Plan* is a collaborative effort between the NYS HIV Prevention Planning Group (PPG) and the NYS Department of Health (DOH). In developing it, care was taken to remain vigilant to the changing HIV prevention needs, circumstances and dynamics both within and outside the State. Local, state, national and international developments continue to affect the State's response to the HIV epidemic. The benefits of building upon what already exists, as well as the potentially devastating consequences of disrupting ongoing systems of HIV prevention and care in a rapidly changing environment has been an ongoing theme for the PPG. There will continue to be challenges and opportunities, as well as threats and risks in the external environment, that will affect both the DOH and the PPG in planning and implementing prevention programs and services.

While the role of effective interventions and strategies informed by HIV prevention community planning is crucial, an appreciation of these other events and issues affecting the provision of HIV prevention services in NYS is essential as well. The external environment changes rapidly and often poses significant prevention challenges. Continued attention to terrorism, the war in Iraq and other global issues, including the burgeoning HIV/AIDS epidemic in communities of color, consideration of budgetary constraints and the resulting need for increased accountability, influence funding priorities in national and statewide arenas.

Among others, the following issues were carefully woven into the deliberations and decisions culminating in this Plan:

HIV/AIDS in Communities of Color The PPG and its respective Committees have consistently identified social and economic factors as key determinants of HIV, particularly among NYS's communities of color. External factors, such as institutionalized racism, discriminatory practices and poverty are key determinants of HIV/AIDS in NYS's African American/Black, Latino/Hispanic, Asian and Pacific Islander and Native American communities. The PPG has taken numerous steps to look at historical underpinnings, cultural norms, external factors and access barriers affecting HIV prevention in these communities. While the elimination of various external factors, such as poverty and racism, are not reasonable goals for the AI, these factors must, nonetheless, be recognized and addressed as co-factors in transmission and acquisition of

HIV.

Rapid Testing The introduction of rapid HIV testing is having a profound impact on the provision of HIV prevention by:

- increasing the number of individuals who have access to testing and actually receive their test results,
- facilitating early identification of infection and help reduce the number of persons who are tested late in the course of their HIV disease,
- preventing new infections by ensuring that those at highest risk for infection learn their status and receive information that can help them protect their partners,
- helping to eliminate perinatal transmission; and,
- making the most efficient use of counseling and testing resources.

CDC's "Advancing HIV Prevention" Initiative While the PPG has always addressed the primary and secondary prevention needs of HIV positive individuals, CDC's initiative provides increased opportunity for examination of those needs, and subsequent recommendations for fulfilling them. "Prevention With Positives" is addressed on a regular basis by the PLWA/PLWHIV Advisory Committee. In addition, the PPG's Regional Gaps Analysis (RGA-- see Chapter 4) identified issues related to Prevention with Positives in all the regions of NYS.

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How to use this Document

The *2005-2010 NYS HIV Comprehensive HIV Prevention Plan* was prepared with the intent that it be more user-friendly and have useful material to guide providers in the development of their HIV prevention programming. Information within the *Plan* is specifically designed to provide relevant knowledge in one place, rather than require constant page-turning and skipping from one spot to another to utilize attachments and appendices.

This *Plan* can be utilized:

- ✓ In the development of new HIV/AIDS prevention programs.
- ✓ To understand the role of behavioral and social science in HIV prevention.
- ✓ To ascertain what behavioral/social science model is most appropriate when developing interventions.
- ✓ In response to funding solicitations.
- ✓ To understand the concepts of historical underpinnings, cultural norms and external factors and their relationship to HIV prevention.
- ✓ To demonstrate the importance of language and culture in HIV prevention
- ✓ In advocacy work for funding services for those affected by, or at risk for, HIV.
- ✓ By other Community Planning Groups and planning entities in their planning work.
- ✓ To provide documentation for the enactment of policies for HIV/AIDS services and programs.
- ✓ As a public relations tool to inform communities in NYS about the work of the PPG.
- ✓ As a training tool to promote an understanding of HIV prevention in NYS.
- ✓ To understand communities and sub groups such as the homeless and transgendered individuals.
- ✓ As a tool for students in public health, teaching or other relevant disciplines at colleges and graduate schools.

2 **An Overview of the New York State (NYS) HIV Prevention Planning Group**

Introduction The *Guidance for HIV Prevention Community Planning* requires broad-based community participation in HIV prevention planning. The NYS HIV Prevention Planning Group (PPG) utilizes multiple methods to ensure that it is representative of the diversity of populations most at risk for HIV infection and community characteristics in NYS, that professional expertise and representation from key governmental and non-governmental agencies occurs and that the process encourages inclusion and parity among community planning members.

The sections in this chapter addressing these issues are:

- **The Structure of the NYS HIV PPG** (pages 1-2)
- **Participants in the Planning Process** (pages 2-4)
- **Initial and Continuing Education for PPG Participants** (pages 4-5)

History and Structure of the NYS HIV PPG

The New York State Department of Health (NYSDOH) AIDS Institute established the PPG in 1994 consistent with the *Guidance for HIV Prevention Community Planning* issued by the Centers for Disease Control and Prevention (CDC). The PPG, in collaboration with the NYSDOH developed *NYS Comprehensive HIV Prevention Plans* in 1994 and 1998 and developed *Comprehensive HIV Prevention Plan Updates* in 1995, 1996, 1997, 1999, 2000, 2001, 2002 and 2003.

Leadership The PPG has a Community Co-Chair and Vice Co-Chair, elected by the full membership, and a Governmental Co-Chair and Vice-Co-Chair, appointed by the NYS Commissioner of Health. Committee members elect Co-Chairs of each Committee. These leadership positions make up the PPG's Executive Committee, which meets ten times a year.

Committees Three standing Committees address the overall governance of the PPG. These include the Executive Committee, the By-Laws/Membership Committee, and the Finance Committee. The PPG has nine population-based Committees that examine HIV prevention needs and issues: (1) Criminal Justice; (2) Emerging Issues; (3) Immigrant/Migrant; (4) Men Who Have Sex with Men (MSM)/Gay Men; (5) PLWA/PLWHIV Advisory Committee; (6) Racial/Ethnic; (7) Substance Use; (8) Women; and (9) Young People. Each Committee works closely with an AIDS Institute Liaison, strengthening the partnership between the community and the Health Department. For the standing and population-based Committees' role in the PPG prevention planning process, see Appendix 1-1.

Meetings The full PPG meets five times each Planning Cycle. At each of these full meetings, which are announced through a press release, the community-at-large is invited to provide comments during an open mic period. The Executive Committee, made up of Co-Chairs from each Committee, meets ten times a Planning Cycle. Population-based Committees usually meet

once a month, primarily via conference call to facilitate ease of participation, as does the Finance Committee. The By-Laws/Membership Committee meets as needed. Co-chairs provide information from the Executive Committee meetings to members of their respective Committees and comments from their Committees to the Executive Committee. An overview of its activities is provided to PPG membership at full meetings. Through this structure, which encourages the sharing of information from all levels of PPG participation, the PPG ensures that each member has an opportunity to provide valuable input.

Participants in the Planning Process

Appointed Members The NYS DOH has statewide responsibility, therefore the PPG includes members from all regions of the state, including the metropolitan New York City area. PPG membership reflects the diversity of NYS. Not only is there racial and ethnic diversity, but also diversity in members' ages, backgrounds, and sexual orientations. The PPG includes people from, or representing, substance use communities, as well as individuals who were formerly incarcerated, many of whom are now service providers. According to the PPG's By-Laws, PLWH/A comprise at least 30% of its total membership. Each member brings a wealth of knowledge and experiences from a wide spectrum of communities impacted by, and at risk for, HIV/AIDS and can be viewed as voices of their communities.

To facilitate retention of members, the AIDS Institute provides prepaid transportation, lodging and meals for all PPG-related meetings. Meetings are as comfortable as possible for members, with meals provided and individual needs met. Members meeting the criteria designated by the AIDS Institute and the Finance Committee may apply for a stipend to cover incidental costs related to PPG participation. Since Executive Committee participation requires more travel, those receiving stipends who are Committee Co-Chairs receive a larger stipend to ensure that their ability to participate is not affected by their financial situation. At full meetings, a closing ceremony reminds members of why they meet and of members' value to the process, providing personal reflection after the stress of a meeting packed with activities and information.

Community Advisors The NYS HIV PPG includes a Community Advisor program by which Community Advisors with specific expertise or experience can be made available to assist Committees in accomplishing specific goals and to broaden and enhance the PPG's diversity. These individuals provide additional perspectives on the HIV prevention needs of the communities they represent. Community Advisors may also apply for PPG membership.

AIDS Institute Committee Liaisons AIDS Institute staff are assigned to fulfill the AIDS Institute's partnership with the community at the Committee level. These AIDS Institute Liaisons serve as partners in the prevention planning process, providing information concerning interventions, prevention practices, AIDS Institute policies, programs and funding in areas relevant to the work of the Committee. Liaisons work with Committee Co-Chairs to facilitate the work of the Committee, such as activities to assess HIV prevention needs or identify HIV prevention interventions, and develop Committee Workplans. Liaisons participate in all Committees' meetings and telephone conference calls. The Liaison serves as the channel of

information to and from the Committee about special needs and requests. The Liaisons provide the Governmental Co-Chair, through the Prevention Planning Unit (PPU) with ongoing updates on the status of each Committees' work, identifying areas requiring attention, such as attendance, Committee tasks and deliverables and needs for additional resource information.

Other AIDS Institute Staff Involvement The AIDS Institute provides significant staff support to the PPG beyond that of the AIDS Institute Liaisons. Both the Director and the Associate Director of the Division of HIV Prevention are intensely involved in all aspects of PPG activities. All Division of HIV Prevention Bureau Directors participate in full PPG meetings and in other PPG activities. An epidemiological profile of the HIV/AIDS epidemic in NYS is developed by compiling, analyzing and synthesizing data from a variety of sources. Division staff also provide technical assistance and training to PPG members in analyzing epidemiological data and assist the population-based Committees in identifying other sources of data. The Office of the Medical Director (OMD) HIV Education & Training Program Section has been involved in PPG work. Staff from the AIDS Institute's Office of Program Evaluation & Research (OPER) have assisted the Division and the PPG. In addition, the AIDS Institute support staff attend to all logistical and practical needs, including travel and lodging arrangements, scheduling of meetings, and preparation and distribution of materials.

Other NYS DOH Staff Involvement Staff from other NYSDOH units are involved with the PPG. The NYS DOH Public Affairs Group (PAG) has been involved in all full PPG meetings and in preparation of brochures and other materials. Representatives from the NYS DOH Bureau of STD Control and Office of Minority Health also participate in the PPG.

State Agency Representatives Representatives from certain other NYS government agencies other than the DOH play a role in the planning process of the PPG. State Agency Representatives, selected by their agencies, bring information about their agencies to the PPG and bring HIV prevention-related information from the PPG back to their agencies. State Agency Representatives participate with population-based Committees of the PPG. These representatives also provide the membership of the entire NYS HIV PPG with input about what activities proposed by the group are legally feasible and compatible with the mission of their agencies. State Agency Representatives also provide the PPG with information about how their agency works with the AIDS Institute to implement HIV prevention activities. Agencies that have designated State Agency Representatives have included the Department of Correctional Services, Division of Parole, Division of Criminal Justice Services, Office of Children and Family Services, State Education Department, Office of Mental Retardation and Developmental Disabilities, Office of Mental Health and the Office of Alcoholism and Substance Abuse Services.

Other Methods of Utilizing Relevant Expertise Numerous methods are used to ensure that relevant expertise supports PPG activities. Experts in behavioral/social science and epidemiology have provided presentations to participants either during the Business Day or Supplementary Day of the full meetings. Committees have brought in such experts on an as-needed basis to present at Committee meetings.

Initial and Continuing Education for PPG Participants

PPG Participant Orientation A comprehensive orientation, developed and conducted by members of the PPG and the AIDS Institute, is provided for new and current members and other participants before attendance at their first PPG meeting. The orientation addresses several different learning styles. The member orientation ensures that all participants have the information needed to participate effectively in the PPG process. During this orientation, a Member Handbook is distributed and PPG “Competency Areas” are introduced, along with a “Competency Area Checklist”. The “Competency Areas” help participants to fully participate in the PPG planning process. Participants have many opportunities to build their “core competencies” throughout the Planning Cycle.

Member Handbook The PPG Member Handbook is provided to all new PPG members. The handbook contains pertinent documents (including Policies and Procedures, PPG Directory, PPG By-Laws, and CDC *Guidance*) and other useful information, such as future PPG meeting dates, times and locations. Space is also reserved in the binder for information distributed during the Planning Cycle. The PPG Member Handbook is updated regularly.

Presentations at full PPG meetings and Supplemental Days To address the variety of participants’ informational needs, the two-day PPG meetings comprise a Business Day and a Supplemental Day. PPG business is conducted on the first day of the meeting, during which plenary presentations are also provided. The second day, known as the Supplemental Day, offers three concurrent workshops, which are conducted twice to ensure that as many participants as possible can take advantage of these learning opportunities. Individualized training is offered to PPG participants during the Supplemental Day, by providing an opportunity for the individual to decide what skill or level of knowledge he or she needs to optimize his or her participation in PPG activities. Each topic is characterized as a “learning opportunity”, a “discussion” or an “update”. In addition, a “Parking Lot” is kept during all full meetings, of issues either not germane to the current discussion, or not immediately addressable. These issues are addressed at a later full meeting, within the Executive Committee and/or in writing.

Epidemiological TA Epidemiological TA is routinely provided to PPG members through presentations at full PPG meetings and Call-Ins.

PPG Member Conference Attendance and Presentations Designated PPG members representing each Committee receive support to attend certain HIV prevention-related conferences, specifically the HIV Prevention Leadership Summit, the CDC National HIV Prevention Conference and the US Conference on AIDS. Information gathered at these conferences is then shared with their Committees for use in their work and other PPG members, as well. The AIDS Institute ensures that each designated participant is able to attend, regardless of financial situation, by pre-paying registration and lodging by purchase order.

Regular Mailings and Distribution of Relevant Materials There is a consistent emphasis on

meeting the informational needs of the PPG through the provision of relevant materials in regular mailings and during full meetings, including *Morbidity and Mortality Weekly Report (MMWR)* articles, HIV/AIDS data, information about interventions, information on HIV/AIDS prevention and communities of color, and other HIV prevention-related topics. Materials are provided in large print when requested.

Appendix 1-1

NYS HIV Prevention Planning Group Committee Descriptions

Standing Committees

Executive Committee The PPG's Executive Committee consists of the Community and Governmental Co-Chairs, the Community and Governmental Vice Co-Chairs, and the Co-Chairs of each standing and population-based Committee. Each Committee has two Co-Chairs, one, ideally, representing "downstate" and the other representing "upstate" New York. The Executive Committee meets ten times each year with senior staff from the AIDS Institute's Division of HIV Prevention to maintain the momentum necessary to complete tasks related to the planning process, to provide guidance to the AIDS Institute on behalf of the full PPG membership, and to discuss emergent issues and concerns.

By-Laws/Membership Committee The By-Laws/Membership Committee is responsible for updating the PPG's By-Laws and ensuring ongoing compliance with them. Committee members participate in a review of member nominations and development of recommendations for appointment of new members. The Committee also works with the AIDS Institute on the orientation process.

Finance Committee The Finance Committee provides recommendations to the Executive Committee on the following issues: developing a budget for planning funds in conjunction with the AIDS Institute; assessing the optimum utilization of planning funds; the disposition of AIDS Institute prevention program funds; and participating in assessment of the linkage between the Comprehensive HIV Prevention Plan and the Cooperative Agreement application. The Executive Committee may assign other responsibilities consistent with the above issue areas.

Population-Based Committees

Criminal Justice Committee The Criminal Justice Committee is concerned with the HIV prevention needs of individuals within the criminal justice system, including county and state correctional facilities, probation and parole, juvenile justice and alternatives to incarceration programs. The Committee makes recommendations, with input from the infected and affected communities and service providers regarding HIV prevention interventions, prevention strategies and new initiatives.

Emerging Issues Committee The Emerging Issues Committee is committed to pursuing HIV prevention and intervention activities that represent the concerns of various populations not represented by other PPG population-based Committees, as well as to bring up for discussion emerging issues, areas and policies that have not yet been addressed. The Committee elicits

feedback from other Committees and populations in order to inform effective HIV prevention interventions, programs and policies.

Immigrant/Migrant Committee The Immigrant/Migrant Committee examines the need for culturally competent programmatic initiatives and anti-discriminatory policies that support the HIV prevention needs of immigrants/refugees and migrants/seasonal farm workers. Key strategies include the facilitation of sound community-based needs assessment with input from immigrant and migrant communities. The Immigrant/Migrant Committee also assists in engaging immigrants migrants in HIV prevention community planning.

MSM/Gay Men Committee The Men Who Have Sex With Men (MSM)/Gay Men Committee monitors trends, identifies needs and makes recommendations related to how the NYS Comprehensive HIV Prevention Plan can best address the needs of MSM/Gay Men. The Committee solicits broad-based community input that addresses the diverse needs of various communities that are collectively referred to as MSM; proposes interventions and strategies for programmatic and organizational development to be; works to identify cross-cutting issues and opportunities for collaboration with other Committees; seeks to ensure adequate federal and state financial resources devoted to preventing HIV transmission among MSM/Gay Men; and coordinates activities with other planning bodies.

PLWA/PLWHIV Advisory Committee The PLWA/PLWHIV Advisory Committee facilitates, in a meaningful way, the participation of persons who are living with HIV and AIDS in HIV prevention community planning. The Advisory Committee represents the voice and experience of the PLWA/PLWHIV community, advocating for increased access to early medical interventions to delay the onset of symptoms and to facilitate the prevention and treatment of HIV infection. It brings well-informed HIV/AIDS policy perceptions, activist traditions, personal experiences and a sense of continuity between prevention and care to HIV prevention planning. Its members have established linkages with other HIV/AIDS-related advisory bodies, task forces and expert panels.

Racial/Ethnic Committee The Racial/Ethnic Committee monitors trends, identifies needs and makes recommendations related to how to address the needs of racial/ethnic individuals at risk of or infected with HIV/AIDS. The Committee identified specific HIV prevention strategies to be adopted in order to better serve communities of color. The Committee works with representatives of all racial/ethnic groups whether or not they are members of the Racial/Ethnic Committee, brings to other PPG population-based Committees issues of particular urgency to racial and ethnic minorities, and provides input to guide the NYS DOH and service providers in their approach to HIV primary and secondary prevention, support, and access to health services.

Substance Use Committee The Substance Use Committee studies HIV prevention issues specific to substance users and formulates recommendations for the development of HIV prevention strategies that address the particular needs of substance users. Prevention issues include not only the needs of injection drug users, who account for the majority of cases of HIV transmission in NYS, but also those of non-injecting drug users. Also of particular concern to

the Substance Use Committee are the needs of those in the criminal justice system, immigrants and migrants. The Substance Use Committee pays particular attention to the impact of AIDS and substance use on communities of color, noting that both have had disproportionately high impact on communities of color.

Women's Committee The Women's Committee develops recommendations surrounding HIV prevention interventions, programs and strategies, represents women's needs and issues with the PPG, provides input on women's issues to the AIDS Institute and seeks to establish or maintain HIV prevention activities that address women's issues. The Committee coordinates with other planning bodies, as needed.

Young People's Committee The Young People's Committee is committed to the provision of community and school-based comprehensive HIV prevention and risk reduction education to youth in order to reduce/eliminate the incidence of HIV/AIDS in this population. The Committee examines the needs of the broad spectrum of youth across NYS and emphasizes the behaviors and interpersonal relationship dynamics of young people, rather than traditional labels.

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PART B: Prevention Tools

HIV PREVENTION PLAN

Introduction: Background of HIV Prevention Interventions in NYS At the onset of the HIV/AIDS epidemic in NYS, prevention efforts focused on health communication through use of media messages and hotlines, as well as on group presentations and institution-based programs. Most group presentations and institution-based programs were provided in single session formats, with little or no follow-up. The role of counseling, testing, referral and partner notification (CTRPN) was recognized, but these services were initially primarily focused on the needs of gay men. A group counseling model using leaders in gay communities was used to reach gay men and sexually explicit information about safer sex techniques and condoms were distributed in gay bars and community centers.

As it became evident that the HIV/AIDS epidemic impacted injection drug users, the importance of reaching them through street and community outreach was acknowledged. Harm reduction programs, coupled with syringe exchange, were developed and CTRPN programs were integrated into substance abuse treatment programs. When the profound effect of the AIDS epidemic on communities of color and non-English speaking persons became clear, the additional emphasis was placed on linguistically and culturally competent peer education programs occurred. Community-level interventions to inform these communities of their risk for HIV were developed and resources were dedicated to increasing the capacity of agencies serving communities of color to integrate HIV prevention into their existing services.

As more women became infected with HIV, greater emphasis was placed on partner notification, counseling for serodiscordant couples, and one-to-one peer counseling. Due to treatment advances that reduced the transmission of HIV from mother to child, more emphasis has been placed on prevention of perinatal transmission of HIV. With the advent of combination drug therapies, there was recognition of an even greater need for prevention with HIV-infected individuals. Consequently, the need for prevention case management and other means of ensuring that HIV-infected individuals had access to primary and secondary prevention services became crucial.

There has been a significant amount of research about the effectiveness of HIV prevention interventions and strategies. It became clear that many of the interventions which were effective with white gay men at the beginning of the epidemic cannot be effectively used with other populations, such as communities of color and women. Research also indicates that it is not sufficient to provide those at risk for HIV solely with education; they must also be assisted in modifying their risk-taking behaviors. These research findings, coupled with the experiential knowledge of HIV prevention providers in NYS, has resulted in a greater emphasis being placed on science-based behavioral interventions.

While documents such as Holtgrave, Valdiserri, and West's Taxonomy of HIV Prevention, CDC's Compendium of HIV Prevention Interventions with Evidence of Effectiveness and Advancing HIV Prevention: Interim Technical Guidance for Selected Interventions are useful, they do not provide a comprehensive picture of issues to be considered in the development of effective HIV prevention interventions. To assess effective interventions for populations at risk in a diverse state such as New York, a wide range of contextual considerations must be considered, including historical underpinnings, external factors and cultural norms related to the specific population. In conjunction, the role of behavioral and social sciences and the concept of technology transfer must be adequately addressed as well.

In the third decade of the epidemic, we are cognizant of the fact that HIV prevention comprises individual, group, and community-level interventions that are culturally and linguistically appropriate for defined populations whose serostatus is unknown, negative, or positive. Years of experience have proven that a "cookie-cutter" approach cannot be used when implementing HIV prevention interventions for New York's diverse communities affected by HIV. It is necessary to avail ourselves of the numerous tools available to appropriately customize interventions for optimum effectiveness.

Chapters 3 and 4 provide summaries of useful information to aid in the development of culturally and geographically appropriate interventions based on accepted HIV prevention science.

3

The Community Services Assessment

Introduction In order to identify priority populations and HIV prevention interventions for NYS, the NYS HIV PPG needs assessment considered numerous inputs. A Community Services Assessment (CSA), as provided for in the CDC *Guidance for HIV Prevention Community Planning*, provides much of that information in the form of current HIV prevention and related resources, a needs assessment and a gap analysis.

Utilizing a logical, evidence-based process to determine the highest priority, population-specific prevention needs in NYS, the PPG's CSA describes the prevention needs of populations at risk for HIV infection, the prevention activities/interventions implemented to address those needs and gaps in HIV prevention services.

The PPG's CSA primarily consists of three components, all of which are designed to be inputs into statewide priority setting:

- **NYS Regional Gaps Analysis** (pages 1-4)
- **NYS Macroanalysis** (page 5)
- **NYS HIV Prevention Service Profile** (page 6)

NYS Regional Gaps Analysis (RGA)

Definition and Purpose The RGA is a systematic approach for identifying gaps between the needs of at risk populations and the availability of existing services within a specific geographic area. The RGA was developed to help consumers and providers in each region, the NYS HIV PPG and the NYSDOH better understand needs of people at risk for HIV infection, people with HIV infection and HIV prevention providers. It also provides information as to how to meet those needs in order to prevent new infections in communities and regions across NYS and helps to identify emergent groups not previously identified as at risk. In addition, it provides data that can be considered by the NYC Department of Health and Mental Hygiene (NYCDOHMH) and the NYC HIV PPG. It was a multi-year effort to improve HIV prevention in NYS over the long term and to answer questions related to how the NYSDOH establishes an HIV prevention infrastructure. In addition, it seeks to assure that individuals who are HIV-infected and individuals who are at high risk have access to critical services and ascertain what, if any, types of service gaps exist. It also was a method of including "community intelligence" in the priority setting process.

