

**2010-2015**



New York State

# **Comprehensive HIV Prevention Plan**

Submitted by the  
New York State HIV Prevention Planning Group

to the  
AIDS Institute  
New York State Department of Health

August 2010

***The New York State HIV Prevention Planning Group (PPG) dedicates all of its Comprehensive HIV Prevention Plans 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.***

***The PPG especially dedicates this 2010-2015 NYS Comprehensive HIV Prevention Plan to three members who died during its development: Ron Gonzalez, Tarah Tapley and Mitchell Harris.***

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## **PART A: Introduction to this Plan**

*HIV Prevention Plan*

The Centers for Disease Control and Prevention's (CDC) *HIV Prevention Community Planning Guidance* specifies 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 necessary to develop effective HIV prevention programs in a state with a diverse population and mature epidemic like NYS.

This *2010-2015 NYS HIV Comprehensive HIV Prevention 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 cognizant of 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 wars in Iraq and Afghanistan, natural and man-made disasters, 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 taken into account during the deliberations and decisions culminating in this Plan:

***HIV/AIDS in Communities of Color*** New York State continues to be the jurisdiction most heavily impacted by HIV/AIDS with people of color disproportionately affected by the epidemic. Furthermore, (a) New York State remains, along with the District of Columbia, the US jurisdictions with the most heavily impacted Communities of Color, (b) broad areas of Queens, a borough of New York City, comprise the most linguistically, culturally, and religiously diverse acreage on the globe, and (c) New York State, and especially New York City, is a magnet for extremely high numbers of immigrants, documented and undocumented, annually.

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. During the past ten years, 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, acknowledged and addressed as co-factors in transmission and acquisition of HIV.

***Sexual Transmission of HIV*** In spite of interventions developed and implemented to date, sexual transmission continues to account for an increasing proportion of new infections, particularly in New York's most vulnerable populations. Young men of color who have sex with men and women of color remain at heightened risk for sexually transmitted HIV. (MMWR, 6/05; CDC, HIV/AIDS Surveillance Report 2005, Volume 17).

Reducing sexual transmission of HIV is complicated by the diversity of approaches needed to reach many populations. Interventions must specifically target heterosexual men and women; homosexual, bisexual and other men who have sex with men; persons of transgender experience; and persons with all of these sexual identities who are of varied racial, ethnic and cultural backgrounds. Other life experiences including drug use, domestic violence, sexual abuse, and cultural powerlessness also have a significant impact on sexual behavior.

In a study conducted, "HIV Among IDUs Entering NYS Department of Correctional Services Facilities – 1988-2005", both male and female injection drug users among incoming NYS prison inmates demonstrate significant and continuing decline in HIV seroprevalence. The rate of decline has been more pronounced among female inmates who are injection drug users as compared to non-injecting groups. However, in spite of interventions developed and implemented to date, sexual transmission continues to account for an increasing proportion of new infections, particularly in New York's most vulnerable populations. Young men of color who have sex with men and women of color remain at heightened risk for sexually transmitted HIV.

***Increasing Numbers of Infected Young People and Young Adults*** During the deliberations resulting in the development of this Plan, the PPG expressed concern about the numbers of young people and young adults still becoming infected with HIV. While there is a law mandating HIV education in public schools, enforcement is uneven amongst the numerous School Districts and School Boards across the State. The PPG strongly feels that uniform enforcement and accountability of this mandate would go a long way towards ensuring that NYS's young people and young adults have the information needed to reduce transmission of HIV.

***Fiscal Climate*** NYS's ability to sustain successes in HIV prevention is increasingly jeopardized by the difficult fiscal climate in the state and federal governments. In previous years, NYS has had the capacity to mitigate the impact of the federal recessions with support from its State Legislature. In recent years, NYS' fiscal issues have become acute and ongoing.

***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. In addition, the PPG’s Regional Gaps Analysis (RGA—see Chapter 4) identified issues related to Prevention with Positives in all of NYS’ regions.

# 1

## How to Use this Document

The *2010-2015 NYS HIV Comprehensive HIV Prevention Plan* was prepared to be user-friendly with useful material to assist providers in developing 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, HIV positive individuals/People Living with AIDS and community characteristics in NYS. Additionally, professional expertise and representation from key governmental and non-governmental agencies occurs to ensure that the process promotes 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 previous *NYS Comprehensive HIV Prevention Plans* in 1994, 1998 and 2005.

**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.

**Committees** Three standing Committees address the overall governance of the PPG: 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) Advisory Committee (PLWHA); (2) Criminal Justice; (3) Emerging Issues; (4) Gay Men/Men Who Have Sex with Men (MSM); (5) Immigrant/Migrant; (6) Racial/Ethnic; (7) Substance Use; (8) Women; and (9) Young People. Each Committee works closely with an NYSDOH 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 is invited to provide comments during an open mic period. The Executive Committee, made up of Co-Chairs from each Committee, meets ten times each Planning Cycle. 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. 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 on an as-needed basis to discuss By-Laws amendments and/or membership issues, including a comprehensive review of member applications. This review yields recommendations to the Commissioner of Health for additions to the approved applicant pool, from which member appointments are chosen. 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, people living with HIV/AIDS (PLWHAs) comprise at least 30% of its total membership. Each member brings a wealth of knowledge and experience from a wide spectrum of communities affected by, and at risk for, HIV/AIDS and can be viewed as voices of their communities.

Applications for membership on the PPG include a request for participation on a specific population-based Committee. Where possible, new members are assigned to their first choice, however present Committee make-up specific expertise, geographic location, race, gender and age needs are considered.

To facilitate retention of members, the AIDS Institute provides prepaid transportation, lodging and meals for all PPG-related meetings. Meetings are made as comfortable as possible for members, with meals provided and individual needs met. In recognition of variable transportation modes and schedules affecting on-time meeting arrival times and health-related limits, members have the option of travel the night before a meeting, again with pre-paid lodging and meals. 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.

***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. 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 and Vice Co-Chair 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. 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 HIV and STD epidemiological data and information on STD prevention. To further enable the population-based Committee work, specific data can be requested as well as assistance provided 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, AIDS Institute support staff attend to all logistical and practical needs, including travel and lodging arrangements, scheduling of meetings, conference calls 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 full PPG meetings and in preparation of brochures and other materials. A representative from the NYS DOH Office of Minority Health also participates in the PPG.

***State Agency Representatives*** Representatives from NYS governmental agencies other than the DOH play an important 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, Division of Human Rights, Office of Children and Family Services, NYS Commission on Quality of Care and Advocacy for Persons with Disabilities, State Education Department, Office of Persons With Developmental Disabilities, Office of Mental Health and the Office of Alcoholism and Substance Abuse

Services.

***Coordination with the NYC Department of Health and Mental Hygiene Group*** Several NYS PPG members are former members of the NYC PPG, and the NYS PPG Governmental Co-Chair is a present NYC PPG member as well. Participants from the two groups met and exchanged information at the PPG's March meeting in NYC and will meet again each year at the NYS PPG's scheduled NYC meeting. As a result of that meeting, some NYS PPG Committees have interfaced with their NYC counterparts and Committee Co-Chair lists have been exchanged.

***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 during either the Business Day or Supplementary Day of the full meetings (see page 4). Population-based 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 and on an ongoing basis for follow-up on specific issues or activities such as the development of the *Comprehensive HIV Prevention Plan*. 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.

***PPG Finance Committee Orientation*** A comprehensive orientation specifically designed for Finance Committee members and other interested PPG members is conducted annually and has recently been opened up to new members as part of their ongoing orientation to the PPG. Orientation topics discussed include the role of the Finance Committee members, state and federal budget process and their connection and relevance to the HIV prevention portfolio in NYS and the Cooperative Agreement and PPG related expenditures. A monthly call is held with members to continue to provide information/updates and solicit input on budget related matters.