History In the 1998-1999 Planning Cycle, the NYS HIV PPG and the AI embarked upon the RGA as a multi-year effort. Work on the RGA during the 1998-1999 Planning Cycle focused on planning and developing the RGA, developing components of the RGA for pilots in two regions (Bedford Stuyvesant/Crown Heights and Northeastern NY), developing methods for these

components, conducting pilot work in those two regions, collecting and analyzing data for each component in the two regions, presenting major findings of the pilots to the PPG, and debriefing and analyzing these findings in the pilot regions. During the 1999-2000 Planning Cycle, the content and process of the pilot RGA components were assessed. Feedback about RGA activities from the PPG, the Regional HIV CARE Networks, the CDC Project Officer, AIDS Institute and other DOH staff and consultants was analyzed and issues that needed to be addressed as the RGA was implemented statewide were identified. A methodology for RGA activities throughout the State was then developed.

RGA Timeframe The first group of RGA regions (Lower and Mid Hudson, Long Island and Northeastern NY) conducted their activities, from 2000-2002. The second group of RGA regions (Binghamton, Buffalo, Rochester, Syracuse regions) conducted RGA activities between 2001 and 2003. The five Boroughs of NYC conducted RGA activities between 2002 and 2004. During 2000-2004 a total of 139 Discussion Groups were held across the state. Participants totaled 1,971 and included both consumers and providers.

Methodology In all areas of the State, except the five Boroughs of NYC, Ryan White CARE Networks were contracted with by the AIDS Institute to engage in prescribed RGA activities. A consultant conducted RGA activities in the five boroughs of NYC. Participants were asked to keep the PPG's "Big Four" transmission categories (Injection Drug Use, Men Having Sex with Men, Heterosexual, and Pediatric/Perinatal) in mind during all RGA activities. A 24-month period was set aside for completion of RGA tasks. The RGA methodology developed by the AIDS Institute included the following activities:

- Teams for each region/Borough were assembled, including PPG members, AIDS Institute staff, regional DOH staff, Ryan White CARE Network members and staff and Lead Agency staff.
- A Kick-Off Meeting, which introduced the concept of the RGA to the region/Borough was designed to begin the RGA process. Relevant data were provided to community participants including a region/Borough-specific Macroanalysis, Service Profile, HIV/AIDS Epi Profile, and Community Needs Index (CNI) information. AIDS Institute and local presenters provided information, including an overview of the RGA and an epidemiologic update.
- During each Kick-Off, community participants engaged in a Planning Session, designed to gain a preliminary view of the HIV prevention infrastructure in each region, ensure a common understanding of primary and secondary prevention, collect initial impressions of HIV prevention needs, assure that the HIV prevention needs of HIV-infected persons are considered, and identify missed opportunities for HIV prevention in the region, especially related to communities of color. Responses were compiled for use during future RGA activities.
- A plan to hold Discussion Groups was developed by the team. These plans were

reviewed, keeping in mind the need to ensure that groups of individuals representative of the epidemic as it affects the region and a broad cross-section of consumers, particularly PLWHIV/PLWAs were included. In addition, the entire geographic area was to be covered to the extent possible. It was understood that these plans were, by necessity, constructed differently in each region/Borough, respecting their differences.

- A list of eight core Discussion Group questions were developed for use in each region/Borough. The questions were:
 1. Who is at highest risk for HIV infection in the region/Borough?
 2. Are there specific things in the region/Borough that increase that risk?
 3. What is being done in the region/Borough to prevent HIV infection among those at highest risk?
 4. What more can be done in the region/Borough to prevent HIV infection, especially among those at highest risk?
 5. What is being done in the region/Borough to meet the HIV prevention needs of people with HIV infection? What more can be done?
 6. Is there anything currently being done to prevent HIV infection in the region/Borough that isn't working?
 7. Where in the region/Borough should HIV prevention efforts be focused?
 - Geographic areas?
 - Community settings?
 - Types of providers?
 8. What would help providers in the region/Borough do a better job of HIV prevention?

Each Region/Borough was also free to add any specific questions of local interest.

- Once the Discussion Groups were completed, a Discussion Group Report was developed, summarizing responses to the above questions. This report was to be used to help rank the HIV prevention needs of people most at risk for HIV infection in the region/Borough and people with HIV infection, as well as the needs of providers.
- Using the Discussion Group Report, the epi profile, the CNI, Macroanalysis, Service Profile, and Kick-off Planning Session Report, a ranking process, was developed by the AIDS Institute and done in a consistent manner in each region/Borough, took place to identify and rank HIV prevention needs including:
 - ▶Most impacted subpopulations
 - ▶Interventions for those subpopulations
 - ▶Settings for those interventions
 - ▶HIV prevention provider needs
- Individuals who participated in ranking activities reflected the demographics of the epidemic in the region, community views and perspectives and included consumers as well as both care and prevention providers. In order to assure that the RGA Discussion Group findings were respected and considered in the ranking process, participants were

required to be familiar with the Discussion Group report, epi data for the region, the Community Needs Index, the regional Macroanalysis and Service Profile.

- Using the AIDS Institute’s Service Profile, each region was also asked to develop an Expanded Service Profile including HIV prevention services funded by other entities.
- All information was included in a Final Report, which included an evaluation of the process.

Special Considerations for the RGA in NYC Recognizing the roles and responsibilities of NYC Department of Health and Mental Hygiene (NYCDOHMH) and the NYC HIV PPG for priority setting for NYC as a whole, and NYC’s role in formulating City-wide plans, the NYS RGA process for NYC did not include development of a separate process for City-wide ranking. Results of the five Borough-specific rankings are included as regions, together with those of other regions, in the NYS HIV PPG’s Statewide priority setting process.

NYCDOHMH-specific data were included in the development of the Macroanalysis and Service Profile prepared for each Borough to ensure a complete picture of resources in NYC. NYCDOHMH staff were invited to participate in the borough-specific teams and NYC HIV PPG members were invited to participate in the discussion groups themselves. NYCDOHMH staff and NYC HIV PPG members, as well as CARE Network representatives from NYC-based Networks participated in the ranking process. Throughout the process, communication with the NYCDOHMH and, through the NYCDOHMH, the NYC HIV PPG, continued. All RGA-related materials (Macroanalysis, CNI, HIV/AIDS epi data, forms and processes for the RGA) were made available to the NYCDOHMH, as were copies of reports, final results and other RGA products.

PDF files of RGA final reports are available from from the AIDS Institute’s Division of HIV Prevention--wjs03@health.state.ny.us.

NYS Macroanalysis

Definition and Purpose A Macroanalysis, or macro-level analysis, is a gross analysis of the extent to which HIV-related resources, and, in particular, HIV-related prevention resources, are matched to the AIDS epidemic within a designated geographical area. A Macroanalysis compares the percentage of prevention funding resources with the percentage of AIDS cases by race/ethnicity and with the percentage of AIDS cases by the four major categories of risk in order to determine at a gross level how well prevention resources are matched to the epidemic and how well funds are targeted to serve those in need of services.

Methodology

The NYS Statewide Macroanalysis compares the percentage of prevention funding resources

with the percentage of AIDS cases in four major categories of risk (injection drug use, men who have sex with men, heterosexual contact, and perinatal transmission) and by race/ethnicity for 2004. It is based on available data from the AIDS Institute Contract Management System, which is based on internal staff assessments, agency estimates, monthly data reports, and contract projections. Although it may not reflect the exact distribution of clients by race/ethnicity and transmission category or the distribution of services provided, it provides the best available data.

NYS HIV Prevention Service Profile

Definition and Purpose The NYS HIV Prevention Service Profile examines: the specific types of HIV prevention services provided within a region; the allocation of funding resources for different types of prevention services; the characteristics of the various types of prevention service providers within the region with respect to the full array of services provided, and the location of providers and service sites within the region.

Methodology

The preliminary NYS HIV Prevention Service Profile is based on available data from the AIDS Institute Contract Management System. It includes NYS HIV prevention programs supported by State and Federal funds as well as NYC-funded and CDC directly funded programs. Within the context of the RGA, each region/Borough developed an expanded Service Profile, incorporating prevention services not funded by these entities, in order to provide a more complete picture of the HIV prevention infrastructure. These regional/Borough-wide Service Profiles are to be compiled and utilized in the development of a more accurate Statewide Service Profile.

Other Relevant Inputs In addition, other relevant informational sources, such as NYS's Statewide Coordinated Statement of Need (SCSN), a mechanism for addressing key HIV/AIDS care issues and enhancing coordination across CARE Act programs and titles, will be utilized in priority setting.

The Statewide Macroanalysis and Statewide Service Profile are available under separate cover.

4

HIV Prevention Intervention Tools

- **Use of Behavioral and Social Sciences in Developing Interventions-** pages 1-15
Behavioral and Social Sciences Bibliography- pages 16-17
- **Lessons Learned to Inform Development of Effective HIV Prevention Interventions in Communities of Color** - pages 18-28
- **The NYS HIV PPG's Socio-Cultural Model** - pages 28-32
- **Economic Evaluation and Technology Transfer-** pages 33-34
- **Useful Websites** - pages 34-36

Use of Behavioral and Social Sciences in Developing Interventions Behavioral science is the study of human behaviors based on observations of behavior, while social science is the study of the interactions between people or groups of people. Many social science fields contribute to our knowledge of social and behavioral science, including epidemiology, psychology, sociology and anthropology. Behavioral and social science knowledge and theory can provide important insights into why people behave the way they do. The more one understands the factors influencing or underlying a person's decision to engage or not to engage in a particular behavior, the more likely one is to develop interventions that can effectively change or modify that behavior.

Behavioral and social science theory says that, by understanding the process of change, interventions can be designed that target specific behaviors, change or modify the behaviors that lead to HIV infection, and assist in the maintenance of protective behaviors once they are adopted. The following four behavioral and social science theories are those most referred to in the development of HIV prevention interventions:

Theory is one of many tools that can have an important influence on HIV prevention programs. Thirteen of the most widely-known general theories are presented below. For each:

- ✓ a concise overview of the model;
- ✓ a brief description of its usefulness in HIV prevention;
- ✓ issues to consider if a program is thinking about using the model;
- ✓ program applications, and
- ✓ sources to go to if more information is needed,

are provided. Please remember, these theories are not mutually exclusive, nor are they HIV specific, but they can be used to develop interventions and guide effective programs. When designing HIV prevention interventions, more in-depth research into these theories is recommended. In addition, interventions based on these theories may be offered in conjunction with non-traditional or alternative therapies and modalities, as appropriate.

Health Belief Model (Janz, Becker)

Overview: The key component for this theory is the belief that the benefits of performing a

behavior(s) outweigh the consequences of not performing it. The Health Belief Model is based on the premise that health-related behaviors depend on four key beliefs, all of which have to be present in order for a new behavior to be adopted:

- **Perceived Risk:** people are motivated for behavior change when they believe they are personally vulnerable to the disease.
- **Perceived Severity:** people must believe that the disease or condition poses an actual threat to their personal health and well-being.
- **Perceived Benefits/Effectiveness:** people must believe that there is something that can be done to prevent the disease.
- People must believe that perceived **barriers** to change **can be overcome** and that the **benefit outweighs the effort.**

Additionally, the model suggests that a specific stimulus or “**cue to action**” is often required to trigger the behavior change process (Petrosa and Jackson, 1991). This “cue to action” can be positive or negative and can include personal and social influences such as media messages or witnessing the illness of a close friend or family member.

Usefulness in HIV Prevention

- Service providers can separately target the beliefs necessary for behavior change and the barriers to prevention.
- It can be used to design interventions to change behavior regardless of the target population’s demographic characteristics so long as the intervention components are culturally appropriate (Abraham and Sheeran, 1994).

Considerations

- The model relies heavily on the presence of “cues to action” in people’s environments, which requires extensive and diverse interventions for at risk communities.
- The model has limited effectiveness in changing habitual behavior or addictions.

Program Application

A needs assessment for a program using the Health Belief Model might include questions such as:

- Does the person see him/herself at risk for that condition?
- Does s/he believe that adopting risk reduction behaviors will decrease their risk?
- What are the barriers to adopting the new behavior?
- Does one’s social network encourage or discourage adoption of the new behavior?
- What types of media does the target group most frequently use?

The following sources may be useful in learning more about the Health Belief Model:

Becker, M.N. (1988). AIDS and Behavior Change. *Public Health Review*, 16, 1-11. Janz, N.D. and Becker, M.H. (1984). The health belief model: A decade later. *Health Education Quarterly*, 11, 1-47.

Kirscht, J.P. and Joseph, J.G. (1989). The health belief model: Some implications for behavior change with reference to homosexual males. In Mays, V.M., Albee, G.W., and Schneider, S.F. (Eds.), *Primary prevention of AIDS: Psychological approaches*. Newbury Park CA: Sage Publications.

Rosenstock, I.M., Strecher, V.J., Becker, M.H. (1994). The health belief model and HIV risk behavior change. In DiClemente, R.J. (Ed.), *Preventing AIDS: Theories and methods of behavioral interventions*. New York, NY: Plenum Press.

Theory of Reasoned Action (Ajzen & Fishbein)

Overview: The Theory of Reasoned Action focuses on how beliefs and perceptions of threat to self lead to intentions to change risky behavior. In order for behavior change to occur, one must have an intention to change. A person's attitudes and beliefs toward the behavior as well as the perception of what significant others think, influence their intentions toward changing their behavior. The theory emphasizes the importance of attitudes and intentions as a prerequisite to behavior change.

- Risk reduction behavior begins with a person's **attitude** that the behavior will lead to positive outcomes.
- This attitude leads to the **intent to perform** a specific behavior.
- The strength of a person's **intention** to undertake the behavior change **depends on** the influence of his or her immediate **social environment** and general **social norms ~ social influence**.

The Theory of Reasoned Action also included the concept of "...perceived behavioral control" which is a component of the Theory of Planned Behavior. Perceived behavioral control is determined by two factors:

- Control Beliefs
- Perceived Power

(Kelli McCormack Brown – http://hsc.usf.edu/~kmbrown/TRA_TPBM.htm)

Usefulness in HIV Prevention

- The theory is that it incorporates the social aspects of human behavior.
- The focus on attitudes and subjective norms suggests a community level HIV intervention designed to influence the perceptions of target groups.

Considerations

- The focus on attitudes and intentions, while predictive of some behaviors, neglects issues of relapse and behavior maintenance.
- Larger social and environmental issues are not highlighted as influences on norms and behaviors.

Program Application

A program using the Theory of Reasoned Action might conduct a needs assessment to

determine:

- Client's attitudes about adoption of risk-reduction behaviors.
- If clients express an intention to change any risk-related behaviors.
- Client's perception about the attitudes and behaviors of their peers.

The following sources may be useful in learning more about the Theory of Reasoned Action:

Ajzen, I. and Fishbone, M. (1980). *Understanding attitudes and predicting social behavior*. Englewood Cliffs NJ: Prentice-Hall.

Fishbein, M. and Ajzen, I. (1975). *Belief, attitude, intention and behavior: An introduction to theory and research*. Boston MA: Addison-Wesley. Fishbein, M., Middlestadt, S. E. (1989).

Using the theory of reasoned action as a framework for understanding and changing AIDS-related behaviors. In Mays, V.M., Albee, G.W., and Schneider, S.F., (Eds.), *Primary prevention of AIDS: Psychological approaches*. Newbury Park CA: Sage Publications.

Cognitive-Social Learning Theory (Bandura)

Overview: Cognitive-Social Learning Theory is based on the premise that behaviors are learned through direct experience or by modeling the behavior of others through observation. It emphasizes the interaction between behavior, social, and physical factors, and maintains that a change in anyone of these factors influences the others. New behaviors often require the acquisition of new skills. The chance of a behavior(s) being repeated is based on the person's assessment of the benefits/costs. Key aspects of the theory include:

- **Information provision** is a first step in behavior change. Individuals are not even considering a change if they have no information about the risk and how it could affect them. (**Knowledge**).
- **Outcome expectancies** are the extent to which a person values the expected outcome of a specific behavior- the expected positive or negative consequences of a behavior. Seeing the rewards (or costs) of a behavior for someone else is one way to develop these expectations.
- **Self-efficacy** is the belief that one is capable of performing a particular behavior and is confident in one's ability, even if it involves challenge. Self-efficacy can be developed by observation of others or by direct practice and experience.
- **Social competency/support** is the extent to which an individual can express and negotiate their needs with others and gets support from others (**Social Influence**).

Usefulness in HIV Prevention

- The importance of **self-efficacy** is a particular contribution of Social Learning Theory.
- Perceived self-efficacy to negotiate condom use with partners has proved a strong predictor of sexual behavior change among gay men (Emmons et al., 1986; McKusick et al., 1990), adolescents (Hingson et al., 1990), and college students (Basen- Engquist, 1994).
- Useful for identifying psychological and environmental factors that may affect behavior change.

Considerations

- The theory is focused on the individual rather than group or community norms, which limits the extent to which broad-ranging changes in the HIV epidemic can occur.
- Known risk factors for HIV infection such as the bio-psycho-social components of addictive behaviors and other profound psychological issues are not easily addressed by this theory.

Program Application

A program using Social Cognitive Theory might assess:

- How much experience people have in talking to their partners about condom use.
- What types of situations present the greatest barriers to practicing risk-reduction behaviors?
- Whether people think that adopting risk-reduction behaviors would produce positive or negative consequences.

The following may be useful in learning more about the Social Learning/Cognitive Theory:

Bandura, A. (1977). *Social Learning Theory*. Englewood Cliffs: Prentice-Hall.

Bandura, A. (1977). *Social foundations of thought and action: A social-cognitive theory*. Englewood Cliffs: Prentice-Hall.

Bandura, A. (1989). Perceived self-efficacy in the exercise of control over AIDS infection. In Mays, V.M., Albee, G.W., and Schneider, S.F. (Eds.), *Primary prevention of AIDS: Psychological approaches*. Newbury Park CA: Sage Publications.

Bandura, A. (1991). A social cognitive approach to the exercise of control over AIDS infection. In DiClemente, R. (Ed.), *Adolescents and AIDS: A generation in jeopardy*. Newbury Park CA: Sage Publications.

Bandura A. (1994) Social cognitive theory and exercise of control over HIV infection. In DiClemente, R.J. (Ed.), *Preventing AIDS: Theories and methods of behavioral interventions*. New York, NY: Plenum Press.

Transtheoretical (Stages of Change) Model (Prochaska, DiClemente & Norcross)

Overview: The premise of the Stages of Behavior Change Model is that behavior change takes place in a series of stages, and each stage depends on having passed through the previous one. A stage can last an indeterminate amount of time. People do not necessarily pass through stages sequentially and may repeat stages. Relapse is viewed as a normal process in a persons attempt to change behaviors. The five stages are:

- **Pre-contemplation** – Before a person is aware of the negative effects of a particular behavior, there is no intention to change. They may be unaware of their risk, or believe that their behaviors do not expose them to risk. They see no need to change. This stage is related to knowledge, attitudes and beliefs.

- **Contemplation** – A person has become aware of the hazards of the behavior, but is not yet certain about whether the necessary change is worth the effort. They are ambivalent about the benefits of making the change versus what they risk by trying to make the change. This stage is related to attitudes and beliefs, self-standards, relationship issues, family/cultural norms, social/peer norms, and environmental barriers.
- **Preparation** – The person intends to make the behavior change in the very near future, and is actively getting ready to do so by expressing readiness or developing a plan. This stage is related to self-efficacy and skills.
- **Action** – The person has changed a risky behavior recently, and the change has been in effect for less than six months. This stage is related to emotions and social/peer norms.
- **Maintenance** – The behavior change has been maintained for six months or more, the person is relatively comfortable with the change and has achieved consistency in enacting the new behavior. This stage is related to emotions and social/peer norms.
- **Termination** – Overt behavior will never return, and there is complete confidence that you can cope without fear of relapse.

Usefulness in HIV Prevention

- Fosters diverse approaches to HIV prevention strategies based on age, gender, race/ethnicity, socioeconomic status and other factors (Valdiserri, et al., 1992).
- Assessment is important, and providers need to target only those at a particular stage or simultaneously design a program that can work with the different stages.

Considerations

- The different types of interventions that may be required may call for a number of different service providers and service settings, and involve collaborations among multiple service organizations to implement the model in a community.
- It may be difficult for a single agency to track the progress of diverse communities; intervention responsibilities are best geared to community-based organizations serving particular target groups.

Program Application

A program using the Stages of Change model can determine what “stage” an individual is in and then intervene in ways that are appropriate for that particular stage. Assessment might include questions like:

- Is a person aware of negative effects of a particular behavior?
- Do they perceive themselves to be at risk?
- Is s/he thinking about changing that behavior?
- What do they feel may be negative for them if they try to make a change?
- If someone is preparing to change, what are the steps they are taking to make it happen?
- Do they feel they have the skills to put a condom on correctly or negotiate safer sex with their partner?
- What problems are being encountered as people try to maintain behavior change?

The following may be useful in learning more about the Transtheoretical (Stages of

Change) Model:

Baranowski, T. (1990). Reciprocal determinism at the stages of behavior change: An integration of community, personal and behavioral perspectives. *International Quarterly of Community Health Education*, 10, 297-327.

Prochaska, J.O. and DiClemente, C.C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51, 390-395.

Prochaska, J.O. and DiClemente, C.C. (1986). Toward a comprehensive model of change. In Miller, W.R. and Heather, N. (Eds.), *Treating addictive behaviors* (pp.3-27). New York: Plenum.

Prochaska, J.O., DiClemente, C.C., Norcross, J.C. (1992). In search of how people change. *American Psychologist*. 47, 1102-1114.

Diffusion of Innovations Theory (Rogers)

Overview: Diffusion refers to the process by which a new idea or practice (**innovation**) is circulated and accepted among members of a group or population over time. Exposure, which involves one's social network, will help to determine the rate at which various people adopt a new idea or a new behavior. Diffusion theory is based on the following five concepts:

- **Communication channels exist** for the dispersal of the innovation (**social networks**). These can be word of mouth, telephone, Internet, newspapers, newsletters, street sheets, and role model stories. The system for diffusing the innovation can be centralized (i.e., transferred from experts from the top down) or decentralized (i.e., transferred through dialogue between source and target group).
- **Time and process is required** for the message to reach people.
- **Opinion leaders** (highly visible, trusted, respected people, who either live in the community or are available through the media) can assist in the diffusion of the innovation (**social influence**). They can be employed to communicate new information and they are most effective when their specific role is determined with the target audience in mind. They may live in the community or be accessible through the media.
- The characteristics of the person or medium communicating the innovation, the "**change agent**" will influence the success of the diffusion.
- The innovation must be compatible with the existing values, experiences, and needs of the target group's social system (Dearing et al., 1994).

Opinion leaders may not be as effective as peer dialogue for disseminating information to unique population groups. A decentralized approach should be used for members of marginalized groups, and the change agent within this decentralized approach ought to be a member of the group.

Usefulness in HIV Prevention

- If the core concepts are appropriately adapted, the diffusion theory can be used to

develop effective interventions for the gay community and injection drug users (Dearing et al., 1994).

- The diffusion theory can be utilized as a framework to reach communities of color.
- The theory takes into consideration the relationship between cultural influence and behavior change.

Considerations

- Since HIV prevention interventions require addressing taboo topics such as sexual and substance use behaviors, communication channels may be restricted and other barriers to dispersing prevention messages are presented.
- Prevention innovations are generally less likely to be accepted because people may deny they are at risk, do not believe that the proposed behavior change (condom or clean needle use) will actually protect them, or feel that the cost of changing their behavior is greater than the benefit of avoiding possible infection (Dearing et al., 1994).

Program Application

A program using the Diffusion of Innovations approach might use a needs assessment to investigate:

- What are the most effective means, within the target population, to get a message out?
- Who are the community leaders or key representatives who can disseminate the program message?
- What kinds of social networks exist in the community?
- Based on the nature of the target group, and on the existing social network links, which people may be particularly hard to reach?

The following may be useful in learning more about the Diffusion of Innovations

Theory:

Rogers, E.M. (1983). *Diffusion of Innovations*. Third Edition. New York, NY: The Free Press.

AIDS Risk Reduction Model (Catania, Kegeles & Coates)

Overview: This model of behavior change is based on three stages:

- **Labeling** - a person must consciously identify a behavior as risky before they will consider any change;
- **Commitment** - a person must make a commitment to reduce the behavior; and
- **Enactment** - a person must take action to remove or reduce any barriers to the desired change and then actually make the change.

Factors influencing movement between these stages include fear/anxiety and social norms. People may move among the stages in any order. The theory is specifically tailored for HIV prevention.

Usefulness in HIV Prevention

- Research on condom use among heterosexuals (Catania et al., 1994) found evidence that

the three stages are linked to commitment to use condoms and concluded that it can be an accurate model for understanding the behavior change process.

Considerations

- It does not address the personal beliefs and social norms that are important determinants of whether people will achieve the goals of the individual stages and whether they will move from one stage to the next.

Program Application

A program using the AIDS Risk Reduction Model might design a needs assessment to include questions such as:

- Is a person aware of negative effects of a particular behavior?
- Do they perceive themselves to be at risk?
- Is s/he thinking about changing that behavior?
- If someone is preparing to change, what are the steps they are taking to make it happen?
- Do they feel they have the skills to put a condom on correctly or negotiate safer sex with their partner?
- What barriers are being encountered as people try to maintain behavior change?
- What action must they take to make the change?

The following may be useful in learning more about the AIDS Risk Reduction Model:

Catania, J.A., Kegeles, S.M., Coates, T.J. (1990). Toward an understanding of risk behavior: An AIDS risk reduction model. *Health Education Quarterly*, 17, 53-72.

Longshore, D., M. D. Anglin, and S-C Hsieh. (1997). Intended sex with fewer partners: An empirical test of the AIDS risk reduction model among injection drug users. *Journal of Applied Social Psychology*, 27(3), 187-208.

Empowerment Theory (Wallerstein and Bernstein)

Overview: The Empowerment Theory is based on Paulo Freire's ideas of Popular Education. It is based on the premise that groups of people change through a process of coming together to share experiences, understanding social influences, and collectively developing solutions to problems. The communities own perspectives, concerns and desires are essential to the planning process. An HIV prevention program designed from this model must emerge from the community for which it is being developed. Key components are:

- Identifying targets for change at the individual and group level.
- Participatory education through listening, dialogue, and support for action. The program planner assists community members in developing their own curriculum, and provides direction and awareness regarding HIV prevention while remaining non-judgmental and non-dictatorial.
- Focus Groups and key informants (i.e., peers, public opinion leaders, etc.) should be used during planning and implementation of the intervention. There is consensus building and planners should function as facilitators.

Usefulness in HIV Prevention

- The theory can be utilized to reach communities of color and/or high-risk populations.
- The theory takes into consideration the relationship between cultural influence and behavior change.

Considerations

- Little is formally known about its effectiveness. However, given its applicability to increasing self-esteem and providing support, it can be projected to have a degree of success. As with theory in general, though, it is recommended that the Empowerment Theory be considered as one of several components of a strong intervention program.

Program Application

A program using Empowerment Theory would assess:

- What people in the target population or community are concerned about, as well as other issues in the community in addition to the ones that planners are dealing with.
- Do people have a history of coming together to work on issues of mutual concern?
- What is the level of awareness regarding structural barriers to change?
- What do people in the community know about HIV?

The following sources may be useful in learning more about the Empowerment Theory:

Wallerstein, N. and Berstein, E. (1988). Empowerment education: Freire's ideas adapted to health education. *Health Education Quarterly*, 15(4), 379-394.

Wallerstein N. (1992). Powerlessness, empowerment, and health: Implications for health promotion programs. *American Journal of Health Promotion*, 6, 197-205.

Theory of Gender and Power (Connel)

Overview: The premise of the Theory of Gender and Power is that social influences compromise disadvantaged women's health and autonomy, which can significantly impact their ability to change some behaviors. It focuses on the relationship between two people. Key points are:

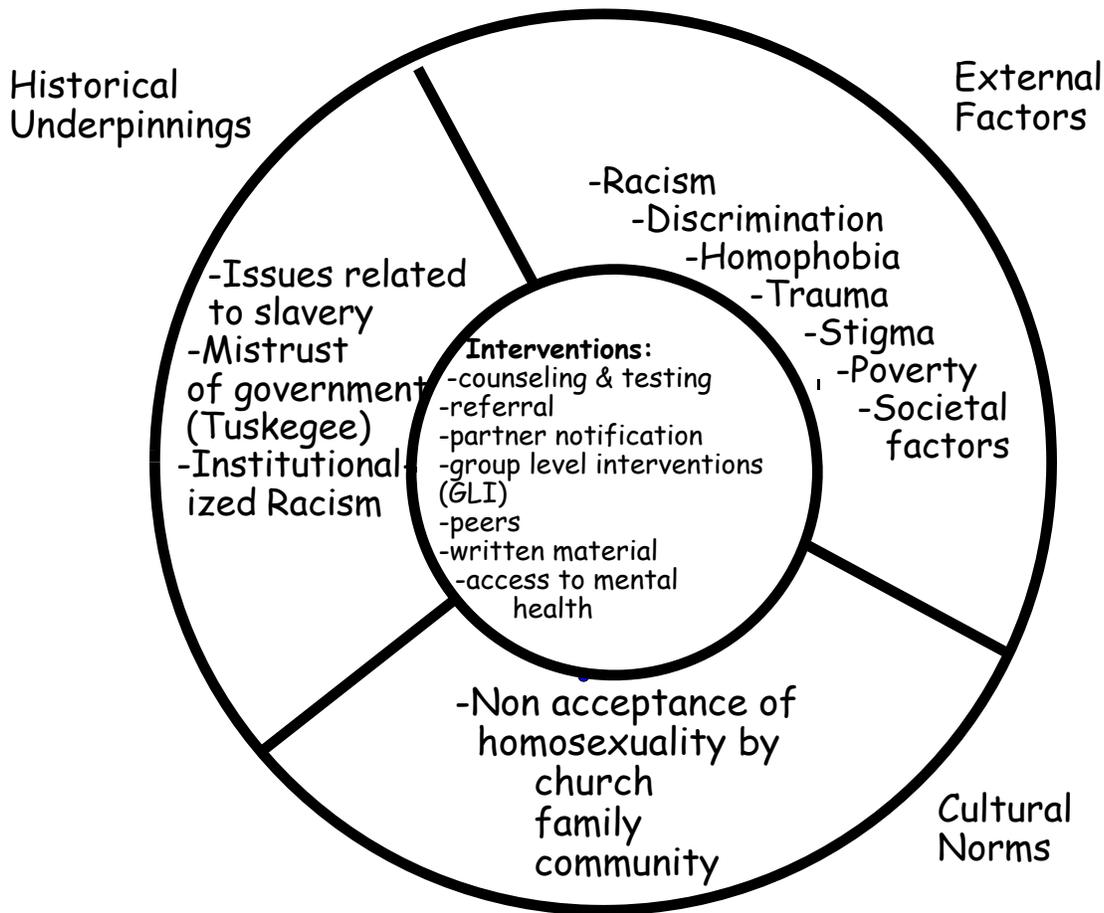
- **Division of Labor** includes issues of childcare, distinctions between paid and unpaid work, and salary inequities between the sexes. This deals with **relationship issues** and **environmental barriers**.
- **Division of Power** recognizes the power imbalances in heterosexual relationships that contribute to men's authority, control, and coercion over women (**Social Influence**).
- **Cathexis** refers to society's gender approved norms and expectations for appropriate sexual behaviors (**Social Norms**).

Usefulness in HIV Prevention

- The theory is utilized to reach women.
- It is useful in understanding additional co-factors related to women at-risk when designing interventions.
- It takes into account patriarchal influence and behavior change.

For example, if an agency is examining the implementation of HIV prevention interventions for African American/Black MSM, the filled in socio-cultural model might resemble the circle below.

Once these elements have been identified, it is incumbent on the agency to ensure that they are taken into account when strategies for implementing each intervention are considered. Any of these elements, which upon first examination may appear to preclude successful prevention efforts, may conceivably be turned into facilitators of HIV prevention if examined in a culturally sensitive manner.



Using this example, for instance, when designing an intervention for African American/ Black MSM, it is important to acknowledge that many African American/Black MSM stay “in the closet” because of negative attitudes about these orientations in the community and within religious institutions. The provision of prevention interventions, therefore, is made more difficult because of the necessity to hide their orientation. Respect must be given to these issues when considering appropriate models, settings and methods to deliver prevention messages. At the same time, issues such as mistrust of the government, racism, trauma, stigma, discrimination and poverty must be factored into mix as well.

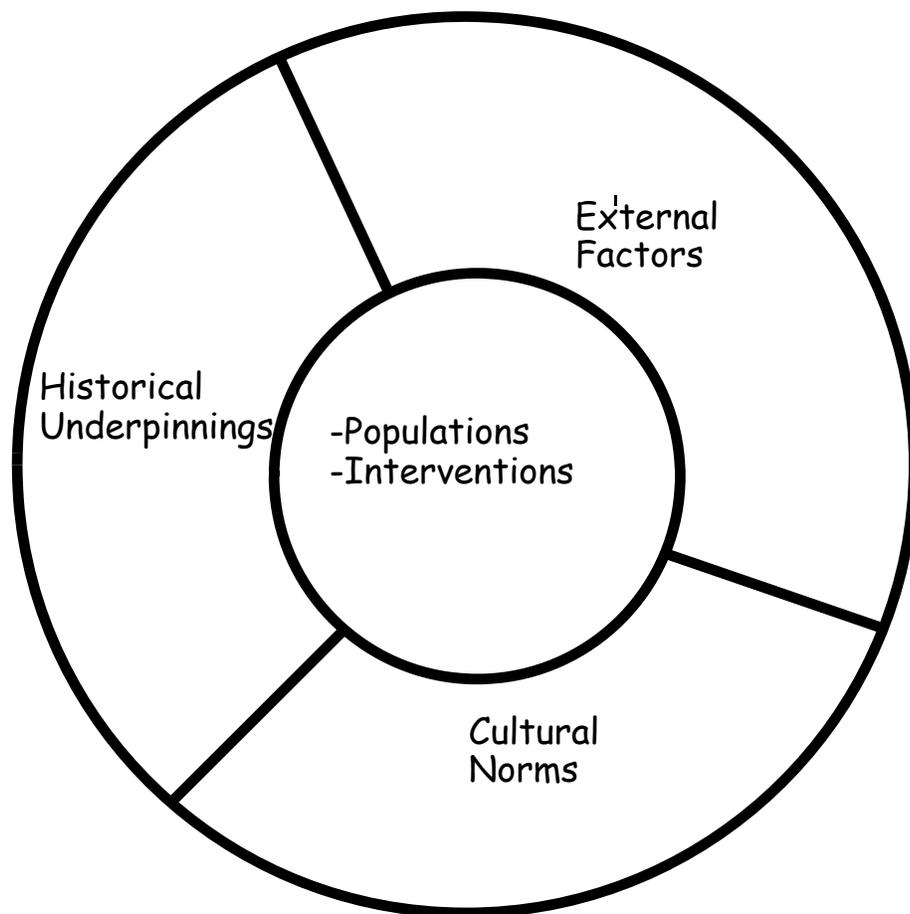
On designing

The following elements must be considered when implementing any HIV prevention intervention:

Historical Underpinnings (events that occurred in the past which may affect how a particular individual or community perceives events or reacts to specific issues)

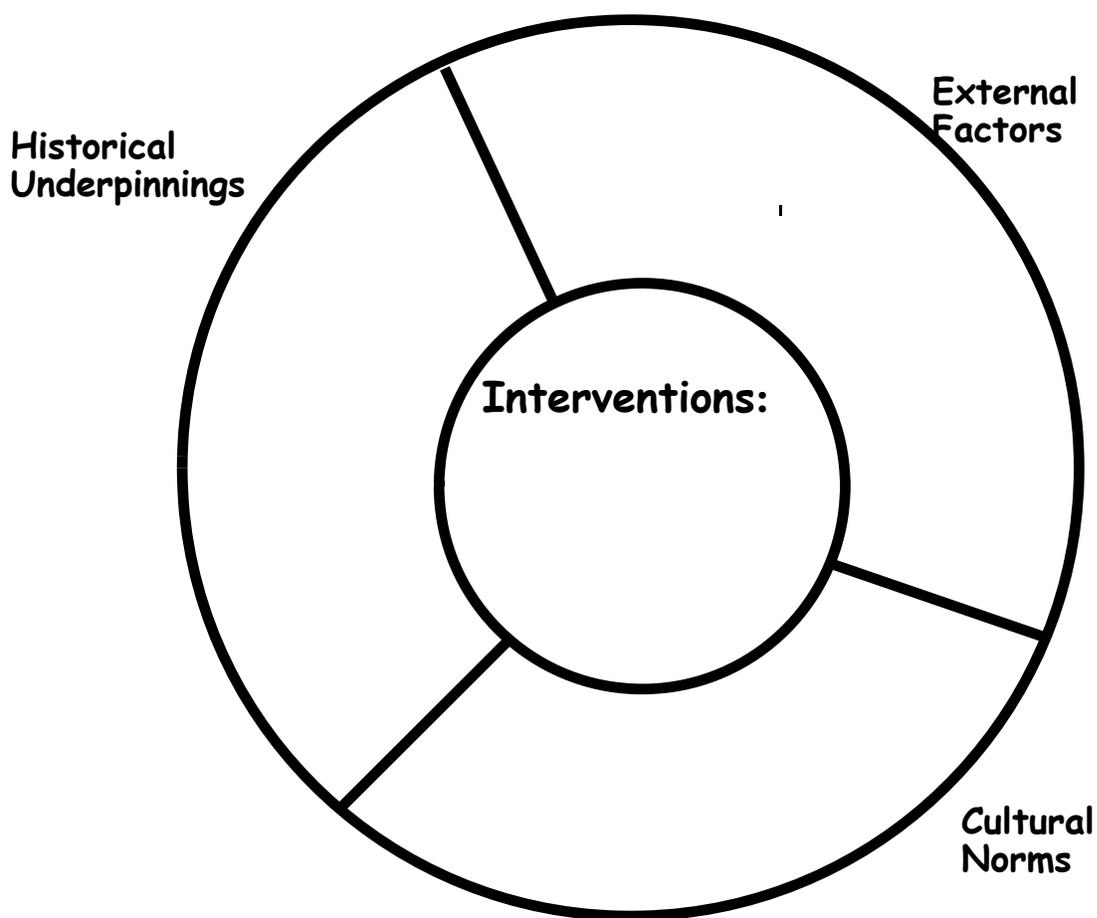
Cultural norms (ideas/traditions/methods of thinking or doing things specific to a particular culture)

External factors (issues/events occurring in the world which may affect HIV prevention)



A circle-based illustration of this model can be useful in developing an understanding that the interventions appropriate for any particular population must be embedded within, and take into account, factors that are longstanding and out of the control of the provider, including historical underpinnings, cultural norms and external factors.

Worksheet: Implementing HIV Prevention Interventions for



Considerations

- Little is formally known about its effectiveness. However, given its applicability to increasing self-esteem and providing support, it can be projected to have a degree of success. As with theory in general, though, it is recommended that Gender and Power Theory be considered as one of several components of a strong intervention program.

Program Application

A program using the Theory of Gender and Power might design a needs assessment to include questions such as:

- Who makes decisions in your relationship?
- Who earns the money; who takes care of the children?
- Do you ever have sex with your partner when you don't want to?
- Do you ever have sex with others when you don't want to? What are the circumstances?
- Have you ever had sex because you needed money, drugs, etc?
- Is it okay for a woman to control what happens during sex?
- Is it okay for a woman to talk about her sexual feelings?

The following may be useful in learning more about the Theory of Gender and Power:

Wingood, G.M., DiClemente, R.J. (1992). Application of the theory of gender and power to examine HIV-related exposure, risk factors, and effective intervention for women. *Health Education & Behavior*, Volume 27, Issue 5, October.

Social Networks/Social Support Theory (Minkler)

Overview: Social networks and social support theories are based on the concept that social ties improve health and well-being (Minkler, 1985). Social networks and social support are related, though distinct, concepts. Social networks are the chains of social ties that link an individual to others. Social support is the positive emotional and practical products that people derive from their social networks. Both are required, as some social networks may not encourage safe or healthy behaviors. There are several components that determine variability among social networks and their importance to health outcomes:

- **Density and complexity**, or the degree of intimacy and communication among members of a network;
- **Size**, or the number of people in a network;
- **Equality**, or the degree to which supports and obligations are shared among members;
- **Geography**, or how close to each other network members live;
- **Homogeneity**, or the degree of demographic similarity among network members; and
- **Accessibility**, or the ability of network members to contact each other (Berkman, 1984).

Usefulness in HIV Prevention

- This theory is helpful in reaching marginalized groups through peer led HIV interventions
- It applies to socially supportive systems and programs such as street outreach, day

- programs, group/individual counseling, peer-led interventions and case management.
- It can be used to link people to new social contacts (e.g., through peer or other HIV education groups) that may become new sources of advice, services and information for them.

Considerations

- It is difficult to assess and evaluate the effects of social support and its relationship to health interventions.

Program Application

A program using Social Networks/Social Support Theory might design a needs assessment to determine:

- The type and quality of the person's social network.
- The person's sense of belonging, feelings of worth and of self esteem.
- The extent of the person's links to nurturing social ties.
- Whether a person's primary social network and source of social support positively influences their HIV risk behavior.

The following may be useful in learning more about the Social Influence Models:

Fisher, J.D. (1988). Possible effects of reference group based social influence on AIDS risk behaviors and AIDS. *American Psychologist*, November, 914-920.

McGuire, W., and Papageoris, D. (1961). The relative efficacy of various types of prior belief-defense immunity to persuasion. *Journal of Abnormal Social Psychology*, 62, 237-337.

Minkler, M. (1985). Building supportive ties and sense of community among the inner city elderly: the Tenderloin Senior Outreach Project. *Health Education Quarterly*, 12, 303-314.

Harm Reduction Theory

Overview: The Harm Reduction Theory accepts that while harmful behaviors exist, the main goal is to reduce the negative effects of those behaviors. Harm Reduction examines behaviors and attitudes of the individual to offers ways to decrease the negative consequences of the targeted behavior. Harm reduction is often used in conjunction with behavioral goals as a way to minimize harm, thus keeping a client healthier during his or her process of behavioral change.

Basic principles include:

- Acceptance of the existence of harmful behaviors and working towards minimizing the harmful effects.
- Belief that a continuum of behaviors exists and some behaviors are clearly safer than others.
- Belief that a successful intervention is based on the quality of individual and community life and well-being.

- A non-judgmental, non-coercive provision of services and resources.
- Ensuring that the targeted population has a real voice in the creation of programs and policies designed to serve them.
- Seeking to empower clients.
- Recognizing that poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect people's vulnerability to, and capacity for, effectively dealing with harm.
- Not attempting to minimize or ignore the real harm and danger associated with risk behaviors.

Usefulness in HIV Prevention

- The theory fosters diverse approaches to HIV prevention strategies based on age, gender, sexual orientation, race/ethnicity, socioeconomic status, drug use, and other factors.
- A strength of this theory is that it incorporates acceptance of all social aspects of human behavior.

Considerations

There is no clear definition of, or method for, implementing Harm Reduction because Harm Reduction dictates that interventions be designed to serve specific individual and community needs.

Program Application

A program using Harm Reduction Theory might design a needs assessment to include questions such as:

- What do you feel are some of the things that you do that put you at risk?
- What would you want to change to reduce your risk?
- What things do you need to assist you in reducing your risk?
- How could we help you achieve your goal?

The following may be useful in learning more about the Harm Reduction Theory:

Brette, R.P. (1991). HIV and harm reduction for injection drug users. *AIDS*. 5, 125-136.

Marlatt, G. A. and Tapert, S. F. Harm reduction: Reducing the risks of addictive behaviors. In J.S. Baer, G. A. Marlatt & R.J. McMahon (Eds.), *Addictive behaviors across the lifespan: Prevention, treatment, and policy issues*. Newbury Park, CA: Sage Publications.

Walch, S.E., Prejean, J. (2001). Reducing HIV risk from compulsive sexual behavior using cognitive behavioral therapy within a harm reduction framework: A case example. *Sexual Addiction & Compulsivity*, 8(2), 113-128.

The website for the Harm Reduction Coalition also provides helpful information:
(<http://www.harmreduction.org/index.html>)

Social Marketing Theory (McQueen)

Overview: Social marketing as a behavior theory applies the concepts of traditional marketing to the "sale" or promotion of healthy behaviors (i.e., the product) to the target group (i.e., the consumer). A particular behavior is made socially desirable by linking it to something that is valued by the targeted community. It is successful when it involves the active participation of both the providers and the recipients of the information or services. The major components of the theory include:

- A market plan
- A carefully designed message
- Use of mass media
- Consensus building
- Appropriate packaging (Coates and Greenblatt, 1990)

Usefulness in HIV Prevention

- This theory is useful in changing community norms.
- It Can be effective with those who need new information to change behavior, or who want to change their behavior but have not.
- It can be accessible to those who are difficult to reach through traditional prevention channels.

Considerations

- May not be appropriate for those engaging in highest risk behavior.
- May be unsuccessful with those who are isolated and do not see themselves in relation to the campaign.

Program Application

A program using the Social Marketing Theory might design a needs assessment to include questions such as:

- What community norm is the most important to address for this population?
- What types of media does the target group most frequently use or see?
- What cultural considerations need to be incorporated into those messages?
- What method of delivery would be most successful in reaching the target audience?

The following may be useful in learning more about the Social Marketing Theory:

Coates, T. and Greenblatt, R. 1990. Behavioral change using interventions at the community level. In K. Holmes, P. Mardrh, P.F. Sparling, and P.J. Wilson (eds.), *Sexually Transmitted Diseases* (2nd ed.). pp 1075-1080. New York: McGraw-Hill.

McQueen, D. (Ed.) (1991). *Health Education Research: Theory and Practice*, 6, 37-255.

Resiliency Theory (Garmezy, Rutter)

Overview: Resiliency theory grew out of a desire to understand what factors were responsible for the success of youth, particularly those growing up in difficult environments. Resiliency is achieved through positive youth development, purposefully seeking to meet youth needs and build youth competencies relevant to enabling them to become successful adults. Rather than

seeing young people as problems, a resiliency approach views them instead as resources and builds on their strengths and capabilities to develop within their own community. To succeed youth must acquire adequate attitudes, behaviors, and skills. Resiliency programs seek to build competencies in the following areas: physical, social, cognitive, vocational, and moral.

Healthy youth development strives to help young people develop the inner resources and skills they need to cope with pressures that might lead them into unhealthy and antisocial behaviors. It aims to promote and prevent, not to treat or remediate. Prevention of undesirable behaviors is one outcome of healthy youth development, but there are others: the production of self-reliant, self-confident adults who can take their place as responsible members of society.

Usefulness in HIV Prevention

- This theory is focused on addressing youth.
- It addresses issues broader than specific risk behaviors in more holistic manner.
- It addresses risk at an individual, family, community and societal level.
- It offers options of what young people can do, rather than what they cannot or should not.
- Since many resiliency programs include a mentoring aspect, they can address HIV risk on a multigenerational level.

Considerations

While much has been studied about resiliency and youth development, its long-term outcomes with respect to HIV prevention have not been fully investigated. This theory assumes that, by giving young people competencies and protective factors, they will reduce their probability of engaging in risk behaviors.

Program Application

A resiliency program will address protective factors on multiple levels. Among the skills to be developed are:

- Communication skills
- Conflict resolution
- Stress management
- Problem-solving and decision-making
- Planning

Additional aspects to a resiliency program might be:

- Mentoring
- Community service
- Skills-building for parents

The following sources may be useful in learning more about Resiliency Theory:

Garmezy, N., Masten, A.S., & Tellegen, A. (1984). The Study of Stress and Competence in Children: A Building Block for Developmental Psychopathology. *Child Development*, 55, 97-111.

Rutter, M. (1987). Psychosocial Resilience and Protective Mechanisms. *American Journal of*

Orthopsychiatry 57(3), 316-331.

Werner, E.E., & Smith, R.S. (1982). *Vulnerable but Invincible: A Longitudinal Study of Resilient Children and Youth* New York: McGraw-Hill.

Werner, E.E. (1989). High Risk Children in Young Adulthood: A Longitudinal Study from Birth to 32 Years. *American Journal of Orthopsychiatry*. 59 (1), 72-81.

Werner, E.E. & Smith R.S. (1992). *Overcoming the Odds: High Risk Children from Birth to Adulthood*. Cornell University Press: Ithaca and London.

Motivational Enhancement Theory (Miller and Rollnick)

Overview: Motivational Enhancement Theory was originally developed through work with “unmotivated drinkers,” and is targeted to individuals who are reluctant to change risk behaviors. It draws on client-centered therapy, cognitive therapy and behavior change theory. It uses specific skills and strategies to move individuals forward towards less risky behaviors. The specific goals of motivational enhancement are to: enhance intrinsic motivational change; assist the individual in recognizing the need to do something about a potential problem; resolve ambivalence and decide to change.