***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.

***Presentations at full PPG meetings and Supplemental Days*** To address the variety of participants' informational needs, the two-day PPG meetings include a Business Day and a Supplemental Day. Regular 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. In addition, a “Parking Lot” is kept during full meetings, of issues either not germane to the current discussion, or not immediately addressable without further information.

***Epidemiological Technical Assistance (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 E-Mails 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 e-mails and during full meetings, including articles, HIV/AIDS data, information about interventions, information on HIV/AIDS prevention and communities of color, and other HIV prevention-related topics. Materials can be provided in large print, if 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 for new members and provides new materials as needed.

**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

**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 voices and experiences 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.

***Criminal Justice Committee*** The Criminal Justice Committee is concerned with the HIV prevention needs of individuals within the criminal justice system, including county, city 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.

***Gay Men/MSM 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.

***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.

***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.

*2010-2015 NYS Comprehensive*  
**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, primarily in English 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 initially were 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, additional emphasis was placed on linguistically and culturally competent peer education programs. 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 services, 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.

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 individuals from 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 on evidence-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 in NYS with its diverse populations, many of whom are without legal documentation. This is particularly true in a state as diverse as NYS. To assess effective interventions for populations at risk, a wide range of contextual considerations must be considered, including historical underpinnings, external factors and cultural norms related to the specific population, including recognition of gender differences and language recognition. The role of behavioral and social sciences and the concept of technology transfer within the context of differing levels of access and understanding must be addressed as well.

At this point in the epidemic, we are cognizant of the fact that HIV prevention comprises interventions delivered to individuals, to groups, and to communities 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 utilized numerous inputs. A Community Services Assessment (CSA), as defined 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 is designed to examine 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 1-5)
- **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 populations at risk 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 is an ongoing 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 ensure that individuals with HIV and individuals at high risk have access to critical services and ascertain what, if any, types of service gaps exist. It also is a way to include "community intelligence" in the priority setting process. Approximately 2000 people participated in RGA activities.

**History** In its 1998-1999 Planning Cycle, the NYS HIV PPG and the AI first 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.

As a result, between 2000 and 2004, the AI, in conjunction with local agencies and stakeholders, engaged in its first RGA to inform the NYS HIV PPG's priority setting process (now known as RGA 1.0). In all areas of the State, except the five Boroughs of NYC, the AI contracted with Ryan White CARE Networks to engage in prescribed RGA activities. A consultant conducted RGA activities in the five boroughs of NYC. Activities included a Kick-Off Meeting, development of and implementation of a discussion group plan using a consistent eight questions in the region, development of a discussion group report, ranking of populations and interventions and development of a final report. A 24-month period was set aside for completion of RGA tasks in each region.

**RGA 2.0** To inform the *2010-2015 NYS Comprehensive HIV Prevention Plan*, the PPG and the AI decided upon a multifaceted approach to build upon and add to the information generated from RGA 1.0. The method used to gather information included numerous activities/sources of information designed to provide an enhanced picture of HIV prevention both in each region of the State and Statewide, with the understanding that priority setting will be performed for the State as a whole.

**Methodology** The activities informing the RGA 2.0 are:

**PPG Baseline Survey re: 2005-2010 priorities** In order to ascertain whether PPG members felt that the priorities recommended in the 2005-2010 NYS Comprehensive HIV Prevention Plan were still applicable, this survey was conducted. An important result of this survey changed the hierarchical order of the PPG's "Big Four" transmission categories. Beginning with this Comprehensive HIV Prevention Plan, the hierarchy used will be: Men who have Sex with Men, especially persons of color; Heterosexual, especially persons of color; Injection drug use, especially persons of color and Perinatal/Pediatric, especially persons of color. This adjustment reflects an epidemiologic shift in the epidemic in NYS since the last comprehensive HIV Prevention Plan.

**Membership Survey** During 2008 the Prevention Planning Group (PPG) Membership Survey was completed. The purpose of this survey was to assess the community's perception of the HIV/AIDS epidemic and the strengths and/or weaknesses of the state's response to it. PPG members were asked to administer five surveys to individuals not involved in HIV/AIDS and who live and/or work in the same community. The survey asked questions such as:

- What are the biggest health problems in your community?