Usefulness in HIV Prevention

Motivational enhancement is a theory designed to address individuals who are ambivalent about changing risky behavior. This state is applicable to the process of changing HIV risk behaviors. The specific skills and strategies have been shown to be effective in addressing addictions, as well as other HIV-related behaviors, such as unprotected sex.

Considerations

The individuals conducting this intervention need to be trained in order to utilize motivational interviewing techniques. Supervisory support and ongoing evaluation will be important to ensure that the intervention is being delivered as it was designed.

Program Application:

Motivational enhancement is achieved through a brief intervention using specific strategies in a one-on-one interchange. While other individuals may be brought into the process, it is the dynamic between the client and counselor which achieves the proposed goal.

The five main principles of motivational enhancement theory are:

1. Express Empathy
2. Develop discrepancy
3. Avoid argumentation
4. Roll with resistance
5. Support self-efficacy

These principles are met using strategies which include:

- Listen Reflectively
- Ask open-ended questions

- Affirm
- Summarize
- Elicit self-motivational statements

The following sources may be useful in learning more about Motivational Enhancement Theory:

Miller, W. and Rollnick, S. (1991) *Motivational Interviewing: Preparing People to Change Addictive Behavior*. New York: Guilford Press

Miller, W.R., Zweben, A., DiClemente, C.C. and Rychtarik, R.G. (1995) *Motivational Enhancement Therapy Manual: A Clinical Research Guide for Therapists Treating Individuals with Alcohol Abuse and Dependence*. (National Institute of Health Publication 94-3723), Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.)

Prochaska, J.O., Redding, C.A., Harlow, L.L., Rossi, J.S. and Velicer, W.F. (1994) The Transtheoretical Model of Change and HIV Prevention: A Review, *Health Education Quarterly*, 21 (4), 472 – 486.

The Diffusion of Effective Behavioral Interventions Project (DEBI)

Overview: DEBI is a national-level strategy, developed by the Academy for Educational Development under the guidance of the Centers for Disease Control and Prevention (CDC) to provide training and technical assistance on specific HIV/AIDS prevention interventions based on one or more of behavioral science theories described above. Materials necessary to implement these interventions were packaged into user-friendly kits. DEBI interventions are either Community Level Interventions (which seek to change attitudes, norms and values, as well as social and environmental context of risk behaviors of an entire community/target population) or Group Level Interventions (which seek to change individual behavior within the context of a group setting).

The following may be useful in learning more about the DEBIs:

www.effectiveinterventions.org

Other References Used for the Section on Behavioral Health Theories:

Basen-Enquist, K. (1994). Evaluation of a theory-based HIV prevention intervention for college students. *AIDS Education and Prevention*, 6(5):412-424.

Berkman, L. F. (1984). Assessing the physical health effects of social networks and social support. *Annual Review of Public Health* 5:413-32.

Can theory help in HIV prevention?. HIV prevention: Looking back, looking ahead. A project of the Center for AIDS Prevention Studies (CAPS), University of California, San Francisco, and The Harvard Institute.

Centers for Disease Control and Prevention (CDC). (November 1999). HIV/AIDS prevention research synthesis project. *Compendium of HIV Prevention Interventions with Evidence of Effectiveness*.

Centers for Disease Control and Prevention (CDC). (1999). *Evaluation Guidance*.

Coates, T. and Greenblatt, R. (1990). Behavioral change using interventions at the community level. In K. Holmes, P. Mardrh, P.F. Sparling, and P.J. Wilson (Eds.), *Sexually Transmitted Diseases* (2nd ed.). pp 1075-1080. New York: McGraw-Hill.

Coloradans Working Together Preventing HIV/AIDS 2001-2006 (2003). Colorado Core Planning Group (CPG).

Dearing, J.W., Meyer, G., Rogers, E.M. (1994). Diffusion theory and HIV risk behavior change in preventing AIDS: Theories and methods of behavioral interventions. In R.J. DiClemente and J.L Peterson (Eds.), Plenum Publishing Corporation: New York.

Emmons, C.A., Joseph, J.G., Kessler, R.C., Wortman, C.B., Montgomery, S.B., and Ostrow, D.G. (1986). Psychosocial predictors of reported behavior change in homosexual men at risk for AIDS. *Health Education Quarterly*, 13:331-345.

Fisher, J.D. and Fisher, W.A. (1992). Changing AIDS-risk behavior. *Psychological Bulletin*, 111:455-474.

Holtgrave, D.R., Qualls, N.L., Curran, J.W., Valdiserri, R.O., Guinan, M.E. & Parra, W.C. (1995). An overview of the effectiveness and efficiency of HIV prevention programs. *Public Health Reports*, 110(2):134-146.

Iowa Comprehensive HIV Prevention Plan 2001-2003 (2001). Iowa HIV Prevention Community Planning Group.

Kelley, J. (1995). *Changing HIV risk behavior: Practical strategies*. Guilford Press, New York. Herlocher, T., Hoff, C., and DeCarlo, P. University of California, San Francisco (UCSF). (1995).

Maine HIV Prevention Plan 2004 - 2008. Maine HIV Prevention Community Planning Group.

McKusick, L., Coates, T.J., Morin, S.F., Pollack, L., Hoff, C. (1990). Longitudinal predictors of reductions in unprotected anal intercourse among gay men in San Francisco: The AIDS behavioral research project. *American Journal of Public Health*. 80(8):978-983.

McLeroy, K.R., Steckler, A.B., Simmons-Morton, B., Goodman, R.M., Gottlieb, N. and Burdine, J.N. (1993). Social science theory in health education: Time for a new model?. *Health Education Research, editorial*. September, 1993.

Petosa, R. and Jackson, K. (1991). Using the health belief model to predict safer sex intentions among adolescents. *Health Education Quarterly*. 18(4):463-476.

Prevention Training Centers, CDC. (October, 1997) "Bridging Theory & Practice" Applying *Behavioral Theory to STD/HIV Prevention*, Participants course manual.

Valdiserri, R.O., West G.R., Moore, M. et al. (1992). Structuring HIV prevention service delivery systems on the basis of social science theory. *Journal of Community Health*, 17(5):259-269.

Wilkerson, D.E. (1996, October). Developing effective theory-based HIV prevention interventions. A workshop presented at the 1996 National Skills Building Conference, Washington D.C.

"Lessons Learned" to Inform Development of Effective HIV Prevention Intervention in Communities of Color Within the context of its ongoing examination of issues related to communities of color and their impact on HIV prevention, the PPG realized that it had learned valuable lessons which could be helpful in developing effective programs. Below are a summary of those "lessons learned", or "tips" for working with African American/Black communities, Latino communities, Asian and Pacific Islander communities and Native American communities.

"Tips" for Working with African American/Black Communities

- ✓ Become familiar with the history of African Americans/Blacks and how historical events have played a role in shaping African Americans'/Blacks' mistrust of governmental programs and traditional health care institutions. Be mindful of certain historical reference points such as the Tuskegee Study experiments on men related to untreated syphilis, studies using an unlicensed measles vaccine in children, and forced attempts to sterilize women.
- ✓ Become familiar with present-day events such as the Health and Human Services Office of Human Research Protections report of violations of federal regulations in four drug studies involving foster children in two New York City hospitals.
- ✓ Remember that the continent of Africa was associated with the origins of HIV/AIDS. Also, in the early stages of the epidemic, Haitians, on the basis of their skin color and quest for political refugee status, were singled out as a population group particularly at risk for HIV. Unfounded and inconsistent media messages, coupled with historical events, have caused some African Americans/Blacks to believe conspiracy and genocide theories that conflict with educational media messages about HIV/AIDS (e.g., public health prevention messages about HIV and condoms).
- ✓ Identify, acknowledge and discuss negative historical events or occurrences in local

communities. Design prevention strategies that address racism, prejudice and other discrimination factors.

- ✓ Learn about the diversity and various ethnic backgrounds of African Americans/Blacks, such as people from the Caribbean and Latin America. Promote program implementation and peer education by culturally diverse staff.
- ✓ Recognize the greater prevalence of poverty within African American/Black communities and understand the conditions associated with this (e.g., institutionalized racism and discrimination) and how this may adversely impact HIV prevention efforts (e.g., low self-esteem, negative feelings about the future, few opportunities for social recreational activities other than sex and drugs).
- ✓ Consider the possibility or likelihood that HIV and drug use epidemics in individual communities may have more to do with geography and poverty than race.
- ✓ Become familiar with the strengths of African Americans/Blacks, such as their history of survival and faith, cultural institutions (e.g., barber shops, beauty salons), strong civic organizations, sororities and fraternities, local community leaders, entrepreneurs, and doctors, nurses and other health care workers in African American/Black communities that provide the infrastructure and indigenous leadership for HIV prevention opportunities.
- ✓ Realize the need to address basic survival needs (e.g., food, shelter, clothing) first since preventive health is often a low priority for those who are economically disadvantaged. Incorporate HIV-related information and discussion in non-AIDS related health and other materials to promote a holistic approach to health and wellness.
- ✓ Realize that although many African American/Black leaders have numerous competing demands for time and attention to high priority needs and issues, their involvement in HIV prevention is imperative. Active involvement of African American/Black leaders in HIV prevention can increase community awareness of the severity of the problem, as well as increase community mobilization and action.
- ✓ Increase the involvement of the traditional “Black Church” in HIV prevention efforts, while recognizing and being sensitive to denominational cultural and theological doctrine. Develop partnerships with traditional African American/Black Churches and be a resource and guide to enhance their response to persons affected by HIV/AIDS. Use peer educators and facilitators to work with African American/Black faith leaders.
- ✓ Become familiar with diversity of immigrants of African descent, in terms of religion, socioeconomic status, geographic locales and languages spoken. When providing information and education, use non-threatening and familiar environments (e.g., beauty salons, barber shops, social clubs) and multi-media approaches designed according to

educational level, populations and sub-group culture. Consider the use of cultural symbols, such as adinkra symbols and kente cloth in prevention messages and interventions.

- ✓ Recognize that many women, including African American/Black women, are often not in a position to negotiate use of condoms with their male partners. Some fear or have experienced rejection, abuse and withdrawal of financial support for insisting that their male partner wear a condom. Strategies focusing on condom use need to be tailored for women and men to achieve optimal benefits for both genders.
- ✓ Be sensitive to negative attitudes about homosexuality in the African American/Black community, particularly by African American/Black men who have sex with men (MSM) and realize that many African American/Black MSM identify themselves as heterosexual and may not relate to prevention messages crafted for gay men.
- ✓ Recognize African American/Black teenagers' beliefs of invulnerability to disease and injury, responses to peer pressure and influences of messages and environments that accept sex and drug use as social norms. Support the development of sites where youth can seek confidential and discreet HIV counseling, testing, referral and other prevention services.
- ✓ Access culturally relevant information through web sites for resources, such as Urban League (www.nul.org), QuiltEthnic (www.quilteethnic.com) and effective interventions for African Americans/Blacks (www.effectiveinterventions.org).

Prepared by: Vanessa Johnson, Capital District African American Coalition on AIDS (CDAACA), Albany, NY and Jay Cooper, AIDS Institute, New York State Department of Health, Albany NY.

Acknowledgments: The “Lessons Learned” are based upon experience working collaboratively with members of African American/Black communities in New York State. This list was prepared with benefit of guidance and insights provided by African Americans/Blacks and African American/Black service providers. The following individuals reviewed and commented on this checklist: Monica Brown (American Red Cross, Greater Buffalo Chapter, Buffalo, NY), Rev. Dr. Arthur Davis (Collins Correctional Facility, Buffalo, NY), Derryck Griffith (Political Educator and Advocate, New York, NY), Daphne Hazel (Project Street Beat, Bronx, NY), Kim-Monique Johnson (Nassau County Department of Drug and Alcohol Addiction, Hempstead, NY), Janet Foster (AIDS Institute, New York State Department of Health, Albany, NY) and Barry Walston (AIDS Institute, New York State Department of Health, Albany, NY).

Suggested Reading:

Darbes, L.A., et al. (2002, March). Systematic Review of HIV Behavioral Prevention Research in African Americans. Found at: <http://hivinsite.ucsf.edu/InSite.jsp?page=kb->

07&doc=kb-07-04-09

Health Watch Information and Promotion Service, Inc. (1991). *AIDS & African Americans: It's Time for Action! A Strategy Development Project for HIV Prevention and Risk Reduction for African-Americans*. New York, NY: Health Watch.

National Alliance of State and Territorial AIDS Directors (NASTAD) (2001, December). *HIV/AIDS: African American Perspectives and Recommendations for State and Local AIDS Directors and Health Departments*. Washington, D.C.: NASTAD.

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention (2003). *HIV/AIDS Among African Americans: Key Facts*. Found at: <http://www.cdc.gov/hiv/pubs/Facts/afam.pdf>

University of California, San Francisco. Center for AIDS Prevention Studies. *AIDS Research Institute* (1999, September). *what are African-Americans' HIV prevention needs?* San Francisco, CA: University of California, San Francisco.

“Tips” for Working with Latino/Hispanic Communities

- ✓ Remember that Latinos/Hispanics have historically felt mistreated and disrespected during health care encounters. They have experienced being talked down to, spoken to rudely or simply ignored. Challenge established norms in your profession related to culture, and question the assumptions of power that go along with being a health professional.
- ✓ Realize that Latinos/Hispanic immigrants come from many different countries or commonwealths such as Mexico, Puerto Rico, Cuba and the Dominican Republic. Due to the ongoing influx of Latinos into the U.S., there is a critical need to disseminate HIV/AIDS information to recently immigrated Latinos. Design HIV/AIDS information in Spanish and for persons with less than a high school education.
- ✓ Realize that Latinos/Hispanics are a part of the U.S. and many who identify as such are “second generation” and older. The Latino/Hispanic identity is a very personal one. Acculturation, non-acculturation and multi-culturalism influences the Latino/Hispanic experience.
- ✓ Accept cultural complexities by addressing the differences in HIV risk related to the diverse backgrounds of the Latino population. Recognize cultural qualities common in Latino communities, such as collectivism, respect and loyalty. Cultural complexities may also include conflicts related to many identities and roles (e.g., a Latino gay man may be conflicted between his race/ethnicity and sexual orientation). Collaborate with Latinos and their community groups to develop messages that are culturally, linguistically and educationally appropriate for the diverse Latino populations.

- ✓ Recognize that Latinos/Hispanics have a lower socioeconomic status than other ethnic groups, have experienced racism and are less educated than the U.S. population as a whole. Develop comprehensive interventions to address these root causes of poor health and health disparities. Develop partnerships to improve education to increase opportunity, decrease poverty and improve health outcomes. Encourage research studies that show the socioeconomic profile of Latinos/Hispanics in the U.S. and the effects on the individual, family, community and larger society.
- ✓ Address limited access to health care services, including needle exchange programs, by immigrants who may fear being deported. Conducting peer outreach and providing services through mobile vans are alternatives to reach immigrants.
- ✓ Seek a better understanding of the disproportionately high rates of HIV/AIDS, STDs, teenage pregnancy, etc. in Latinas. Identify the health needs of this population and improve access to health care services. Include variables related to identity formation, perceived discrimination and cultural negotiation.
- ✓ Become familiar with cultural norms related to gender, such as men resisting condoms to prove their masculinity and women allowing men to refuse condom use to maintain their passivity or submissiveness. Emphasize the protective role of the Latino male to encourage condom use. Equate safer sex with being a good mother and protecting the survival of the family.
- ✓ Realize that conflict arises for Latino gay men who date non-Latino gay men. A power differential exists and Latino gay men often experience a higher sense of racism and homophobia than those in non-interracial relationships.
- ✓ Be aware of stereotypes related to drug use and sexuality. These can be dehumanizing and enhance Latinos' sense of not being in control of sexual and drug using situations.
- ✓ Realize that there is a cultural fear of homosexuality and many Latinos may perceive homosexuality as wrong due to expectations related to family and gender roles. Latino gay men are often unwelcome by the mainstream gay community; those who try to access this community often experience discrimination or are idolized as exotic sexual beings. This influences the sexuality and sexual behavior of Latino men who have sex with men (MSM). This also causes low self-esteem and personal shame, leading Latino MSM to engage in more risky behaviors. Convince Latinos to encourage healthy sexuality by discussing their gender role expectations and accepting diversity in their community.
- ✓ Remember that there is a "second generation" of Latinos/Hispanics who are caught in between traditional roots and Americanization. The impact of family obligations can restrict individuality. Some Latinos rebuild a new family outside of traditional family structures (e.g., drug using partners).

Prepared by: Guillermo Chacon, Latino Commission on AIDS, New York, NY; Vanessa Johnson, Capital District African American Coalition on AIDS (CDAACA), Albany, NY; and Jay Cooper, AIDS Institute, New York State Department of Health, Albany NY.

Acknowledgments: The “Lessons Learned” are based upon experience working collaboratively with members of Latino/Hispanic communities in New York State. This list was prepared with benefit of guidance and insights provided by Latinos/Hispanics and Latino/Hispanic service providers. The following individuals reviewed and commented on this checklist:

Ronald Gonzalez (Alianza Latina, Buffalo, NY) and Janet Foster (AIDS Institute, New York State Department of Health, Albany, NY).

Suggested Reading:

Amaro, H., de la Torre, A. (2002, April). “Public Health Needs and Scientific Opportunities in Research on Latinas” *American Journal of Public Health*, 92(4): 525-529.

Cultureline Corporation (1991). *Hispanics & HIV. Strategies and Tactics for Education/Prevention*. New York, NY: Cultureline Corporation.

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ETR Associates, Inc. Rodriguez-Trias, H., Kane, W. and Quackenbush, M. (Eds.) (2003). *Eliminating Health Disparities: Conversations with Latinos*. Santa Cruz, CA: ETR Associates.

Miller, J.E., Guarnaccia, P.J. and Fasina, A. (2002, April). “AIDS Knowledge Among Latinos: The Roles of Language, Culture, and Socioeconomic Status”. *Journal of Immigrant Health*, 4(2): 63-71.

University of California, San Francisco, Center for AIDS Prevention Studies (2002, April). *What are U.S. Latinos’ HIV prevention needs?* San Francisco, CA: University of California, San Francisco.

“Tips” for Working with Asian and Pacific Islander Communities

- ✓ Learn about the diversity of Asians and Pacific Islanders. This is a group of more than 50 ethnic subgroups and more than 100 languages and dialects. Tailor prevention and care efforts around the many differences in geographic origin, culture, history and socioeconomic status.
- ✓ Become familiar with Asian and Pacific Islander culture and history, which is diverse and complex. Many neighboring Asian countries were historically in conflict and many

are still in conflict. Therefore, when targeting Asians and Pacific Islanders in New York State, the diversity among Asians and Pacific Islanders needs to be represented. Otherwise, people may not relate messages to themselves.

- ✓ Realize that Asians and Pacific Islanders have historically faced hardships in this country. An example is the exclusion of Asians from the naturalization process until 1943. Another example is the Japanese internment/concentration camps during World War II. This historical complexity could lead to distrust of authority and distancing themselves from voicing their opinions.
- ✓ Identify HIV and AIDS cases by a separate Asian and Pacific Islander category. Do not lump Asians and Pacific Islanders with Native Americans and Alaskan Natives under “Other” or “Unknown”.
- ✓ Acknowledge that many immigrants may avoid accessing health care services for fear of deportation or denial of permanent residency. Immigrants may be afraid to access government services, such as HIV testing, because the U.S. immigration law prevents many HIV-positive individuals from obtaining permanent status. Additionally, some immigrants with proper identification may be afraid to file for an income tax refund for fear of deportation.
- ✓ Keep in mind that mis-communication can greatly reduce trust. Unpleasant experiences during appointments and multiple interviews prevent individuals from seeking future health care services. Ensure linguistic access and cultural competence.
- ✓ Be aware of cultural perceptions of health care providers as authority figures. An individual may be silent, say “yes” or smile during an appointment out of respect for the provider, but may not understand or agree with what the provider is saying.
- ✓ Realize that many Asians and Pacific Islanders are linguistically isolated in households where adults may speak little or no English.
- ✓ Appeal to Asians’ and Pacific Islanders’ beliefs surrounding family and community. With the permission of the individual being served, welcome family members into discussions if they want to assist. Develop peer-based programs.
- ✓ Use discretion when discussing sex and condoms with women. Remember that these discussions are often seen as improper and uncomfortable. Women are expected to be modest due to cultural beliefs and spouses/partners may not accept use of contraceptives.
- ✓ Consider the power dynamics between genders, including the reliance of some women on their husbands for their legal immigration status, and the possibility of abusive situations by husbands, male friends or older family members.

- ✓ Be aware of naturalistic, religious or spiritual beliefs. Do not attempt to force a change in individuals' use of traditional remedies, but rather integrate other healing practices.
- ✓ Recognize that mental illness is highly stigmatized in many Asian and Pacific Islander cultures. Some cultures may express these problems in terms of headaches, fatigue or poor appetite.
- ✓ Be aware of beliefs surrounding homosexuality as a mental disease or perversion, and that AIDS only exists within the gay community, among people with multiple sex partners, the poor and undereducated.
- ✓ In addition to homophobia, men who have sex with men also deal with the combined issues of racial discrimination, poverty and language barriers, all of which contribute to low self-esteem and negative self-identity.
- ✓ Include youth and transgendered individuals when focusing on Asians and Pacific Islanders at risk.

Prepared by: Therese Rodriguez, Asian and Pacific Islander Coalition on HIV/AIDS (APICHA), New York, NY and Jay Cooper, AIDS Institute, New York State Department of Health, Albany NY.

Acknowledgments: The “Lessons Learned” are based upon experience working collaboratively with members of Asian and Pacific Islander communities in New York State. This list was prepared with benefit of guidance and insights provided by Asians and Pacific Islanders and Asian and Pacific Islander service providers. The following individuals reviewed and commented on this checklist: Iline Chung-Eddie (Project Hospitality, Staten Island, NY) and Janet Foster (AIDS Institute, New York State Department of Health, Albany, NY).

Suggested Reading:

APICHA, Inc. (2001). *The Role of Culture in HIV/AIDS Health Care: A Practical Guide for Providers Serving Asian and Pacific Islander Americans*. New York, NY: APICHA, Inc.

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U.S. Department of Health and Human Services. Office of Minority Health (2003, January/February). "Wellness Center Targets Asian & Pacific Islander Communities: Addressing Prevention, Treatment, and Care" *HIV Impact*, 1-2.

University of California, San Francisco, Center for AIDS Prevention Studies (1998, April). what are Asian and Pacific Islander HIV prevention needs? San Francisco, CA: University of California, San Francisco.

"Tips" for Working with Native American Communities

- ✓ Study, learn and become knowledgeable about Native American history, including sovereignty and governance issues, in both the United States and within your jurisdiction.
- ✓ Be cognizant of Native American sovereignty. Many Native American nations self-identify as sovereign entities, and may not consider themselves to be within your jurisdiction. Remain sensitive to the fact that public health activities such as HIV name reporting and partner notification may be "lightning rods" in the context of sovereignty and other issues.
- ✓ Be sensitive to Native American protocol. Native American governments and leadership have pre-established means for government-to-government relations and interaction.
- ✓ Due to sovereignty issues, many Native Americans do not vote. Since there is no Native American constituency whose support is sought during elections, elective processes rarely result in support for Native American issues, including funding. Many times, Native American issues and/or concerns are overlooked in policy-making.
- ✓ Recognize and acknowledge that the federal government has not fulfilled treaties and promises and that your state government, of which you are a representative, may also have not fully honored obligations to Native American communities that are sovereign nations in your jurisdiction.
- ✓ Keep your word. Avoid making commitments that you cannot fulfill.
- ✓ Become familiar with the history, culture, traditions and values of Native American communities in your jurisdiction.
- ✓ Become familiar with the appropriate terminology used by a particular Native American nation/community. Each nation/community is different. Be cognizant of how Native Americans/Hawaiian Natives/Alaskan Natives refer to themselves and their people. This includes:
 - Preference of the terms - Native American, Indian, American Indian, or a term in a Native language; nation or tribe; Nation territory, reservation, or reserve; etc.