- What are the most important issues or concerns in your community?
- If a sick friend had no money and needed medical care, do you know where to send your friend?
- Do you know where to get *free* condoms and tubes?
- Can a person buy new, sterile syringes at a pharmacy in NYS without a prescription?
- Should schools in NYS be required to teach students about HIV/STD prevention?
- At what grade should HIV/STD Prevention Education begin?
- Do you or have you known anyone living with HIV/AIDS?
- Do you know someone who has had or is living with an STD other than HIV/AIDS?

In addition, questions were asked to rate the quality of HIV/STD prevention in their community, county or borough, region, and NYS as a whole and for the respondent's suggestions for improvement. Two hundred and seventy one participants completed this survey.

**Regional Provider Assessment of RGA 1.0 ranking activities (via Survey Monkey)** This survey, administered through the internet-based survey site [surveymonkey.com](http://surveymonkey.com), targeted providers of HIV prevention services in 5 NYC boroughs and 7 Ryan White Regions. In an effort to ascertain the validity of the population/intervention pairs as detailed in each region's RGA 1.0 final report, a link to this questionnaire was disseminated to providers throughout the State electronically. Questions were specific to the participant's region/Borough. It provided participants with the priority population/intervention pairs as detailed in the region/Borough's RGA 1.0 Final Report, asked if those priorities are still valid. In addition, the survey asked the respondents to identify new emergent priority populations and intervention strategies, if any, in the region whether they provide services.

Data collection began in October 2008 and completed in December 2008. A total of 209 providers completed the survey online.

**Regional HIV/AIDS Prevention Gaps Analysis Questionnaire (via Survey Monkey)** The purpose of this survey was to assess regional HIV/AIDS and STD prevention gaps across New York State. The target audience was community members. The survey was internet-based and hosted by the website [surveymonkey.com](http://surveymonkey.com). It was advertised on the NYSDOH website, which offered a direct link to the survey. A promotional flyer was distributed in a variety of settings to further advertise the survey. PPG members and AIDS Institute-contracted service providers were invited to participate via e-mail by AIDS Institute staff. They were also asked to disseminate the link to the survey to any contacts and consumers who might be interested in participating. A paper version of the survey was developed and distributed in a variety of settings to increase participation from individuals who may not have access to the internet.

The survey contained questions regarding: 1) HIV/AIDS and STD Prevention Needs of Specific Populations; 2) HIV/AIDS and STD-Related Services; 3) General Community Services and Resources; 4) General Knowledge about HIV/AIDS and STDs; and an optional section that contained questions about HIV Testing and Personal Experiences related to HIV/AIDS.

Data collection for the Regional HIV/AIDS Prevention Gaps Analysis Survey began in October 2008. Over 866 surveys were completed.

**AI Regional Listening Forums** These forums were held by the AIDS Institute around the state to hear what consumers and providers feel are important HIV/AIDS issues which need to be addressed surrounding HIV/AIDS in their communities. Five hundred three individuals participated in the Listening Forums.

**Opportunistic Information Gathering** On an ongoing basis, information surrounding focus groups which have been held around the state, relevant presentations at conferences, articles and reports have been collected and disseminated to PPG participants.

**“Virtual” Binders** Each population-based Committee has developed a “Virtual Binder” of information relevant to its population to inform priority setting. These Binders include reports, presentations, Fact Sheets, articles which, together, are designed to ensure that all PPG members have enough relevant information about the populations represented by each of the Committees to make informed decisions when prioritizing interventions.

**Discussion Groups** Once information is gathered, it will be assessed and the PPG will determine gaps and make recommendations as to how to obtain missing information/data. In addition, discussion groups were held with populations that typically “fall through the cracks” and summaries will be developed to ensure that information will be considered during priority setting deliberations. Over 100 participants attended discussion groups.

**Coordination with the NYC Department of Mental Health and Hygiene** The NYCDOHMH and the NYC PPG assisted in disseminating flyers promoting RGA events as well as links to all RGA online surveys. In addition, The NYCDOHMH provided information on its funded agencies. Upon completion of the RGA, the NYCDOHMH and the PPG were provided with the results of the RGA for NYC as a whole as well as each of its five Boroughs.

**The Community Need Index (CNI)** *The Community Need Index Report Series* is a resource for HIV/AIDS related need assessments, program planning, and evaluation. The report series includes eight regional reports that cover all 62 New York counties. Each regional report provides summary tables and thematic maps that display levels of HIV/AIDS related service needs in local communities at the ZIP code level. An all-new edition of the CNI report series was released in 2008.

**Population Profiles** The Population Profiles describe the HIV/AIDS, STI//STD and other key features of the each of the population groupings addressed by the NYS HIV Prevention Planning Group (PPG). These include MSM (Men who have Sex with Men), Substance Users, Heterosexuals, Women, Young People, Emerging Issues, Criminal Justice, Immigrants and Migrants, the PLWHA/H (People Living With HIV/AIDS) Advisory Group, and the Racial/Ethnic Populations. Profiles will be completed during 2009, with continued presentation and dissemination activities planned into 2010.

**Risk Area Maps** The Risk Area Maps (RAM) Report is a 2-volume compendium that consists of a STD series and an IDU series. In each series, high risk areas are identified at the ZIP-code level and the number of service sites targeting at least 40% of STD or IDU clients is also displayed. The RAMs in each series are organized by region and county. Each region begins with a regional map that provides an overview of the high risk areas and the locations of service sites in the counties that make up the region. It is followed by individual county maps that show the level of risk and the number of service sites by ZIP code. IDU risk is determined by the three-year average of the annual rate of opioid-related hospital discharges among people aged 13-64 per 100,000 persons in this age group. STD risk is determined by the three-year average of the annual rate of syphilis, gonorrhea, and chlamydia cases among people aged 13-64 per 100,000 persons in this age group. A ZIP code may be classified as high, moderate, or low risk area relative to other ZIP codes in the same statistical area. Three statistical areas are used (see table below). A high risk area is defined as a ZIP code in which IDU risk or STD risk is higher than 80% of the ZIP codes in the same statistical area.

In addition, the number of service sites targeting STD and IDU are also displayed in the report. Service site information is extracted from AIDS Institute's Contract Management Systems database (current as of August, 2008). For the IDU series, only service sites targeting at least 40% of clients classified in the IDU and IDU+MSM exposure categories are included. For the STD series, only service sites targeting at least 40% of clients classified in the MSM and heterosexual sex exposure categories are included.

**Regional Profiles** Regional Profiles are one-page documents providing HIV/AIDS-related demographic information specific to the entire state as well as each region/NYC Borough will be provided to the PPG.

**Statewide Coordinated Statement of Need (SCSN)** The 2006 Statewide SCSN was developed with information gathered from community input from each of the Ryan White CARE Networks in NYS. It provides a summary of service needs across the spectrum of care for HIV positive persons.

**Regional Service Delivery Plans** Information about HIV prevention needs has been teased out and summarized from available regional or Borough –specific HIV CARE Network Service Delivery Plans. These Plans are developed with extensive community input.

### **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, is utilized in priority setting.

**RGA reports, the Statewide Macroanalysis and the Statewide Service Profile are available separately.**

## 4

## HIV Prevention Intervention Tools

- **Use of Behavioral and Social Sciences in Developing Interventions** (pages 1-19)
- **Behavioral and Social Sciences Bibliography** (pages 19-21)
- **The Importance of Cultural Competence in Developing and Implementing Interventions** (pages 21-22)
- **The NYS HIV PPG's Socio-Cultural Model** (pages 22-25)
- **Socio-Cultural Model changes since 2005** (page 26)
- **Social Networks** (pages 26-27)
- **Virtual Binders** (page 27)
- **Economic Evaluation and Technology Transfer** (pages 27-28)
- **Partner Services: An evidence-Based Prevention Tool** (pages 28-29)
- **Useful Websites** (pages 30-32)

*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.