- Some Native Americans refer to their nation using a term in their native language, not the English term used commonly by outsiders (Haudenosaunee, not Iroquois; Lakota, not Sioux; etc.).
 - Some Native Americans also identify themselves according to their clan, or extended family.
-
- ✓ When historical facts and experiences of Native communities are shared, especially by individual Native Americans whom you know and care about, sometimes it can be difficult, even when there is no finger pointing or blame. Learn from history, but do not take it personally. Bear in mind that sovereignty issues continue to impact Native Americans and that the issues at stake often engender intense reactions. Try to understand the various perspectives on these issues.
 - ✓ Respect and honor history, culture, traditions and values in your work and interactions with Native communities. Strive to meet Native people in person, do not rely on letters, email or telephone contact. Avoid stereotyping Native Americans, their nations and tribes.
 - ✓ Recognize that “Native American” includes a broad range of perspectives and that there are different views concerning who is Native American, who represents traditional Native communities, what values Native people have, and other issues. Prevention efforts should incorporate a variety of Native perspectives.
 - ✓ Remain aware of issues in the external environment that are of concern to Native communities. Recognize that these, together with historical events or “underpinnings”, form the larger framework within which HIV prevention can be pursued.
 - ✓ Support culturally appropriate HIV prevention interventions developed and delivered by Native Americans. Select art work and any images for Health Department materials in consultation with members of Native communities. (Moved up from page 2 as suggested)
 - ✓ Recognize and acknowledge traditional concepts of Native American health and healthy lifestyles. This includes a holistic view of health, comprised of the physical, mental, emotional, and spiritual components of the individual and/or community.
 - ✓ Seek assistance from a Native agency/agencies in meeting needs of individuals from Native communities, with their consent to do so.
-
- Some Native medicine healers will not work with a non-Native caseworker. When an HIV-infected client with a non-Native caseworker wishes to access Native traditional medicines, a Native agency may be able to assist in the traditional process of finding a medicine healer on Nation territory and help other

needs, such as transportation to the reservation.

- At the same time, recognize that some Native people, especially those who may be at high risk for HIV/AIDS (i.e., MSM) may not be comfortable working with Native providers.
- ✓ Examine epidemiologic and other data concerning the health status of Native Americans in your jurisdiction and in the United States. Become familiar with the multiple epidemics and inter-generational trauma impacting Native American nations/communities. Some of the most common include substance use, diabetes, suicide, physical and sexual abuse, and boarding school experiences. The most effective HIV prevention may occur when Native American nations/communities have the means to address these related issues.
- ✓ Promote awareness and understanding of Native American issues among your community planning group and include Native Americans as members. Native Americans who are from and actively engaged in their Native nations/communities are the most knowledgeable about them. Support and encourage their participation. Be reasonable in your expectations. Remember that individuals speak from their own experiences and cannot speak for all members of their community or all Native communities.
- ✓ Raise awareness of Native American needs and issues among other planning/advisory bodies, as opportunities arise.
- ✓ Respect and use needs assessments that are conducted by Native Americans within their communities in your needs assessments and planning processes. Involve Native Americans in your HIV prevention needs assessments and look for ways to meet identified needs.
- ✓ Use a variety of methods to promote awareness and understanding of Native American issues among Health Department staff.

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Suggested Reading:

ETR Associates, Inc. Bird, M., Kane, W., and Quackenbush, M. (Eds.) (2002) *Eliminating Health Disparities: Conversations with American Indians and Alaska Natives*. Santa Cruz, CA: ETR Associates.

Native American Community Services of Erie and Niagara Counties, Inc. *Native American Training Initiative (NATI) (1997). Community Input Report*. Buffalo, NY: Native American Community Services of Erie and Niagara Counties, Inc.

New York State Department of Health AIDS Institute. (1995, August). *Empowering Native American HIV Educators. Protect Our Nations from HIV/AIDS*. Albany, NY: New York State Department of Health.

Rowell, R. (1990, February/March). *Native Americans, Stereotypes, and HIV/AIDS: Our Continuing Struggle for Survival. SIECUS Report*. 18(3): 9-15.

University of California, San Francisco. Center for AIDS Prevention Studies. *AIDS Research Institute (2002, January). what are American Indian/Alaskan Natives' HIV prevention needs?* San Francisco, CA: University of California, San Francisco.

The NYS HIV PPG's Socio-Cultural Model of Developing HIV/AIDS Interventions: The NYS HIV Prevention Planning Group (PPG) and the NYS Department of Health AIDS Institute (AI) developed an approach for exploring the development of effective HIV prevention interventions. This model can be employed by providers when writing proposals and designing culturally competent interventions for communities at risk for HIV.

Respect for a community's past experiences, its traditions, what is deemed acceptable within its culture as well as forces affecting the present political and social climate are crucial ingredients affecting programmatic success. The influence socio-cultural factors have on the successful provision of HIV prevention services must be integrated into the development of HIV prevention interventions for specific populations. For example, social inequalities, racism, sexism, heterosexism, and socioeconomic stratification are deeply embedded in our culture, and they affect the resources available to people, as well as the health-related behaviors that people adopt. These inequalities can affect, for example, the quality of available health care. People may be treated differently by doctors depending on their social class, race, or gender. The dispersal of accurate information may also vary - - misinformation about how HIV is transmitted may persist among people with less access to education. Finally, trust in government (including public health) may be diminished among members of groups that have historically received unequal treatment in the past.

The following elements must be considered when implementing any HIV prevention intervention:

Historical Underpinnings - events that occurred in the past which may affect how a

particular individual or community perceives events or reacts to specific issues.

Cultural norms - ideas/traditions/methods of thinking or doing things specific to a particular culture.

External factors - issues/events occurring in the world which may affect HIV prevention.

The following page has a circle-based illustration of this model which can be useful in developing an understanding that the interventions appropriate for any particular population must be embedded within, and take into account, factors that are longstanding and out of the control of the provider, including historical underpinnings, cultural norms and external factors.

Economic Evaluation Economic evaluation, which can take several forms, compares the costs of implementing an intervention to the benefits derived from it. Cost-effectiveness analysis is a form of economic evaluation that has been increasingly used to evaluate the effectiveness of HIV prevention interventions. A cost-effective program is one that provides “good bang for the buck”

What we want are effective interventions at low cost. However, as was illustrated in the socio-cultural model, cost-effectiveness is only one of several criteria to be considered in the development of effective interventions. In some cases, social, political, ethical, and individual concerns may take precedence over cost-effectiveness (e.g., equity, access, and community support). Therefore, cost-effectiveness is a tool which can inform decision-making but it is important to remember that, in HIV prevention, numbers can never supplant human needs.

In HIV prevention, one measure of cost-effectiveness is the cost per HIV infection averted. This is affected by many factors: intervention cost, number of people reached, their risk behaviors and HIV incidence, and the effectiveness of the intervention in changing behavior. The purpose of cost-effectiveness analysis is to quantify how these factors combine to determine a program’s value.

Cost-effectiveness analysis can determine if an intervention is cost-saving (cost per HIV infection averted is less than the lifetime cost of providing HIV/AIDS treatment and care) or cost-effective (cost per HIV infection averted compares favorably to other health care services such as smoking cessation or diabetes detection). Cost-effectiveness analyses also break down the costs and resources needed to implement interventions—personnel, training, supplies, transportation, rent, overhead, volunteer services, etc. This can help CBOs decide if they can implement an intervention.

HIV prevention cost-effectiveness estimates cannot be generalized easily because the effectiveness of programs is determined by rates of infection and risk behaviors that may vary greatly across populations. Unlike a surgical procedure, which is likely to be as effective in Cleveland as it is in Dallas, HIV prevention programs can be more or less effective depending on the status of the epidemic in a community at risk. More and more, HIV prevention programs are being asked to “prove their worth” by showing they are cost-saving or cost-effective. Just because a program doesn’t save society money, doesn’t mean it’s not good or needed. A program that does not save money might still be cost-effective; or, it might not be cost-saving or cost-effective yet still be something that society wants and needs.

Adapted from: *Center for AIDS Prevention Studies (CAPS) Fact Sheet*, “Can cost-effectiveness analysis help in HIV prevention?” University of California at San Francisco, <http://www.caps.ucsf.edu/FSindex.html>

HIV Prevention Technology Transfer Technology transfer refers to the process by which research-based prevention science informs the work of frontline prevention workers. It addresses the inherent differences between scientists and practitioners in terms of language, values, and purposes and attempts to address the problem of relevance for community-based

practice. By examining the issues of timeliness, clarity, acceptability, ownership, fidelity and capacity, technology transfer works to bring the findings of HIV prevention science to HIV prevention practice with the ultimate goal of working toward a stronger integration of HIV prevention sciences and prevention practice. Nowadays, the proliferation of internet access and other cutting-edge communication technologies facilitates technology transfer. However, for the concept of technology transfer to truly work, there must be respect by research scientists for interventions not yet in the literature, but proven by its use in a community at-risk, to be effective.

For more information on the issues mentioned in this chapter the following websites may be helpful:

Academy for Educational Development (AED)

HIV/AIDS Interventions: A Suggested Taxonomy

www.hivaidsta.org/pdf/What_Studies_Say_About_Interven/Appendices.pdf

American Indian Community House (AICH)

Organization Web Site

<http://aich.org/>

Asian Pacific Islander Coalition on HIV/AIDS (APICHA)

Organization Web Site

www.apicha.org

The Black AIDS Institute

Organization Web Site

www.blackaids.org

Centers for Disease Control and Prevention

Compendium of HIV Prevention Interventions with Evidence of Effectiveness

www.cdc.gov/hiv/pubs/hivcompendium/HIVcompendium.htm

Advancing HIV Prevention: Interim Technical Guidance for Selected Interventions

www.cdc.gov/hiv/partners/Interim-Guidance.htm

Selected Interventions: Helpful Web Sites and Readings/Journal Articles, Slide Presentations, and Other Resources

www.cdc.gov/hiv/partners/ahp.htm#otherlinks

Fact Sheets

www.cdc.gov/hiv/pubs/facts.htm

CDC National Prevention Education Network (NPIN)

www.cdcnpin.org/scripts/index.asp

Procedural Guidance For Selected Strategies And Interventions For Community-Based Organizations Funded Under Program Announcement 04064

www.cdc.gov/hiv/partners/pa04064_cbo.htm

Incorporating HIV Prevention into the Medical Care of Persons Living with HIV: Recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America

www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm

Center for Health and Behavioral Training

University of Rochester Site

www.urmc.rochester.edu.chbt

Cicatelli Associates, Inc.

Organization Web Site

www.cicatelli.org/AboutCAI/home.htm

Harm Reduction Coalition

Organization Web Site

www.harmreduction.org

Trainings Offered

www.harmreduction.org/hrti/cur/index.html

Henry J. Kaiser Family Foundation for educational information and training

Organization Web Site

www.kaisernetwork.org

NYS Department of Health

Expanded Syringe Access Demonstration Program

www.health.state.ny.us/nysdoh/hivaids/esap/regover.htm

HIV Counseling and Testing

www.health.state.ny.us/nysdoh/aids/index.htm

HIV Reporting and Partner Notification

www.health.state.ny.us/nysdoh/hivaids/hivpartner/intro.htm

Materials

www.health.state.ny.us/nysdoh/aids/edmat.htm

Project WAVE

www.health.state.ny.us/nysdoh/hivaids/projwave/index.htm

Statewide Training Calendar

www.health.state.ny.us/nysdoh/aids/training.htm

National Development and Research Institutes, Inc. (NDRI)

Organization Web Site

www.ndri.org/

Latino Commission on AIDS (LCOA)

Organization Web Site

www.latinoaids.org/index.asp

National Minority AIDS Council (NMAC)

Organization Web Site

www.nmac.org/

Native American Community House (NACS)

Organization Web Site

<http://www.nacswny.org/customers/customindex/NAmerican.cfm?SID=5>

University of California at San Francisco (UCSF)

Best of Prevention Science

www.caps.ucsf.edu/toolbox/SCIENCEindex.html

Center for AIDS Prevention Studies (CAPS) Fact Sheets

www.caps.ucsf.edu/FSindex.html

CAPS Research Projects

www.caps.ucsf.edu/capsweb/projectregistry.html#prevention

Effective Behavioral Interventions: Related Resources

hivinsite.ucsf.edu/InSite?page=kbr-07-01-03

Prevention links

hivinsite.ucsf.edu/InSite?page=li-07-00

For information about interventions and programs in your area, you can:

- ✓ Look on local agency's websites
- ✓ Check with your Ryan White Title II CARE Network
- ✓ Speak with your AIDS Institute Contract Manager
- ✓ Look in the AIDS Institute's Service Directory

2005-2010 NYS COMPREHENSIVE

PART C: NYS HIV Prevention Priorities

HIV PREVENTION PLAN

In essence, the PPG began gathering input for its next priority setting of populations and interventions as soon as its previous *Comprehensive HIV Prevention Plan* was submitted in 1998. Development and implementation of the NYS RGA took six years to complete. Activities related to the PPG's African American/Black Initiative and focus on Communities of Color began in 2000. Examination of historical underpinnings, cultural norms and external factors, and the development of the Sociocultural Model were accomplished through painstaking research, hours of work by population-based Committees and AIDS Institute staff and numerous presentations by nationally known experts on topics such as poverty, trauma and transgendered populations. By 2005, all the "ingredients" had been gathered, examined, and synthesized and the elements for accurate statewide priority setting were in place.

Caveats Considered During Priority Setting Before priority setting could take place, issues related to the AIDS Institute's existing platform of HIV prevention services needed to be articulated so that they would be considered during deliberations. Due to the complexities of the HIV epidemic in New York and the significant resources provided by the state and CDC, the AIDS Institute's prevention program is large and multi-faceted. It employs multiple approaches for providing prevention services, including:

- (1) large regional programs;
- (2) initiatives targeting broad communities of racial/ethnic minorities;
- (3) programs that focus on populations with specific risks or other characteristics, such as injection drug users, MSM, heterosexuals, and women of childbearing years.

While anonymous HIV counseling and testing is conducted in the neighborhoods and prisons directly by state staff, other prevention services are largely carried out by a network of hundreds of community-based health and social service contractors. In order to provide a client-friendly one-stop-shopping HIV continuum, the AIDS Institute often provides funds from multiple funding streams (state, CDC and Ryan White) to the same agency. The NYS DOH also provides Medicaid reimbursement for certain services, such as HIV counseling and testing and condoms. In New York City, there are also programs operated or supported by the NYC Department of Health and Mental Hygiene's CDC HIV Prevention Cooperative Agreement or through city tax levy dollars. Beyond these activities are those supported directly by CDC, as well as those receiving prevention dollars through counties or private funding.

With these complexities in mind, below are outlined assumptions that were taken into account during priority setting:

- NYS has a well-established, mature HIV prevention infrastructure which has been influenced by PPG input.

- NYS HIV prevention programs are often supported by a variety of funding streams/

mechanisms.

- AIDS Institute-funded programs do not exist in a vacuum/in isolation from those of other funders.
- Stability provided by the AIDS Institute has contributed to continuity of prevention and care services in the face of resolicitations by other funders (i.e., CDC, NYCDOH, Ryan White).
- NYS has a platform of HIV prevention programs that play an important role in making services accessible to individuals. Longevity, name recognition, and an established track record of an agency or program can promote acceptance, confidence and use.
- AIDS Institute-funded programs have often served as the foundation for building other programs and services.
- Referral linkages between AIDS Institute-funded programs and other community health and human service providers have required time to develop and nurture.
- These referral linkages are part of a larger web/network of linkages that can help to assure continuity of prevention and care services to meet needs of individuals, families and communities.
- Resolicitation of HIV prevention programs and services can have unexpected consequences for the State, communities, community health and human service providers, families and individuals.
- When carefully planned, resolicitations and funding shifts can help place new community resources where they are most needed and advance the prevention agenda.
- One way goals and unmet needs can be fulfilled is by shifting funding resources around to place effective interventions where they are most needed.
- Careful consideration should be given to various ways to address identified unmet needs, including:
 - * Changing emphasis of existing contracts: populations, interventions, regions
 - * Technical Assistance, training, technology transfer
 - * Retooling/refocusing current providers' efforts
 - * Targeting underserved sub-populations
 - * Developing linkages among providers
 - * Creating consortia, collaborations, coalitions
 - * Forming new partnerships
 - * Integration, mainstreaming
 - * Missed opportunities, "value add-on"
 - * Using other funding streams, reimbursement, etc.

The following three Chapters detail the approach taken to accomplish priority setting and the results derived from that process.

5

The Approach to Priority Setting

Introduction The approach to priority setting that was developed took the following four aspects into consideration:

Aspect #1 “The Big Four” transmission categories (IDU, MSM, Heterosexual, Pediatric/Perinatal), a framework developed for the last *Comprehensive HIV Prevention Plan*, has served the PPG and the Department of Health well over the years and remains epidemiologically valid. The definitions of these categories, as described in that *Plan*, are:

IDU: This is the CDC hierarchical category of (1) injection drug users, (2) all those who fall in the CDC category of men who have sex with men/injection drug users, and (3) a portion of cases that fall under no risk reported.

MSM: This is the CDC hierarchical category of (1) men who have sex with men, and (2) a portion of cases that fall under no risk reported.

Heterosexual: This is the CDC hierarchical category of (1) heterosexual transmission, and (2) a portion of cases that fall under no risk reported.

Perinatal/Pediatric: This is the CDC hierarchical category of all those cases of AIDS diagnosed among individuals ages 0 - 12. This includes those whose infection stemmed from perinatal transmission as well as other routes.

Aspect #2 A focus on communities of color Building on the successful model developed for its African American/Black Initiative, the PPG has made HIV prevention needs for communities of color a priority focus. Epidemiologic data confirm the fact that the HIV/AIDS epidemic in NYS continues to disproportionately impact communities of color, including:

- ▶ African Americans/Blacks,
- ▶ Latinos/Hispanics,
- ▶ Asian and Pacific Islanders, and
- ▶ Native Americans

The PPG, therefore, felt it crucial to attach the phrase “especially persons of color” to each prioritized population to recognize and acknowledge the devastating extent of the epidemic in communities of color in NYS and to guide HIV prevention programs.

Aspect #3 The Center for Disease Control and Prevention’s (CDC) Advancing HIV Prevention (AHP) Initiative CDC’s *AHP Initiative* requires top priority be placed on the prevention needs of HIV-infected individuals:

“*Advancing HIV Prevention* will impact the HIV Prevention Community Planning priority setting process. Because of its potential to substantially reduce HIV incidence, HIV Prevention Community Planning Groups will be required to prioritize HIV-infected persons as the highest priority population for appropriate prevention services.”

CDC’s 2003-2008 HIV Prevention Community Planning Guidance

Aspect #4 The “Sociocultural Model” for HIV Prevention For HIV prevention to be effective, examination of cultural norms, external factors and historical underpinnings is crucial given the extent of the epidemic in communities of color in NYS. During deliberations, the PPG regularly relied on a Sociocultural Model to provide guidance for the establishment and interpretation of intervention priorities. A full description of the Sociocultural Model, along with a blank worksheet, can be found in Chapter 4 of this *Plan*, “HIV Intervention Tools”.

This chapter covers the following priority setting process-related topics:

- **Process for Determining the 2005-2010 NYS Priority HIV Prevention Populations-** pages 2-3
- **“Tiers”- A Useful Way to Organize the 2005-2010 NYS Priority Populations** - page 3
- **2005-2010 NYS Priority HIV Prevention Populations** - page 4
- **A Level Playing Field: The Priority Setting Institute--November 2004** - page 4
- **Putting it All Together: Setting Intervention Priorities--January 2005** - page 4
- **Finalizing Intervention Priorities** - page 5

Process for Determining the 2005-2010 NYS Priority HIV Populations Using the above aspects, and to ensure consistency with *AHP*, it was determined that within each of the “Big Four” transmission categories (IDU, especially persons of color, MSM, especially persons of color, Heterosexual, especially persons of color and Perinatal/pediatric, especially persons of color), it would consider the prevention intervention needs of the following populations:

▶ **HIV Infected**- an individual testing HIV positive.

▶ **HIV status unknown** - an individual who is unaware of his/her HIV status because he/she has never been tested and who has a behavioral risk of HIV infection.

▶ **HIV negative/presumed negative**- an individual who has tested negative and has a behavioral risk of HIV infection.

This approach emphasizes the extent of the HIV/AIDS epidemic among communities of color and provides a structure which fosters inclusiveness of all communities and populations, as reflected by race/ethnicity, gender HIV-infection status and other relevant factors.

It was also decided that the needs of providers would be prioritized, so that technical assistance, capacity building and other agency-specific needs could be met. This mirrored the statewide approach successfully used within the RGA (described in Chapter 3 of this *Plan*, “The

Community Services Assessment”). After intervention priorities were set, it was decided that population-based Committees would have an opportunity to articulate intervention “considerations” for at-risk subpopulations. These considerations provide a wealth of information for the provider to take into account when planning for intervention implementation.

“Tiers”- A Useful Way to Organize the 2005-2010 NYS Priority Populations and Interventions

Recognizing that the approach detailed in the *Introduction*, above, would yield twelve priority populations and thirty-six population-intervention pairs, the PPG organized its priority populations into tiers. The “Tiers” correspond the priority level within the context of HIV prevention, with “Tier I” being considered “highest priority”, “Tier II” as “high priority”, and “Tier III” as “priority”.

Without Tiers the group would have been faced with putting these interventions into priority order (1,2,3, etc.). In addition, a thirty-six item-long list is difficult to grasp, remember and work with. The rationale for the development of priority population “Tiers” included the following issues:

- ▶ Using “Tiers” reflects a public health approach inclusive of all populations.
- ▶ NYS has a large, diverse population with a mature and widespread epidemic encompassing all modes of transmission and large numbers of persons in each priority population.
- ▶ “Tiers” offer a framework that can maximize use of funds from multiple sources.
- ▶ “Tiers” can provide necessary flexibility as need and circumstances change, as the epidemic and prevention approaches continue to evolve and as more becomes known about risks and influences of other determinants (sociocultural factors).
- ▶ “Tiers” recognize that an individual/population may have more than one risk (i.e., an IDU may also have a sexual risk(s)).
- ▶ With “Tiers” we can recognize the needs of all four major risk populations (“Big Four”/modes of transmission) within the first Tier.
- ▶ “Tiers” reflect a less overwhelming, more time efficient approach that offers potential for additional focused work by the PPG and AIDS Institute (i.e., we can do more next year, perhaps on a Tier-by-Tier basis and also across Tiers).
- ▶ “Tiers” respect the fact that it is human nature to be reluctant to prioritize needs of one group over another.
- ▶ “Tiers” can be reexamined at any time should the need arise.

2005-2010 NYS Priority HIV Prevention Populations Note that when defining the Tiers, CDC’s Advancing HIV Prevention Initiative (AHP) required that interventions to meet the needs

of HIV-infected persons be the highest priority, or “Tier I”.

Tier I: HIV Infected, especially persons of color

IDU

MSM

Heterosexual

Perinatal/Pediatric

Tier II: HIV Status Unknown, especially persons of color

IDU

MSM

Heterosexual

Perinatal/Pediatric

Tier III: HIV Negative/presumed negative especially persons of color

IDU

MSM

Heterosexual

Perinatal/Pediatric

A Level Playing Field: The Priority Setting Institute--November 2004 Few contemporary community PPG members had the benefit of being present for all the discussions/presentations/document preparation which occurred since the development of the last *Comprehensive HIV Prevention Plan*. Indeed, only three present community PPG members had been a part of the previous priority setting process. Therefore, to ensure a level playing field, the November PPG meeting was entirely dedicated to holding a “Priority Setting Institute” to bring everyone “up to speed” and to practice the agreed-upon priority setting process.

Putting it all Together: Setting Intervention Priorities--January 2005 At its January 2005 meeting, the PPG was dedicated to prioritizing interventions for each of its prioritized populations. To accomplish this, participants had to “put it all together”, using the information gathered since 1998, all of which was summarized during the Priority Setting Institute. As a group, participants brainstormed appropriate effective interventions for each priority population. Transcribers wrote the interventions on newsprint and participants discussed the effectiveness/appropriateness of the interventions for the population as it was worked on.

At the end of the brainstorming for each priority population, participants got three “dots”—one was put on each of the three interventions the participant deemed most appropriate/effective for the population being discussed at that time. When everyone had finished, the dots were counted and the three interventions receiving the most “votes” were considered the draft prioritized interventions for that population. This approach is known as the Nominal Group Technique.

Clarification: Finalizing Intervention Priorities As the PPG was at such a critical juncture in this process and because statewide planning is so important, a special meeting was convened to incorporate these concerns into the results of the priority-setting process conducted by the PPG

in January. At the special meeting, the PPG's Executive Committee addressed issues surrounding concerning the priority-setting. Some interventions identified by the group were not prevention interventions, *per se*, and inconsistent terminology had been used to describe the same or similar interventions. There was also concern that factors such as effectiveness and cost-effectiveness needed to be considered (although the latter was not expressly taken into account by the Executive Committee during this special meeting.)

The task for the Executive Committee during this special meeting was to review the complete listings of interventions for each transmission category to 1) assure that the prioritized items described interventions, rather than considerations, modes of service delivery, or other descriptions of service, and 2) eliminate duplication within each transmission group within a "Tier". The Executive Committee also decided on the appropriate terms by which interventions would be presented in the priority listings.

The Executive Committee worked from listings that showed, for each transmission category, both the priority interventions as determined by the voting results of the PPG as well as the interventions that did not receive sufficient numbers of votes to place them among the top three or four priority interventions. With the assistance of a facilitator, the Executive Committee reviewed each of the priority items. If a priority item was not an intervention, it was relocated for review as an overarching consideration or mode of service delivery, for example, and replaced by another intervention from the list. If necessary, the wording for an intervention was revised to more appropriately describe the intervention. A separate chart of the relocated items (considerations, modes of service delivery, etc.) was kept so that the information from the priority setting was not lost.

The results of the Executive Committee's review were priority listings reflecting appropriate interventions and their respective transmission categories, expressed in terms that were consistent across populations. In addition, lists of "considerations" and definitions were generated as companion pieces to the priority listings to clarify and support the priority listings.

The Executive Committee was careful not to "redo" or "second guess" the work of the full PPG or otherwise "tamper with the evidence." The clarifications provided by the Executive Committee reflected the priorities as identified by the PPG. The considerations, captured separately, were further reviewed and elaborated upon by the full PPG, working in its population-based Committees. For a full description of the PPG's Priority Interventions, see Chapter 6 and for a full description of considerations to be taken into account when implementing 2005-2010 HIV Intervention Priorities, see Chapter 7.

6

Effective Interventions for Priority Populations

2005-2010 Priority Population/Intervention Pairings According to the Goals, Objectives and Guiding Principles of the *2003 CDC Guidance on Community Planning*, Community Planning Groups, in conjunction with their Health Department counterparts, must not only identify priority interventions for each identified target population, but also ensure that the priority prevention interventions for priority target populations are science-based. To that end, this Chapter not only enumerates NYS's 2005-2010 priority population/intervention pairs, but also provides a science basis for their choice. Below are the 2005-2010 priority populations, within Tiers, matched with prioritized interventions:

TIER I: HIV INFECTED, ESPECIALLY PERSONS OF COLOR

Population: IDU

- ✓ Individual Level Intervention (ILI) and Group Level Intervention (GLI) using a harm reduction approach with educational component
- ✓ Syringe Exchange within the context of comprehensive harm reduction
- ✓ Case Management (including housing and supportive services)
- ✓ Mental Health Counseling (individual and group)

Population: MSM

- ✓ Community Level Intervention (CLI) including Social Marketing
- ✓ ILI (including Prevention With Positives)
- ✓ GLI (including Education and Outreach)

Population: Heterosexual

- ✓ Case Management
- ✓ Mental Health Counseling (individual and group)
- ✓ Health Education/Risk Reduction
- ✓ Counseling and Testing for Partners/Family

Population: Perinatal/Pediatric

- ✓ Mental Health-Individual/ Family Counseling
- ✓ Linkage to Care (i.e., CAPC)
- ✓ Sexuality and sex education for pediatrics/family/support system/partners

TIER II: HIV STATUS UNKNOWN, ESPECIALLY PERSONS OF COLOR

Population: IDU

- ✓Syringe Exchange
- ✓Counseling and Testing
- ✓HIV Prevention Education
- ✓Outreach

Population: MSM

- ✓Education and Outreach
- ✓Counseling and Testing
- ✓Health Education/Risk Reduction (HE/RR) (including issues relevant to gay men)

Population: Heterosexual

- ✓Counseling and Testing with Incentives
- ✓ILI (HE/RR around skills building, condom use and safer sex negotiation)
- ✓GLI (HE/RR around skills building, condom use and safer sex negotiation)
- ✓CLI (Social Marketing)

Population: Perinatal/Pediatric

- ✓Couples HIV/AIDS prevention education
- ✓Counseling Testing and Partner Notification (CTPN)

TIER III: HIV NEGATIVE/PRESUMED NEGATIVE, ESPECIALLY PERSONS OF COLOR

Population: IDU

- ✓Counseling and Testing
- ✓Syringe Exchange
- ✓Outreach

Population: MSM

- ✓Counseling and Testing
- ✓CLI (Social Marketing campaign addressing healthy sexuality and homophobia)
- ✓GLI (including healthy sexuality and acceptance)

Population: Heterosexual

- ✓Counseling and Testing with Incentives
- ✓CLI (Social Marketing)
- ✓GLI (Sexuality education/HIV education)

Population: Perinatal/Pediatric

- ✓GLI (comprehensive education)
- ✓Prevention Case Management in Prenatal Settings
- ✓ILI (comprehensive education/relationship skills building)

Science Basis for Priority Interventions All of the above priority interventions has been proven to be effective with their paired populations. Each is defined below, along with a brief description of findings confirming the intervention's effectiveness with its paired populations and sources for those findings. When a study is applicable to all populations, that is included and described as such. Keep in mind that this is not meant to be an exhaustive literature search, and there may be other citations relevant to each intervention/population pairing.

Case Management

Definition Case Management is a formal and systematic multi-step process designed to assess the needs of a client to ensure access to needed services. It strives to ensure that clients with complex needs

receive timely coordinated services. The case manager functions as an advocate for services for the client, with particular emphasis placed on the client's self-sufficiency in the community.

Steps of the case management process include:

- (1) **intake** or the collection of identifying information concerning the client, family, care givers, and informal supports;
- (2) **assessment** to identify the client's and/or family's problems and service needs
- (3) development and implementation of an individualized **service plan** which translates assessment information into specific short and long term goals and objectives.
- (4) **reassessment**/service plan updates

Literature relevant to all priority populations:

A study by Gardner, et al. (2005) showed that a brief intervention with an HIV infected individual by a case manager was associated with a significantly higher rate of successful linkage to HIV care.

Source:

Gardner, L.I., Metsch L.R., Anderson-Mahoney, P., Loughlin, A.M., del Rio, C., Strathdee, S, Sansom, S.L., Siegal, H.A., Greenberg, A.E., Holmberg, S.D. (2005). Antiretroviral Treatment and Access Study Group. Efficacy of a Brief Case Management Intervention to Link Recently Diagnosed HIV-Infected Persons to Care. *AIDS*. 19(4):423-31.

Priority intervention for: **IDU, especially persons of color**
 ✓HIV Infected

According to the literature:

► In a study where in the case management program was a hybrid between the brokerage and full-service models described by Rapp (1998) and Sorenson (2003) found that, while in many cases, case management with the drug users in the study was no more effective than brief contact, the exception was when case management focused on linking drug users with treatment programs. The clear focus on treatment entry may have been a factor that influenced the successful outcome.

► A study examined the effectiveness of a combined counseling and case management behavioral intervention, using motivational interviewing strategies, in engaging Hispanic injection drug users in treatment and reducing drug use and injection-related HIV risk behaviors.

Literature Relevant to All Priority Populations--

There was a significant increase in consistent condom use, and maintenance of condom use was found in communities exposed to the Community Promise intervention, which can serve any community or population since the messages come from are communicated within the community (CDC, 1999).

Source:

CDC AIDS Community Demonstration Projects Research Group (1999). Community-level HIV Interventions in Five Cities: Final Outcome Data from the CDC AIDS Community Demonstration Projects. *American Journal of Public Health*, 89 (3): 336-345.

Priority intervention for: **MSM, especially persons of color**
 ✓HIV Infected
 ✓IDU HIV Negative/ Presumed Negative

According to the literature...

- ▶Community-level prevention interventions have long been advocated for addressing HIV in the MSM community because: 1) the large number of young gay men who must be reached with HIV prevention efforts makes individual-level interventions impractical and prohibitively expensive; 2) individual-level interventions may be less effective in addressing social system contributors, which are likely to be important contributors to risk-taking behavior; 3) community-based organizations report that young gay men rarely seek out AIDS prevention services (Kegeles,1996).
- ▶Research with gay men has shown that perception of peer norms surrounding sexual risk behavior is strongly associated with one's own sexual behavior (Lemp et al.,1994).
- ▶Community-level interventions aimed at decreasing high-risk behavior among MSM are at least as effective as small and individual-level interactions and interventions that focused on promoting interpersonal skills (Johnson, 2002).
- ▶ Kraft, et al., (2000) found that the community building inherent in a community level intervention might identify leaders, create new settings, and create opportunities for dialogue between MSM and African American community groups to address negative perceptions of homosexuality.
- ▶Findings suggest that Popular Opinion Leader (POL), which is based on the social diffusion theory, significantly reduces the mean number of occasions of unprotected anal intercourse and increases condom use for anal intercourse (Kelly, St. Lawrence, et al., 1991; and Kelly et al., 1997). In addition, Pinkerton et al. (1998) found the Popular Opinion Leader program for prevention of HIV transmission can be highly cost-effective.
- ▶ A study documented the process by which a community-based organization replicated and adapted POL (see above) to its own use and explored the effectiveness of that HIV prevention program for male prostitutes and other patrons in New York City "hustler" bars. The effects of

the current intervention were assessed on a sample of 1,741 male prostitutes and bar patrons. Analyses indicated significant reductions in paid, unprotected sexual intercourse and oral sex following the intervention. Analyses further indicated that the data were partially consistent with the program's model. The intervention's effects varied by bar and by participants' race/ethnicity. Data support the utility of the intervention model for an urban sample of men at high risk for HIV infection (Miller et al., 1998)

►The Mpowerment Project found reduction in the frequency of unprotected anal intercourse with both primary and non-primary partners (significantly more than amongst men in the comparison community) (Kegeles et al., 1996).

Sources:

Johnson, W.D., Hedges, L.V., Diaz, R.M. (2002). Interventions to Modify Sexual Risk Behavior for Preventing HIV Infection in Men Who Have Sex With Men. *The Cochrane Database of Systematic Reviews*, Issue 4.

Kegeles, S.M., Hays, R.B., Coates, T.J. (1996) The Mpowerment Project: A Community-level HIV Prevention Intervention for Young Gay Men. *American Journal of Public Health*, 86(8): 1129-36.

Kelly, J.A., St. Lawrence, J.S., Diaz, Y.E. (1991). HIV Risk Reduction Following Intervention with Key Opinion Leaders of a Population: An Experimental Analysis. *American Journal of Public Health* ; 81: 168-71.

Kelly, J.A., Murphy, D.A., Sikkema, K.J., et al.(1997). Randomized, Controlled, Community-level HIV Prevention Intervention for Sexual Risk Behavior Among Homosexual Men in US Cities. *Lancet*, 350(9101): 1483-89.

Kraft, J.M., Beeker, C. Stokes, J.P., Peterson, J.L. (2000, August). Finding the "Community" in Community-level HIV/AIDS Interventions: Formative Research with Young African American Men Who Have Sex. *Health Education & Behavior*. 27(4):430-41.

Lemp, G, Hirozawa, A.M., Giovertz, D., et al. (1994) HIV Sseroprevalence and Risk Behaviors Among Young Gay and Bisexual Men: The San Francisco/Berkeley Young Men's Survey. *Journal of The American Medical Association*, 272: 449-54.

Miller, R.L., Klotz, D., Eckholdt, H.M. (1998, February) HIV Prevention with Male Prostitutes and Patrons of Hustler Bars: Replication of an HIV Preventive Intervention. *American Journal of Community Psychology*, 26(1):97-131.

Pinkerton, S.D., Holtgrave, D.R., DiFranceisco, W.J. (1998) Cost-effectiveness of a Community-level HIV Risk Reduction Intervention. *American Journal of Public Health*, 88(8): 1239-42.

Priority intervention for: Heterosexual, especially persons of color
 ✓HIV Status Unknown

✓IDU HIV Negative/ Presumed Negative

According to the literature...

► In a three-year study, individuals from the following at risk populations: IDUs, their female sex partners, sex workers, non gay identified men who have sex with men, high-risk youth, residents of areas with high STD rates were exposed to a community level intervention where role model stories were distributed with condoms and bleach by community members who encouraged behavior change. Consistent condom use with main and non-main partners, increased condom carrying was shown to be greater in intervention communities. In addition, respondents were more likely to carry condoms and to have higher stage-of-change scores for condom and bleach use (CDC AIDS Community Demonstration Projects Research Group, 1999).

► There is no documentation specific to heterosexual males. However, findings suggest that POL significantly reduces the mean number of occasions of unprotected anal intercourse and increases condom use for anal intercourse (Kelly, et al. 1997).

► Women in Real AIDS Prevention Project (RAPP) communities reported a greater increase in consistent condom use with main and non-main partners than women (mostly African-American) in comparison communities. (Lauby, 2000)

► Sikkema et al., (2000) found that women provided with Public Opinion Leader (POL) were less likely to report unprotected intercourse in the follow-up than women in comparison conditions.

► Smith et al. (2000) describes Students Together Against Negative Decisions (STAND), a 28-session teen-centered and skills-based peer educator training program implemented in a rural county in a southeastern state, promoting both abstinence and sexual risk reduction, focusing on both individual and community norm change. Results from a pilot study showed significantly greater increases in condom use self-efficacy and in consistent condom use. Adolescent trainees also reported a sevenfold increase in condom use and a decrease in unprotected intercourse. Acceptance and participation in STAND suggest that adolescents in rural communities can be accessed through community-based interventions, that they are willing to participate in such intensive programs, and that they perceive the intervention as valuable and enjoyable.

Sources:

The CDC AIDS Community Demonstration Projects Research Group (1999) Community-level HIV Intervention In Five Cities: Final Outcome Data from the CDC AIDS Community Demonstration Projects. *American Journal of Public Health*, 89: 336-45.

Kelly, J.A., Murphy, D.A., Sikkema, K.J., et al. (1997) Outcomes of a Controlled Community-level HIV Prevention Intervention: Effects on Behavior Among At-Risk Gay Men in Small U.S. Cities. *Lancet*, 350:1500-1505.

Lauby, J.L., Smith, P.J., Stark, M., et al. (2000) A Community-level Prevention Intervention for Inner City Women: Results of the Women and Infants Demonstration Projects. *American Journal of Public Health*, 90(2): 2 16-22.

Sikkema, K.J., Kelly, J.A., Winett, R.A., et al. (2000) Outcomes of a Randomized Community Level HIV Prevention Intervention for Women Living in 18 Low-income Housing Developments. *American Journal of Public Health*, 90:57-63.

Smith, M.U., DiClemente, R.J. (2000, June) STAND: A Peer Educator Training Curriculum for Sexual Risk Reduction in the Rural South. Students Together Against Negative Decisions. *Preventive Medicine*, 30(6):441-9.

Counseling and Testing (C&T)

Definition Counseling and Testing (C&T) provides persons at risk of HIV infection with relevant risk reduction and prevention information and the opportunity to be screened for the presence of antibodies to HIV, using a chosen testing modality (Rapid, either skin prick or oral fluid,

venipuncture). Pretest counseling must be provided in accordance with the New York State HIV Confidentiality Law Article 27-F to all individuals seeking HIV antibody testing and written informed consent obtained prior to any testing. Post test counseling must also be provided to all clients in conjunction with the provision of the HIV antibody test result.

Literature Relevant to All Priority Populations--

Higginbotham, et al (2000) reported that respondents in his study had changed their behavior since learning of their HIV infection. Prior to diagnosis, the females reporting having vaginal sex with males and males reporting anal sex with males 25% reported never using a condom, 69% reported sometimes using a condom, and 6% reported always using condoms. After diagnosis, the females reporting having vaginal sex with males and males reporting anal sex with males, 30% reported not having sex, 6% reported never using a condom, 11% reported sometimes using a condom, and 47% reported always using condoms. The number of sexual partners for the males and females decreased as well.

A meta-analysis of 27 published studies involving 19,957 participants was conducted to see whether HIV counseling and testing leads to a reduction in sexual risk behavior. This analysis found that after counseling and testing, HIV positive individuals and persons in serodiscordant couples reduced unprotected intercourse and increased condom use more than people who received HIV negative results or those who did not test (Weinhardt, et al, 1999).

Rapid HIV testing increases the number of people tested as well as the likelihood that people receive their test results (Kassler, et al. 1997; Kellen, et al. 1999).

Sources:

Higginbotham, S., Holmes, R., Stone, H., Beil, J., Datu, Costa, S., G.B., Paul, S., (2000) Adoption of Protective Behaviors Among Persons With Recent HIV Infection and Diagnosis--- Alabama, New Jersey, and Tennessee, 1997--1998. *MMWR* June 16, 2000/49(23); 512-515

Kassler WJ, Dillon BA, Haley C, et al. (1997) On-site, Rapid HIV Testing with Same-day Results and Counseling. *AIDS*, 11:1045-51.

Kelen GD, Shahan JB, Quinn TC. (1999) Emergency Department-based HIV Screening and

Counseling: Experience with Rapid and Standard Serologic Testing. *Annals of Emergency Medicine*, 33:147-55.

Weinhardt, L.S., Carey, M.P., Johnson, B.T., Bickham, N.L. (1999) Effects of HIV Counseling and Testing on Sexual Risk Behavior: a Meta-analytic Review of Published Research, 1985-1997. *American Journal of Public Health*, 89(9):1397-1405.

Priority intervention for: **IDU, especially persons of color**
 ✓HIV Status Unknown
 ✓ HIV Negative/ Presumed Negative

According to the literature...

► In some studies, greater reduction in syringe sharing behavior has been found among IDUs following an HIV-positive diagnosis (Casadonte et al. 1990 and Robertson et al. 1998).

► Other studies have shown that high risk behaviors were associated with poor health status and avoidant coping behaviors as a result of an HIV positive test result (Avants et al. 2001; and Celentano et al. 1994).

► Studies have also shown that IDUs who found out that they were HIV infected sought drug treatment or were admitted to drug treatment more frequently than those who were not infected (McCusker et al. 1994).

Sources:

Avants, S.K., Warburton, L.A., Margolin, A. (2001) How injection drug users coped with testing HIV seropositive: Implications for Subsequent Health Related Behaviors. *AIDS Education and Prevention*, 13: 207-18.

Casadonte, P., Des Jarlais, D. (1990) Psychological and Behavioral Impact among Intravenous Drug Users of learning HIV test results. *The International Journal of Addiction*, 25(4): 4 09-426.

Celentano, D., Munoz, A., Cohn, S, et al. (1994) Drug-related Behavior Change for HIV Transmission Among American Injection Drug Users. *Addiction*, 89:1309-17.

McCusker, J., Stoddard, A.M., Zapka, J.G., et al. (1992) AIDS Education for Drug Abusers: Evaluation of Short-term Effectiveness. *American Journal of Public Health*, 82(4): 533-40.

Robertson, J.R., Skidmore, C.A., Roberts, J.K. (1998) HIV Infection in Intravenous Drug Users: A Follow-up Study Indicating Changes in Risk Taking Behavior. *British Journal of Addictions*, 83: 387-91.

Priority intervention for: **MSM, especially persons of color**
 ✓HIV Status Unknown
 ✓IDU HIV Negative/ Presumed Negative

According to the literature...

► MSMs who participated in a longitudinal study of counseling and testing activities reported

reductions in risky behavior. A greater decrease in risky behavior was reported for MSMs who were seropositive as compared to those who were seronegative, those who did not test and those who were unaware of their serostatus (Higgins et al. 1991).

Source:

Higgins, D.L., Galavotti, C., O'Reilly, K.R., et al. (1991) Evidence for the Effects of HIV Antibody Counseling and Testing on Risk Behaviors. *Journal of The American Medical Association*, 266: 2419-29.

Priority intervention for:

Heterosexual, especially persons of color

✓HIV Infected (partners and family)

✓HIV Status Unknown

✓IDU HIV Negative/ Presumed Negative

According to the literature...

► Studies have shown that, as a result of a counseling and testing intervention, condom use increased and no new HIV infections were reported among discordant heterosexual couples (Padian et al. 1993; Higgins et al. 1991).

Source:

Higgins, D.L., Galavotti, C., O'Reilly, K.R., et al. (1991) Evidence for the Effects of HIV Antibody Counseling and Testing on Risk Behaviors. *Journal of The American Medical Association*, 266:2419-29.

Padian, N.S., O'Brien, Y.R., Chang, Y., et al. (1993) Prevention of Heterosexual Transmission of Human Immunodeficiency Virus through Couple Counseling. *Journal of Acquired Immune Deficiency Syndromes*, 6:1043-48.

Priority intervention for:

Perinatal/Pediatric, especially persons of color

✓HIV Status Unknown

According to the literature...

► The US Preventive Services Task Force (2005) recommended that all pregnant women, not just those considered at high risk, be screened for HIV, reflecting the fact that testing has helped prevent many potential mother-to-baby HIV transmissions.

► Chou et al. (2005) synthesized current evidence on the risks and benefits of prenatal screening for HIV infection. In developed countries, the rate of mother-to-child transmission from untreated HIV-infected women is 14% to 25%. Targeted screening based solely on risk factors would miss a substantial proportion of infected women. "Opt-out" testing policies appear to increase uptake rates. It was found that rapid testing can facilitate timely interventions in persons testing positive and identification and treatment of asymptomatic HIV infection in pregnant women can greatly decrease mother-to-child transmission rates.

► Effective Rapid HIV testing programs have been implemented for pregnant women, permitting early counseling and discussion of risk reduction and therapy (Malonza, et al. 2003).

Sources:

Chou, R., Smits, A. K., Huffman, L. H., Fu, R., Korthuis, P. T. (2005) Prenatal Screening for HIV: A Review of the Evidence for the U.S. Preventive Services Task Force. *Annals of Internal Medicine*, 143: 38-54

Malonza IM, Richardson BA, Kreiss JK, et al. (2003) The Effect of Rapid HIV-1 Testing on Uptake of Perinatal HIV-1 Interventions: A Randomized Clinical Trial. *AIDS*, 17:113-8.

US Preventive Task Force (2005) Screening for HIV: Recommendation Statement, *Annals of Internal Medicine*, 143(1):32-37.

Couple's HIV/AIDS Prevention Education

Definition Couple's HIV/AIDS Prevention Education provides HIV health education/risk reduction and testing information to partners together either in a group or individual format.

Priority intervention for: Perinatal/Pediatric, especially persons of color
✓HIV Status Unknown

According to the literature...

▶ Studies of discordant couples (i.e., where one is HIV-infected and the other isn't) have shown that when couples are counseled together about safer sex, condom use increases, and HIV seroconversion decreases. In one study, none of the couples who consistently used condoms seroconverted (Padian, et al. 1993).

▶ Findings suggest an HIV/STI sexual risk reduction intervention for heterosexual couples was efficacious in reducing unprotected sex at 12 months post-intervention, compared with the education control group. No significant differences were observed when comparing whether couples received the intervention together or when the woman received it alone (El Bassel, et al. 2005).

El-Bassel, N., Witte, S.S., Gilbert, L., et al. (2005) Long-term Effects of an HIV/STI Sexual Risk Reduction Intervention for Heterosexual cCouples. *AIDS and Behavior*, 9(1):1-13.

Padian, N.S., O'Brien, T.R., Chang, Y., et al. (1993) Prevention of Heterosexual Transmission of Human Immunodeficiency Virus through Couple Counseling. *Journal of Acquired Immune Deficiency Syndrome*, 6:1043-1048

Group Level Interventions

Definition GLIs are health education and risk reduction interventions provided to groups of varying sizes. GLIs are designed to assist clients with planning, achieving and maintaining behavior change using a science-based model (e.g., cognitive model and health

belief model). GLIs use models that provide a wide range of skills-building activities, information, education and support, delivered in a group setting.

Literature Relevant to Youth in all Populations:

In a study by Rotheram-Borus et al (2001), HIV-positive youth were provided with one or two different modules of a group level intervention (Stay Healthy, a 12-session group intervention, and Act Safe, an 11-session group intervention). Those who participated in the first module had increased coping in various domains, while participants in the second module had fewer unprotected sexual acts, fewer sex partners, fewer HIV-negative sex partners, and less substance use. This intervention was tested prior to HAART and has now been updated and is named “CLEAR: Choosing Life: Empowerment, Action, Results Intervention for youth living with HIV.”

Sources:

Rotheram-Borus, M.J., Lee, M.B., Murphy, D.A., Futterman, D., Duan, N., Birnbaum, J.M., Lightfoot, M. (2001). Efficacy of a Preventive Intervention for Youths Living with HIV. *American Journal of Public Health*, 91, 400-405.

Priority intervention for: **MSM, especially persons of color**
 ✓HIV Infected
 ✓HIV Negative/ Presumed Negative

According to the literature...

- ▶ Various studies have found that group level, multi-session interventions are effective in reducing the frequency of self-reported unprotected anal intercourse (Peterson et al. 1996) and the number of sex partners (Choi, et al. 1996).
- ▶ Kalichman, et al. (2001) conducted a community-based small-group intervention trial in Atlanta, called Healthy Relationships. All participants were followed for 6 months. Participants were 74% African American, 22% White, and 4% of other ethnicities (52% identified as gay, 9% bisexual, and 39% heterosexual). Two group facilitators, including an HIV-positive peer counselor, led the intervention sessions. The intervention resulted in significantly less unprotected intercourse and more condom use at follow-up. Risk behaviors with HIV-negative sexual partners and estimated HIV transmission rates over the next one year were also lower. This study was among the first to demonstrate effects of a behavioral intervention designed to reduce HIV sexual transmission risks among men and women living with HIV infection.
- ▶ Sexual Health Approach (“an approach to sexuality founded in accurate knowledge, personal awareness and self-acceptance and in which one’s behavior, values, and emotions are congruent and integrated into one’s personality and self-definition”) was provided to 422 gay men within the context of a two-day comprehensive human sexuality seminar designed to contextually address long-term risk factors and cofactors. The prevalence of unsafe sex at baseline was 14.2%. At 12 months, while a control group reported a 29% decrease in use of condoms during anal intercourse, the intervention group reported an 8% increase in condom use (Rosser, et al., 2002).

Sources:

Choi, KH, Lew, S., Vittinghoff, E.E., et al. (1996) The Efficacy of Brief Group Counseling in HIV Risk Reduction Among Homosexual Asian and Pacific Islander Men. *AIDS*, 10:81-7.

Kalichman, S. C., Rompa, D., Cage, M., DiFonzo, K., Simpson, D., Austin, J., Luke, W., Buckles, J., Kyomugisha, F., Benotsch, E., Pinkerton, S., & Graham, J. (2001). Effectiveness of an Intervention to Reduce HIV Transmission Risks in HIV-Positive People. *American Journal of Preventive Medicine*, 21, 84-92.

Peterson, J.L., Coates, T.J., Catania, J., et al. (1996) Evaluation of an HIV Risk Reduction Intervention Among African American Homosexual and Bisexual Men. *AIDS*, 10:319-25.

Rosser, S.B.R., Bockting, W.O., Rugg, D.L., et al. (2002). A Randomized Controlled Intervention Trial of a Sexual Health Approach to Long-Term HIV Risk Reduction for Men Who Have Sex with Men: Effects of the Intervention on Unsafe Sexual Behavior. *AIDS Education and Prevention* 14, Supplement A: 59-71.

Priority intervention for: **Heterosexual, especially persons of color**
 ✓HIV Status Unknown
 ✓IDU HIV Negative/ Presumed Negative

According to the literature...

▶ A multiple session group level workshop increased knowledge of HIV risk and promoted behaviors that reduce risk, common misconceptions about HIV/AIDS and decreased infection among high risk women in urban settings (Kelly, et al., 1994)

▶ SISTA is based on an intervention that was demonstrated to be effective in increasing consistent condom use, and in improving skills and perceived norms from partners among African American women in a low income community in San Francisco (DiClemente, et al., 1995)

▶ In the Choices Project, women were randomly assigned to a Relapse Prevention intervention (experiment) or a health education and social support intervention (control). Both interventions were 16-session, 2-hour weekly groups. Both groups yielded a reduced number of risky sexual acts at 4 months and the change was sustained at 12 months. Both groups also increased and maintained safer sex negotiation skills (Basen-Engquist, et al. 2001).

▶ Men who participated in VOICES/VOCES had a significantly lower rate of new STD infection than men in the comparison condition (O'Donnell, et al. 1998)

Basen-Engquist K., Coyle K., et al. (2001) Schoolwide Effects of a Multicomponent HIV, STD, and Pregnancy Prevention Program for High School Students. *Health Education & Behavior*, 28 (2): 166-185.

DiClemente, R. J., Wingood, G.M. (1995) A Randomized Controlled Trial of an HIV Sexual Risk-Reduction Intervention for Young African American Women. *Journal of the American Medical Association*, 274(16):1271-1276.

Kelly, J.A., Murphy, D.A., Washington, C.D., Wilson, T.S., et al. (1994). The Effects of HIV/AIDS Intervention Groups for High-risk Women in Urban Clinics. *American Journal of Public Health*, 84(12), 1918-1922.

O'Donnell, C.R., O'Donnell, L., San Doval, A., Duran, R., & Labes, K. (1998). Reductions in STD Infections Subsequent to an STD Clinic Visit: Using Video-based Patient Education to Supplement Provider Interactions. *Sexually Transmitted Diseases*, 25 (3), 161 - 168

**Health Education/Risk Reduction
(HERR)**

Definition Health Education/Risk Reduction (HE/RR) are organized efforts to reach people at increased risk of becoming HIV infected or, if already infected, of transmitting the virus to

others.

Priority intervention for: **MSM, especially persons of color**
✓HIV Infected
✓IDU HIV Status Unknown

According to the literature...

►Studies show that HERR sessions are effective in increasing condom use with anal and oral sex (Roffman, et al. 1996; and Valdiserri, et al. 1989).

►HERR sessions as an HIV prevention intervention have been shown to be effective and cost-saving as compared to other health service interventions (Holtgrave, et al. 1996; and Pinkerton, et al. 1997).

Sources:

Holtgrave, D.R., Kelly, J.A. (1996). Cost-effectiveness of a Cognitive-behavioral, HIV Prevention Intervention for Gay Men. Abstract Mo.D.1847 . XI International Conference on AIDS, Vancouver.

Pinkerton, S.D., Holtgrave, D.R., Valdiserri, R.O. (1997). Cost-effectiveness of HIV Prevention Skills Training for Men who have Sex With Men. *AIDS*, 11(3): 347-57.

Roffman, R.A., Picciano, J.F., Ryan, R., et al. (1996) HIV Prevention Group Counseling Delivered By Telephone: An Efficacy Trial with Gay and Bisexual Men. *AIDS and Behavior*, 1(2): 137-54.

Valdiserri, R.O., Lyter, D.W., Leviton, L.C., et al. (1989) AIDS Prevention in Homosexual and Bisexual Men: Results of a Randomized Trial Evaluating Two Risk Reduction Interventions. *AIDS*, 3(1): 21-6.

Priority intervention for: **Heterosexuals, especially persons of color**
✓HIV Infected

According to the literature...

- ▶ Kelly, et al. found that the women who participated in HERR intervention groups reported a significantly greater increase in condom use with their partner and significantly greater decrease in their frequency of unprotected sex in general than women in the comparison condition (1994).
- ▶ Jemmott, et al. (1992) found that HERR sessions based on the social cognitive theory was effective in increasing young women's intention to use condoms and enhanced their perceptions of efficacy related to condom use. In another HERR intervention based on the social cognitive theory and the theory of reasoned action, Kamb, et al. (1998) also found that participants reported significantly higher condom use than women in comparison conditions.

Sources:

Kamb, M.L., Fishbein, M., Douglas, J.M., et al. (1998) Efficacy of Risk Reduction Counseling to Prevention Human Immunodeficiency Virus and Sexually Transmitted Diseases: A Randomized Controlled Trial. *Journal of The American Medical Association*, 280:1161-67.

Kelly, J.A., Murphy, D.A., Washington, C.D., et al. (1994) The Effects of HIV/AIDS Intervention Groups for High-Risk Women in Urban Clinics. *American Journal of Public Health*, 84: 1918-22.

Jemmott, L.S., Jemmott, J.B. (1992) Increasing Condom Use Intentions Among Sexually Active Black Adolescent Women. *Nursing Research*, 41; 273-79.

Individual and Group Level Health Education Risk Reduction (HERR)

Definintion Individual and Group Level Health Education and Risk reduction interventions are risk reduction interventions using a combination of group and individual

approaches. HERR interventions are provided to individuals/groups of individuals to assist them in making plans for individual behavior change and ongoing appraisal of their behavior. These interventions are also intended to facilitate linkages to services in both clinic and community settings in support of behaviors and practices that prevent transmission of HIV and help clients make plans to obtain these services. These interventions are designed to ensure that a client's need for both peer reinforcement and individual assessment are addressed and that accurate risk reduction information is provided.

Priority intervention for:

IDU, especially persons of color

✓HIV Infected

✓HIV Negative/ Presumed Negative

According to the literature...

- ▶Safety Counts was designed to assist drug-using clients of community-based organizations to reduce their risks of HIV infection. By engaging the client in group and individual sessions, the

program helps form a partnership between the client and agency staff. Clients in the enhanced intervention were generally about 1.5 times more likely to reduce drug-and sex related risk behaviors (e.g., injection drug use, crack cocaine use, unprotected sex) than clients in the standard intervention and were more likely to enter drug treatment (Rhodes, et al. 1993)

- ▶ Findings suggest that men and women who participate in group level HERR sessions are significantly less likely to inject drugs than those in the comparison condition. A study of women methadone patients showed that women who participated in an intervention significantly increased their frequency of condom use with their partners as compare to women in the comparison condition (EI-Bassel, et.al., 1992).
- ▶ A study found that after release from jail, youth who participated in a group and individual risk reduction intervention while incarcerated were significantly more likely to use condoms during intercourse than youth in the comparison condition (Magura, et al. 1994).
- ▶ VOICES/VOCES was effective in lowering the rate of new STD infections among the men who participated (O'Donnell, et al. 1998).

Sources:

EI-Bassel, N., Schilling, R.F. (1992) 15-Month Follow-up of Women Methadone Patients Taught Skills to Reduce Heterosexual HIV Transmission. *Public Health Report*, 107(5): 500-04.

Magura, S., Kang, S., Shapiro, J.L. (1994) Outcomes of Intensive AIDS Education for Male Adolescent Drug Users in Jail. *Journal of Adolescent Health*, 15(6): 457-63

O'Donnell, C.R., O'Donnell, L., Sandoval, A., Duran, R., Labes, K. (1998) Reductions in STD Infections Subsequent to an STD Clinic Visit: Using Video-based Patient Education to Supplement Provider Interactions. *Sexually Transmitted Diseases*, 25(3):161-168.

Rhodes, F., Humfleet, G.L. (1993). Using Goal-oriented Counseling and Peer Support to Reduce HIV/AIDS Risk Among Drug Users Not in Treatment. *Drugs & Society* (3/4):185-204.

**Individual Level Interventions
(ILI)**

Definintion ILIs are health education and risk reduction counseling services provided to one individual at a time. ILIs

involve assessing client risk and readiness for change. ILIs assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. Interventions include a skills-building component and also facilitate linkages to service in both clinic and community settings in support of behaviors and practices that prevent the transmission of HIV.

Literature Relevant to HIV Positive Individuals in all Populations:

Research conducted by Fisher, et al. (2004) on the Options project, a clinician-initiated HIV prevention intervention for HIV-positive patients showed that HIV prevention interventions by

clinicians treating HIV-positive patients can and should be integrated into routine clinical care.

Fisher, J.D., Cornman, D.H., Osborn, C.Y., Amico, K.R., Fisher, W.A., Friedland, G.A. (2004, October 1) Clinician-Initiated HIV Risk Reduction Intervention for HIV-Positive Persons: Formative Research, Acceptability, and Fidelity of the Options Project. *Journal of Acquired Immune Deficiency Syndromes*, 37:S78-S87.

Priority intervention for: **IDU, especially persons of color**
✓HIV Infected

According to the literature...

► A study by Stephens, et al. (1991) described an individual level intervention whereby 322 African-American males, mostly street addicts not in treatment, participated in one-on-one counseling sessions delivered by a professionally trained health educator. The session provided basic information on HIV transmission using a segment of a film, discussed sexual risk reduction and condom use, covered ways to reduce risk due to injection drug use and concluded with information on HIV testing. Those participating in a three month follow up interview reported that the percent of participants injecting decreased from 92% to 71%, those sharing decreased from 67% to 24%.

Sources:

Stephens, R.C., Feucht, T.E., Roman, S.W. (1991) Effects of an Intervention Program on AIDS-Related Drug and Needle Behavior Among Intravenous Drug Users. *American Journal of Public Health* 81(5): 568-571.

Priority intervention for: **MSM, especially persons of color**
✓HIV Infected

In the literature...

► Compared to control participants in a trial of a single session individual level intervention with repeat testers, participants reported decreased unprotected anal intercourse with non-primary partners of unknown or discordant HIV status at 6 and 12 months (from 66% to 21% at 6 months and to 26% at 12 months). Overall retention at 6 and 12 months was 87% and 83%, respectively (Dilly, et.al. 2002).

► Patterson, et al. (2003) sought to test brief (60–90 minutes) risk reduction interventions, primarily among men living with HIV/AIDS who identified as homosexual (91% male, 85% homosexual). They randomized participants to one of four conditions: (a) a single targeted counseling session (i.e., on condom use, negotiation, disclosure); (b) a single-session comprehensive intervention that covered all three intervention domains; (c) the same comprehensive intervention, plus two monthly booster sessions; or (d) a three-session diet and an exercise attention control condition. All four conditions (including the exercise comparison condition) resulted in a significant median decrease in total unprotected occasions over 12 months.

Sources:

According to the literature...

- ▶ The CAPC Initiative supports the development of community coalitions dedicated to the reduction of perinatal HIV transmission through the recruitment of high-risk pregnant women into prenatal care in targeted high risk zip codes. From January, 2002-September, 2002, 633 high-risk women were enrolled in CAPC; 61 percent were pregnant or suspected pregnancy. Due to time lags, at the time this presentation was provided, birth outcomes were known for only 95 delivering CAPC women. Of these, 2 were HIV-positive, but did not transmit HIV to their infants. (Doyle et al 2003).

- ▶ In Minnesota, a statewide program used disease intervention specialists to actively and successfully link HIV-positive youth, ages 13-22 to medical care and other relevant services (Remafedi 1998).

- ▶ A study by Latkin, et al. (2004) showed that odds of risky sex were lower among those currently receiving HIV medical care. Lower odds of receiving HIV medical care were associated with current drug use, sharing drugs with a sex partner, and exchanging sex for drugs or money. Findings suggest the importance of community-based HIV prevention intervention targeting HIV-positive drug users not recovery HIV medical care.

Sources:

Doyle, P.A., Rogers, P., Gerka, M., Vasquez, N., Smith, A., Birkhead, G, Glaros, R. Implementation of a Comprehensive Model for Recruiting Pregnant Women at Risk for HIV and Late or No Prenatal Care. National HIV Prevention Conference, July 27, 2003; abstract #T1-C1002.

Latkin, C.A., Forman-Hoffman, V.L., D'Souza, G., Knowlton, A.R.. (2004, October). Associations Between Medical Service Use and HIV Risk Among HIV-Positive Drug Users in Baltimore, MD. *AIDS Care*, 16(7):901-8.

Remafedi, G. (1998). The University of Minnesota Youth and AIDS Projects' Adolescent Early Intervention Program: A Model to Link HIV-Seropositive Youth With Care. *Journal of Adolescent Health*, 23, 115-121.

Mental Health Counseling

Definition There is a close association between mental health, social and environmental factors and an individual's ability to make and maintain behavior changes. In mental health

counseling, mental health problems such as (but not limited to) low self esteem, anxiety and depression, sexual abuse issues and post-traumatic stress disorder in clients are identified and addressed. Poverty, racism and marginalization can lead to mental health problems such as low self-esteem which can in turn, lead to substance use and other HIV risk behaviors. Inner-city young adults with high rates of HIV risk behaviors also experience higher rates of suicidal ideation, substance misuse, antisocial behavior, stressful events and neighborhood murders. Such mental health issues, which can vary according to community and geography, are often overlooked because of stigma on an institutional and individual level. Addressing mental health

problems is an integral part of HIV prevention.

Priority intervention for: **IDU, especially persons of color**
 ✓HIV Infected
 ✓IDU HIV Negative/ Presumed Negative

According to the literature...

► Routine screening for underlying psychiatric and substance use disorders and early treatment intervention before initiating antiviral therapy is essential to prevent worsening of depression and to optimize the outcome of treatment with IFN. Co-management treatment models involving mental health care may expand the pool of patients eligible to receive treatment with IFN, as well as enhance treatment outcomes (Fireman, et al. 2005).

Sources:

Fireman, M., Indest, D.W., Blackwell, A., et al. (2005) Addressing Tri-Morbidity (hepatitis C, psychiatric disorders, and substance use): The Importance of Routine Mental Health Screening as a Component of a Co-management Model of Care. *Clinical Infectious Diseases*, 40 (Suppl. 5):S286-S291.

Priority intervention for: **Heterosexuals, especially persons of color**
 ✓HIV Infected

According the literature...

► Symptoms of depression and of anxiety can interfere with most intervention models for self-care. Secondary HIV prevention interventions should address the high levels of mental health concerns that can exist among participants, as these concerns may attenuate intervention effects and be associated with poor clinical outcomes (Safren, et al. 2005).

► Psychosocial interventions can help infected parents with HIV-related challenges with their partners as well as with their children and their children's children (Rotheram-Borus 2004).

Sources:

Rotheram-Borus, M.J., Flannery, D., Lester, P., Rice, E. (2004, October 1) Prevention for HIV-Positive Families.[Editorial] *Journal of Acquired Immune Deficiency Syndromes*, 37 (Supplement 2):S133-S134.

Safren, S.A., Kissler, B., Capistrant, B., Wilson, I.; Mayer, K.H., (2005) The Importance of Addressing Mental Health Needs in Self Care Interventions in HIV. 2005 National HIV Prevention Conference, presentation #Ti-A1401.

Outreach

Definintion Outreach activities are HIV/AIDS interventions that are client-engaging and generally conducted face to face (or in virtual environments such as the Intenet) with individuals who are at high risk in the neighborhoods and areas where they congregate.

Outreach is designed to increase awareness of the risk of HIV transmission, to provide an

overview of risk reduction information, to communicate the benefits of early knowledge of one's serostatus, and to provide information about the availability of local resources for HIV-related services. Individuals and groups are engaged where they are, on their terms, and in their environment, with outreach activities being linguistically and culturally competent and specifically designed to reach targeted populations or sub-populations of individuals at risk for or infected/affected by HIV. Outreach methods may include, but are not limited to, street outreach on sidewalks and street corners, door-to-door contacts, media events and public service messages, participation in community or neighborhood fairs and events, mass mailings, and small group interactions at business establishments such as beauty and nail salons, barber shops, bars, and strip clubs.

Priority intervention for: **IDU, especially persons of color**
✓HIV Status Unknown
✓IDU HIV Negative/ Presumed Negative

According to the literature...

- ▶ Studies show that IDUs change their drug related and sex related risk behaviors following participation in an outreach based HIV risk reduction intervention. Studies also show significant effects in promoting entry into drug treatment related to outreach efforts. The findings suggest that utilizing peer-driven interventions with IDUs and providing them with a nominal incentive plays an important part in outreach efforts. The peer driven intervention outperformed the traditional outreach with respect to the number of IDUs recruited, the ethnic and geographic representation of the recruits and the effectiveness of the HIV prevention education. This intervention has been proven to be an effective first step in identifying IDUs, developing relationships with them and linking them to services (Coyle, et al. 1998).
- ▶ As reported by Larkin (1998), in Baltimore, Maryland, 36 African-American peer leaders were trained to promote prevention among contacts within and beyond their sex and drug networks. Peer leaders had 2165 HIV prevention interactions, of which 84% were with active drug users. Peer leaders reported a significant increase in condom use and cleaning used needles with bleach. The leaders' risk network members, compared with controls, were significantly more likely to report greater needle hygiene.
- ▶ Neaigua, et al. (1990) studied the effects of an outreach intervention by street educators who were ex-addicts on 276 IDU of color. Follow-up four and a half months later revealed that drug use in the last 30 days decreased, times injected decreased and 84% went for testing (although half did not return for their results).
- ▶ Starting in 1997, the SHIELD (Self-Help in Eliminating Life-Threatening Diseases) intervention trained injection drug users to conduct risk reduction outreach education among their peers. Many participants saw their outreach as "work," which gave them a sense of meaning and purpose and motivated them to make other positive changes in their lives (Dickenson-Gomez, et al. 2004).

Sources:

Coyle, S.L.; Needle, R.H.; and Normand, J. (1998) Outreach-based HIV Prevention for Injecting

accessing needed medical, psychological, and social services that affect clients' health and ability to change HIV-related risk-taking behavior.

Priority intervention for: **Perinatal/Pediatric, especially persons of color**
✓HIV Negative/ Presumed Negative

According to the literature...

▶A number of studies have shown that Prevention Case Management (PCM) can be effective in changing HIV-related risk behaviors (Choi, et al., 1994; and Kalichman,et al.1996).

Sources:

Choi, K.H., Coates, T.J.. (1994) Prevention of HIV Infection. *AIDS*, 8:1371-89.

Kalichman, S.C., Carey, M.P. and Johnson, B.P. (1996) Prevention of Sexually Transmitted HIV Infection: A Meta-analytic Review of the Behavioral Outcome Literature. *Annals of Behavioral Medicine*, 18: 6-15.

Sexuality and Sex Education

Definintion Sexuality and Sex Education is a process of acquiring information and forming attitudes and beliefs about sex, sexual orientation, relationships and

intimacy. It is also about developing individual's skills so that they make informed decisions, and feel confident and competent about acting on these decisions.

Priority intervention for: **Perinatal/Pediatric, especially persons of color**
✓HIV Infected

According to the literature...

Across the US and around the world, studies have shown that sexuality education for children and young people does not encourage increased sexual activity and does help young people remain abstinent longer. Effective educational programs have focused curricula, have clear messages about risks of unprotected sex and how to avoid risks, teach and practice communication skills, address social and media influences, and encourage openness in discussing sexuality (UNAIDS 1997).

Source:

UNAIDS. (1997) Impact of HIV and Sexual Health Education on the Sexual Behavior of Young People: A Review Update. Report prepared by UNAIDS, The Joint United Nations Programme on HIV/AIDS for World AIDS Day.

Syringe Exchange

Definintion Syringe Exchange programs distribute clean needles and safely dispose of used ones, and also generally offer a variety of related services, including referrals to drug treatment and HIV counseling and testing

Priority intervention for: **IDU, especially persons of color**
✓HIV Infected
✓IDU Status Unknown
✓HIV Negative/ Presumed Negative

According to the literature..

- ▶ A study found that IDUs who began using a syringe exchange program (SEP) were 2.68 times more likely to quit than those not enrolled in a program. Those who were already enrolled and continued in an exchange program were 1.98 times more likely to quit sharing needles than those who did not participate. These findings indicate that use of syringe exchange programs can be an important component in reducing the spread of blood-borne infectious diseases among high-risk IDUs. Although political controversy surrounds SEPs, the data suggest they are among the most effective HIV prevention programs for active IDUs (Bluthenthal, et al. 2000).
- ▶ Numerous studies have shown that easy, legal access to syringe exchange programs has resulted in a decrease in prevalence of HIV infection among injection drug users without any corresponding increase in drug use (Des Jarlais, et al. 1996; Lurie et al. 1993; Hagen et al. 1995).
- ▶ IDUs who participate in syringe exchange programs increase the incidences in which they use syringes only once (Heimer et al. 1998), have lower rates of HIV infection compared to IDUs that do not use syringe exchange programs (DesJarlais, et al. 1996) and they have good short term outcomes when referred for treatment when compared to IDUs in treatment that were referred from other sources (Brooner, et al. 1998).
- ▶ In a study conducted by Groseclose et al. (1995) it was found that after the laws permitting the possession of drug paraphernalia went into effect, sharing of syringes among IDUs decreased substantially and there was a shift from street syringe purchasing to purchasing syringes from pharmacies.
- ▶ In multiple logistic regression analyses, primary-only needle exchange was significantly associated with lower levels of receptive needle sharing, backloading, sharing other injection equipment and lending used needles, and positively associated with obtaining drug treatment. Mixed/secondary needle exchange was associated with less receptive needle sharing and a greater likelihood of drug treatment. Secondary exchange facilitated HIV risk reduction but the salutary effects of NEPs were attenuated in mixed/secondary exchangers (Huo, et al. 2005).

Sources:

Bluthenthal, R., Kral, A., Gee, L., Erringer, E. and Edlin, B. (2000) The Effect of Syringe Exchange Use on High-Risk Injection Drug Users: A Cohort Study. *AIDS*, 14, pp. 605-611.

Brooner R, Kidorf M, King V, et al. (1998) Drug Abuse Treatment Success Among Needle Exchange Participants. *Public Health Report*, 113(10): 129-3 9.

Des Jarlais, D.C., Marmor, M., Paone, D., et al. (1996) HIV Incidence Among Injecting Drug Users in New York City Syringe Exchange Programs. *Lancet*, 348: 987-91.

Groseclose, S.L., Weinstein, B., Jones, T.S., et al. (1995) Impact of Increased Legal Access to Needles and Syringes on Practices of Injection Drug Users and Police Officers- Connecticut 1992-1993. *Journal of Acquired Immune Deficiency Syndromes*, 10: 82-9.

Hagan, H., Des Jarlais, D.C., Friedman, S.R., Purchase, D. & Alter, M.J. (1995). Reduced Risk of Hepatitis B and Hepatitis C Among Injecting Drug Users in Tacoma Syringe Exchange Program. *American Journal of Public Health*, 85:1531-1537.

Heimer, R., Khoshnood, K., Bigg, D., Guydish, J., & Junge, B. (1998). Syringe Use and Re-use: Effects of Syringe Exchange Programs in Four Cities. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, 18 (Suppl 1), S37-S44

Huo, D., Bailey, S.L., Hershov, R.C., et al. (2005) Drug Use and HIV Risk Practices of Secondary and Primary Needle Exchange Users. *AIDS Education and Prevention*, 17(2):170-184.

Lurie, P., Reingold, A. (1993) The Public Health Impact of Needle Exchange Programs in the United States and Abroad. Berkley CA: University of California, Institute for Health Policy Studies.

7

Considerations

Overarching Considerations The priority interventions described in Chapter 6, while valuable for the development of any HIV prevention program, cannot successfully be implemented without taking the larger context of “overarching considerations” into account. For instance, the fact that African American/Black communities are disproportionately affected by the HIV/AIDS epidemic has been, and will continue to be, an “overarching consideration” in HIV prevention intervention implementation in NYS.

As preparations for priority setting progressed, the PPG identified many of these “overarching considerations”, which are listed below. In addition, each of its nine population-based Committees identified numerous considerations to take into account when implementing the priority interventions with for their populations. The most frequently mentioned of these are listed below as well.

PPG-generated considerations:

- ✓ All HIV prevention program staff should receive overall cultural competency training as well as training relevant to the specific community being targeted.
- ✓ All HIV prevention interventions should be age-appropriate.
- ✓ All HIV prevention interventions must be linguistically appropriate, including, but not limited to, American Sign Language.
- ✓ When implementing HIV prevention interventions the specific needs of transgender individuals relative to the modes of transmission must be considered.
- ✓ Regulations pertaining to school-based HIV prevention education should be enforced.
- ✓ All HIV counseling and testing programs should be culturally competent.
- ✓ When implementing interventions, take into account:
 - ▶immigration status, particularly for individuals who are undocumented.
 - ▶the overwhelming prevention needs of hard to reach populations, such as family members of incarcerated individuals and the homeless
- ✓ Access to condoms is necessary for sexual risk reduction.
- ✓ Access to sterile syringes is necessary for risk reduction for Injection drug users.
- ✓ Access to microbicides, when developed and available, should be provided as

appropriate.

- ✓ When providing services to a particular community, consider the strengths of that community.
- ✓ For agencies providing multiple services, sensitivity towards the epidemic should be exhibited throughout the agency, not just within the HIV/AIDS component.
- ✓ Access to transportation should be readily available.
- ✓ There is a paucity of prevention research surrounding how best to meet the needs of communities of color. This issue, along with the need for investigators from that community, needs to be addressed.

Population-based Committee-generated considerations:

- ✓ To be effective in delivering services (e.g., outreach, education), peers reflecting the target population should be utilized in the design, development, evaluation and implementation of programs.
- ✓ Discussions related to HIV prevention must include consideration of the stigma attached to HIV/AIDS and the stigma attached to various populations (e.g., MSM).
- ✓ Services should be conducted in non-traditional venues and settings, reflecting locations where the target population can be effectively reached.
- ✓ The location of services should respect the confidentiality of individuals and provide space where individuals can feel comfortable and safe.
- ✓ Interventions should include the provision of referrals associated with the specific needs of each individual.
- ✓ Issues related to trauma (e.g., history of abuse, testing HIV positive) experienced by the individual and/or family should be explored sensitively.
- ✓ HIV counseling and testing services should utilize rapid HIV testing technologies when appropriate.
- ✓ Consider the provision of incentives for participating in particular services and for returning to obtain follow-up services (e.g., transportation tokens).
- ✓ As appropriate, efforts should include outreach to, and partnerships with, faith-based organizations and their leaders.

PDF files of Committee population-based considerations are available from from the AIDS Institute's Division of HIV Prevention--wjs03@health.state.ny.us.

Specific Considerations for NYS's 2005-2010 Priority Populations: While engaged in priority setting, the PPG identified specific key considerations to take into account when providing HIV prevention interventions for certain priority populations. These are:

Tier I

IDU HIV positive - especially persons of color

- ▶ Harm reduction models should be employed.
- ▶ Housing is a crucial consideration that affects the success of prevention programs.
- ▶ Transportation is an issue, particularly in rural areas of the State.
- ▶ Access on demand to substance use treatment is needed.
- ▶ Substance use services need to be available to women in general as well as women with children.

MSM HIV positive - especially persons of color

- ▶ Maintenance of a "safe space" (confidential, supportive and nonjudgmental)
- ▶ Providers should be culturally responsive.
- ▶ Use of peer models improves the possibility of prevention effectiveness

Heterosexual HIV positive - especially persons of color

- ▶ The availability of "one stop shopping" for prevention services increases utilization

Perinatal HIV positive - especially persons of color

- ▶ Competent training for obstetricians/gynecologists and pediatricians should be provided

Tier II

IDU-HIV Status Unknown-especially persons of color

- ▶ Access on demand to substance use treatment is needed.
- ▶ Substance use services need to be available to women in general as well as women with children.

MSM-HIV Status Unknown-especially persons of color

- ▶ A holistic approach to men's health and wellness should be demonstrated.
- ▶ Collaborative outreach surrounding HIV and STD services should be considered.

Tier III

IDU- Negative/Presumed Negative-especially persons of color

- ▶ Access on demand to substance use treatment is needed.
- ▶ Substance use services need to be available to women in general as well as women with children.
- ▶ There is an urgent need for access to mental health treatment for this population.
- ▶ Harm reduction models should be employed.

MSM- Negative/Presumed Negative-especially persons of color

- ▶ Use of peer models improves the possibility of prevention effectiveness.
- ▶ Tolerance and diversity campaigns promoting healthy sexuality should be implemented.

Heterosexual- Negative/Presumed Negative-especially persons of color

- ▶ Testing in non-traditional settings with incentives should be offered.
- ▶ Use of peer models improves the possibility of prevention effectiveness.

Perinatal- Negative/Presumed Negative-especially persons of color

- ▶ Providers should concentrate on strengthening social support systems.

8

Provider Needs

Although the preceding Chapters provide important information needed for the implementation of appropriate, culturally competent, science-based HIV prevention interventions, it must be recognized that these services cannot be offered to at-risk communities by agencies lacking the wherewithal to provide them. Those actually delivering needed services cannot successfully implement prevention interventions unless they are adequately equipped with what they need to do the work.

A consistent question surrounding provider needs was posed to the almost 2,000 RGA participants around the state during its 139 discussion groups. Each region ranked its top three provider needs. The highest ranked provider needs were:

Funding-related:

- ✓ more funding
- ✓ less competition for funds
- ✓ more jobs for PLWHIV
- ✓ diversification of funding streams
- ✓ support for implementing innovative strategies
- ✓ streamline paperwork and bureaucracy
- ✓ funding to address HIV-related stigma/discrimination

Technical Assistance (TA)-related:

- ✓ TA surrounding HIV prevention issues
- ✓ development of policies and procedures
- ✓ knowledge of best practices
- ✓ better coordination and referral

Staff Needs-related:

- ✓ staff development
 - comprehensive sex education
 - cultural sensitivity training for staff
 - understanding/compassion
 - support to address stress management
- ✓ linguistically competent staff
- ✓ more volunteers

Prevention Materials/supplies-related:

- ✓ better translation services
- ✓ More prevention supplies
- ✓ Vans

- ✓ Syringe access/safe disposal

Miscellaneous needs:

- ✓ more community openness about HIV
- ✓ co-locate psychiatric/mental health staff in CBOs
- ✓ media coverage on public transportation
- ✓ Revise CDC transmission risk categories
- ✓ Expansion of prevention activities in rural areas
- ✓ More collaboration

PPG Prioritized Provider Needs: Based on its careful review of the provider needs as detailed by statewide RGA activities, the Executive Committee developed a list of three priority prevention needs for HIV prevention providers in NYS. These needs were subsequently approved by the full PPG. With the understanding that NYS is a large, diverse state and that provider needs vary regionally, the needs encompass three categories of statewide needs common to providers. They are:

- ✓ increased funding
- ✓ staff development/training
- ✓ technical assistance

Although each provider within the State has its own unique needs, most will naturally fall within the above three categories. While the possibility of entirely realizing everyone's needs relies heavily on events and issues not necessarily within anyone's control, creative strategies can assist providers in ensuring that they are able to offer needed HIV prevention services to those at risk.

9

Useful Acronyms, Words and Phrases

Useful Acronyms

AA/B	African American/Black
AAC	AIDS Advisory Council
ACT	Anonymous Counseling and Testing
ADAP	AIDS Drug Assistance Program
A&PI	Asian and Pacific Islander
BHAE	Bureau of HIV/AIDS Epidemiology
BRFSS	Behavior Risk Factor Surveillance Study
CARE ACT	Comprehensive AIDS Resources Emergency Act
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CDI	Community Development Initiative
CJI	Criminal Justice Initiative
CMS	Contract Management System
CNAP	Contact Notification Assistance Program (NYC only)
CNI	Community Needs Index
CQI	Continuous Quality Improvement
CPG	Community Planning Group
CSP	Community Service Provider (county or borough and AIDS specific)

CTRPN	Counseling, Testing, Referral Partner Notification
DL	“Down Low”
DOCS	Department of Correctional Services
DOH	Department of Health
EMA	Eligible Metropolitan Area
ESAP	Expanded Syringe Access Demonstration Program
GLBT	Gay Lesbian Bisexual and Transgendered
HITS	HIV Testing Survey
HIV CTRPN	HIV Counseling Testing and Referral/ Partner Assistance
HRSA	Health Resources & Services Administration
IDU	Injecting Drug Users
IOM	Institute of Medicine
LHU	Local Health Unit
LTI	Leadership Training Institute
MMWR	Morbidity + Morality Weekly Report
MSA	Multiple Service Agency (city or borough specific and serve communities of color)
MSM	Men Who Have Sex With Men
NIR	No Identified Risk
NYC	New York City
NYS	New York State
OASAS	Office of Alcoholism and Substance Abuse
OCFS	Office of Children and Family Services

OMD	Office of the Medical Director
OMH	Office of Mental Health <i>also</i> Office of Minority Health
OMRDD	Office of Mental Retardation and Developmental Disabilities
OPER	Office of Program Evaluation & Research
PLWA	Persons Living With AIDS
PLWHIV	Persons Living With HIV
PNAP	Partner Notification Assistance Program (statewide)
PPG	Prevention Planning Group
PPU	Prevention Planning Unit
R/E	Racial/Ethnic
RFA	Request for Applications
RFP	Request for Proposals
RGA	Regional Gaps Analysis
RW II	Ryan White Title Two (statewide)
RW I	Ryan White Title One (NYC, Dutchess County and Nassau/Suffolk Eligible Metropolitan Areas (EMA)).
SAMHSA	Substance Abuse Mental Health Services Administration
SASDC	Statewide AIDS Service Delivery Consortium
SED	State Education Department
SEP	Syringe Exchange Program <i>also</i> Special Emphasis Panel
SOC	Stages of Change behavioral science model
SOFA	State Office For the Aging
STD	Sexually Transmitted Disease

STI	Sexually Transmitted Infection
TA	Technical Assistance
TG	Transgender
YMS	Young Mens Study

Useful Words and Phrases

Adaption: Adaptation of an intervention or strategy implies that it is being delivered to a different population or in a different venue than the one in which efficacy was originally demonstrated. For example, the Popular Opinion Leader intervention was originally designed to reach gay men in bars; but was successfully adapted for use with African American women in an urban housing project. VOICES/VOCES was originally tested in sexually transmitted diseases (STD) clinics but has been adapted for drug treatment settings.

In other words--When you adapt an effective behavioral intervention (EBI) you make modifications as to **who** receives it and **where** it is delivered.

Adoption: When you adopt an EBI, it needs no modifications.

AIDS (Acquired Immunodeficiency Syndrome): a disease caused by the human immunodeficiency virus. For public health surveillance, the CDC defines AIDS as the diagnosis of one or more specified indicator conditions, CD4+ T-cells less than 200/ml, or less than 14% of total lymphocytes and a positive HIV test or absence of other cause of immune deficiency.

Barebacking: intentional unprotected anal intercourse with someone other than a primary partner.

Behavioral Interventions: programs designed to change individual behaviors without an explicit or direct attempt to change the norms (social or peer) of the community (e.g., geographically defined area) or the target population (e.g., IDUs or MSM). Example: risk reduction counseling.

Centers for Disease Control and Prevention (CDC): the federal agency responsible for monitoring diseases and conditions that endanger public health and for coordinating programs to prevent and control the spread of these diseases. Based in Atlanta, GA, it is an agency of the U.S.

Department of Health and Human Services.

Case Management is a formal and systematic multi-step process designed to assess the needs of a client to ensure access to needed services and collateral services such as access to transportation and access to appropriate physicians and specialists. The steps of a case

management process include the following: intake, assessment, service plan development and implementation, ongoing monitoring and evaluation, reassessment and service plan update, exit planning/case discontinuation.

Community-based organization (CBO): an organization offering services to a specific group of people in a defined area. Usually a non-profit, CBOs are governed by a board of directors and staffed by a combination of employees and volunteers.

Community Level Interventions (CLIs) are intended to generate interest in and commitment to HIV/AIDS-related matters in the community. They encourage individuals and community organizations to increase community support of the behaviors known to reduce the risk for HIV transmission. These interventions reduce risky behaviors by changing attitudes, norms and practices. Activities include community mobilization, social marketing campaigns, community-wide events and policy interventions.

Comprehensive Sexuality Education provides a wide range of information and choices, with information on sexuality, pregnancy, contraception and prevention of HIV and sexually transmitted diseases (STDs).

Counseling, testing, referral, and partner notification (CTRPN): voluntary HIV/AIDS counseling and testing, referral to appropriate medical and social services, and anonymous or confidential notification of sex or needle-sharing partners by health department staff.

Cultural competence: the knowledge, understanding, and skills to work effectively with individuals from differing cultural backgrounds.

Down Low: a term coined by African American/Black men who have sex with other men but do not consider themselves gay and maintain the public appearance of being straight.

Epidemiologic profile: a description of the current status, distribution, and impact of an infectious disease or other health-related condition in a specified geographic area.

Epidemiology (also known as epi) : the study of factors associated with health and disease and their distribution in the population.

Group Level Interventions (GLIs) are health education and risk reduction interventions provided to groups of varying sizes. GLIs are designed to assist clients with planning, achieving and maintaining behavior change using a science-based model (e.g., cognitive model and health belief model). GLIs use models that provide a wide range of skills-building activities, information, education and support, delivered in a group setting.

Harm Reduction is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence. Harm reduction strategies meet drug users "where they're at," addressing conditions of use along with

the use itself and is based on the stages of change model (see chapter 4).

Health Communication/Public Information (HC/PI) is the delivery of HIV/AIDS prevention messages and/or promotion of HIV-related activities through one or more media to target audiences. The purpose is to increase awareness, build general support for safe behaviors, support personal risk reduction efforts, and/or provide individuals with general information about programs and available services.

Health Education/Risk Reduction (HE/RR) is provision of information and distribution of materials to raise awareness about personal risk and educate individuals at risk/HIV infected about methods to reduce the spread of HIV. HERR interventions are provided to individuals/groups of individuals to assist them in making plans for individual behavior change and ongoing appraisal of their behavior. These interventions are also intended to facilitate linkages to services in both clinic and community settings in support of behaviors and practices that prevent transmission of HIV and help clients make plans to obtain these services.

HIV Counseling Testing and Referral/ Partner Assistance Services is the process for conducting a test to identify the presence of HIV infection and provide public health intervention. This process must be conducted in accordance with Public Health Law and include specific activities to assess the client's knowledge, attitudes, behaviors and beliefs related to HIV. An assessment of personal risk behaviors and interventions to diminish those risk behaviors must be included in the counseling session(s). HIV counseling also includes an assessment of the threat for abuse and/or harm related to HIV disclosure and a demonstrated understanding of HIV stigma. Testing cannot occur unless there is a determination of the client's ability to understand the test results, confidentiality, HIV reporting and partner notification.

For clients identified as HIV-infected, there must be education provided on HIV treatment and care options as well as referral for medical assessment, linkage to medical, social and supportive services. Consumers who test positive must be given support to report and notify their needle sharing and sex partners of possible exposure to HIV infection. Utilization of Contact Notification Assistance Program (CNAP) in NYC and PartNer Assistance Program (PNAP) in the rest of NYS is encouraged. HIV counseling and testing must be conducted consistent with the requirements of New York State Public Health Law and applicable regulations.

Human Immunodeficiency Virus (HIV): HIV is the virus that causes AIDS. Persons with HIV in their system are referred to as HIV infected or HIV positive.

Implementation: putting into effect a precise plan or procedure (e.g., collecting information about the interventions identified in the HIV prevention comprehensive plan).

Individual-level interventions (ILI): health education and risk-reduction counseling provided to one person at a time. ILIs assist clients in making plans to change individual behavior and to appraise regularly their own behavior. These interventions also facilitate linkages to services in

both clinic and community settings (i.e., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV. Interventions also help clients plan to obtain these services.

Injection drug users (IDU): people who are at risk for HIV infection through the shared use of equipment used to inject drugs with an HIV-infected person (e.g., syringes, needles, cookers, spoons).

Men who have sex with men (MSM): men who have sexual contact with other men (i.e., homosexual contact or bisexual contact) whether or not they identify as homosexual or bisexual.

Outreach is a planned HIV/AIDS activity and is often the first point of contact with an individual or a group. It has specific objectives and methods for reaching populations at highest risk. Outreach activities are conducted face to face with high-risk individuals in the neighborhoods or areas where they typically congregate. Activities must be culturally and linguistically appropriate and address the needs of the priority population(s). Outreach may also include regularly scheduled events that provide consistent support and guidance for at-risk individuals. In addition, outreach activities include case finding, program promotion and activities that facilitate access to individuals most at risk, those who are HIV infected and not currently engaged in care, and those who do not yet know their HIV status.

Outreach is not:

- ✗ dropping off literature at fixed sites
- ✗ distributing literature on the street
- ✗ handing out cards, condoms or other incentives

Partner counseling and referral services (PCRS): a systematic approach to notifying sex and needle sharing partners of HIV-positive people of possible exposure to HIV so the partners can avoid infection or, if already infected, can prevent transmission to others. PCRS help partners gain early access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.

Partner Notification Assistance Counseling and Skills Building is the process of educating HIV-infected clients about the importance of and their responsibilities for informing past and present sexual and needle-sharing partners of their exposure to HIV. It also involves discussing with infected individuals the different options available for partner notification. Skills building includes assisting in developing notification skills to enable the client to self-notify partners. The development of notification skills can be accomplished through coaching, role playing/modeling, and other relevant skills-building activities and techniques, as well as through discussions of how to handle potentially problematic situations, which may develop during notification. Multiple sessions may be needed before clients are comfortable with the notification process. Public health staff is available through the PartNer Assistance Program (PNAP) in all areas outside of NYC and the Contact Notification Assistance Program (CNAP) in NYC to provide partner assistance counseling and referral services.

Peer Delivered Services are provided by an individual who has the same or similar characteristics, background, and life experiences as those of the population being served. The greater the number of commonalities that the peer has with the target audience, the easier it may be for the peer to be accepted by members of the community and to establish meaningful bonds with group members that are conducive to the exchange of information and ideas. The peer model has proven to be extremely successful in building the trust and bonding necessary for individuals to look carefully at their behaviors and successfully make behavior change.

Peers should be recruited from the communities to be served and be provided with comprehensive training designed to assist them in performing the required duties of their job. The peer educator/counselor is expected to conduct outreach to the target population, engage members of the target group in receiving the services of the agency/organization, provide HIV/AIDS education to individuals or groups, answer questions, present facts, identify resources for people who want more information, and provide guidance and support to those making choices about personal behavior to reduce the risk of HIV infection to themselves and others.

Peer training should provide peers with the facts and skills necessary to teach and counsel others about HIV infection and AIDS. Training programs should use a variety of exercises and activities designed to stimulate learning and increase the peers' knowledge and understanding of HIV and AIDS.

Perinatal: refers to events that occur at or around the time of birth (i.e., transmission of HIV/AIDS between mother and child at birth).

Prevention Case Management is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple complex problems and risk-reduction needs; a hybrid of HIV risk reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage. HIV Prevention Case Management (HIV/PCM) is a one-on-one, multi-session, intensive intervention that is intended for clients who would otherwise have a poor prognosis for changing behaviors or clients for whom other, less-intensive interventions have failed. HIV/PCM clients may be either living with HIV or at highest risk of becoming infected. HIV/PCM services are not a substitute for medical case management, extended social services or long-term psychological care. HIV/PCM is also intended to improve client skills in accessing community resources that support behavior change.

Prevention with positives: refers to the use of any of these strategies with persons already infected with HIV in order to prevent transmission to others and to support HIV-positive individuals in living safely.

Rapid Testing: a rapid screening test for detecting antibody to HIV is a screening test that produces very quick results, usually in 20 minutes.

Referral: a process by which an individual or client is connected with a provider who can serve

that person's need (usually in a different agency) through face-to-face contact, telephone, written or any other type of communication. For example, individuals with high-risk behaviors and those infected with HIV are guided towards prevention, psychosocial, and medical resources needed to meet their primary and secondary HIV prevention needs. Referral activities may occur formally through a memorandum of understanding (MOU) or informally.

Risk factor or risk behavior: whatever places a person at risk for disease. For HIV/AIDS, this includes such factors as sharing injection drug use equipment, unprotected male-to-male sexual contact, and commercial unprotected sex.

Seroconversion: the development of antibodies to a particular antigen. When people develop antibodies to HIV, they seroconvert from antibody-negative to antibody-positive. It may take from as little as one week to several months or more after infection with HIV for antibodies to the virus to develop. After antibodies to HIV appear in the blood, a person should test positive on antibody tests.

Serodiscordant: a couple in which one partner has tested positive for HIV and the other has not.

Serostatus: results of a test for specific antibodies; testing either seropositive or seronegative to HIV antibody test.

Social Marketing is a research-based process that adapts proven marketing techniques to raise awareness, change attitudes, beliefs and behaviors. It seeks to "sell ideas" and influence social behaviors to benefit the target audience and the general society. Commonly used in public health and other social change campaigns.

Stigma: refers to prejudice, discounting, discrediting, and discrimination directed at people, and the individuals, groups, and communities with which they are associated.

Supportive Services are those that enhance a client's ability to access prevention, health and social services. Examples of supportive service include: transportation, housing, child-care, support groups and counseling services. These services should ideally be offered to a client in conjunction with case management geared toward assisting the client in obtaining needed medical and social services. Emergency cash for necessities such as groceries and toiletries may also be included depending on the funding source.

Syringe Exchange services are provided as part of a comprehensive harm reduction model, through which clients who will not or cannot abstain from drug use or will not or cannot enter into treatment, can learn methods to reduce the risk of HIV infection and other harm to themselves and their partners. Programs must have sought and obtained community support to receive State approval.

In addition to the provision of clean injection equipment, harm reduction services include:

- provision of information on risk reduction practices related to sexual and drug-using behaviors;
- distribution and demonstration of condoms and dental dams;
- distribution and demonstration of bleach kits and safer injection techniques;
- distribution of other harm reduction supplies and literature; and
- direct provision of or referrals to HIV counseling and testing, partner notification assistance, drug treatment, health care, legal, housing and social services

Tailoring: Tailoring occurs when an intervention or strategy is changed to deliver a new message (for example, addressing condom use versus limiting the number of partners), at a new time (at a weekend retreat rather than over a series of weeks) or in a different manner (using verbal rather than written messages) than was originally described.

In other words-- When you tailor an EBI you make modifications as to **when** it is delivered, **what** is delivered and **how** it is delivered.

Target populations: groups of people who are the focus of HIV prevention efforts because they have high rates of HIV infection and high levels of risky behavior. Groups are often identified using a combination of behavioral risk factors and demographic characteristics.

Transmission categories: in describing HIV/AIDS cases, same as exposure categories; how an individual may have been exposed to HIV, such as injection drug use, MSM, and heterosexual contact.