Theory is one of many tools that can have an important influence on HIV prevention programs. HIV interventions that are based on sound theoretical models are most effective at effecting behavior change (Fisher & Fisher 1992; Valdiserri, West, Moore, Darrow & Hinman, 1992). Formal behavior theories help service providers understand the components of behavior and the steps that commonly lead to behavior change. Behavior theory can be used to disentangle the complexities behind the behaviors targeted in HIV prevention programs and can help to determine the design and goals of an HIV intervention. Furthermore, using theories can improve the overall quality of interventions and conserve limited resources.

Things to consider when selecting a model or theory:

- ✓ Who is my target population?
- ✓ What are my objectives for my target population?

- ✓ What resources are available? Personnel? Buildings?
- ✓ What theory or model best suits the target population? Why?
- ✓ How will the theory or model apply to the intervention? Apply to behavior change?

Fourteen of the most widely-known general theories are presented below. For each of these theories, the following are provided:

- ✓ 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

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. Because there are variances within each at-risk population in terms of race, gender, geography and life experiences, effectiveness of these theories may not be as cut-and-dried as the summary implies. Also, the researchers developing these theories vary in terms of their own demographics and life experiences, which may conceivably influence results. 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 persons 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\\_TPB.htm](http://hsc.usf.edu/~kmbrown/TRA_TPB.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 any one 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 person's attempt to change behaviors. The 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.

**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:**

Garnezy, 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 arguments
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.)

### **Ecological Systems Theory (Bronfenbrenner)**

**Overview:** The Ecological Systems Theory (Bronfenbrenner, 1989) emphasizes the dynamic relationship between and individual and the social environment. Each domain may affect other domains, thereby influencing outcomes in indirect and/or reciprocal ways. Instead of operating on the assumption that positive, healthy decision-making follows a rational decision-making process, the ecological systems theory takes into account that decisions are made within broader social, economic, and political contexts that in conjunction strongly influence behaviors (Kim, 2002). These systems include intrapersonal, interpersonal, institutional, community, and public policy factors.

**Usefulness in HIV Prevention:** The Ecological Systems Theory refocuses HIV risk reduction or prevention efforts to shift from the model of individual behavior change to a model of environmental systems that together affect an individual's behavior.

**Considerations** There are a number of different versions of ecological models but, in general, they recognize that successful activities to promote health, including HIV risk reduction, involve not only changing individual behaviors, but also advocacy, organizational change, policy development, economic supports, environmental change, and multi-method programs.

According to this model, behavior is determined by the following:

1. Intrapersonal factors-characteristics of the individual such as knowledge, attitudes, behaviors, self concept skills.
2. Interpersonal process-formal and informal social network and social support systems, including the family, work group, and friendships.
3. Institutional factors-social institutions with organizational characteristics and formal and informal rules and regulations for operation.
4. Community factors-relationships among organizations, institutions and informal networks within defined boundaries.
5. Public polity-local, state, and national laws and policies.

**Program Applications:** Numerous articles and reports use this model to assist clients in issues related to HIV disclosure. HIV/AIDS prevention programs based on this framework strives to influence these interrelated social environments in an effort to alter the circumstances in which individuals are at risk of HIV infection (Parker and Aggleton, 2003).

**The following sources may be useful in learning more about Ecological Systems Theory:**

Bronfenbrenner, U. 1979. *The Ecology of Human Development*, Cambridge, MA; Harvard University Press.

U.S. Department of Health and Human Services. "National Institutes of Health" Theory at a Glance: A guide for health promotion practice," [http://oc.nci.nih.gov/services/theory\\_at\\_a\\_glance](http://oc.nci.nih.gov/services/theory_at_a_glance).

### **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). To learn more about the DEBIs go to: [www.effectiveinterventions.org](http://www.effectiveinterventions.org)

#### **Other References Used for the Section on Behavioral Health Theories:**

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

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

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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).

Kim, Julia. (2002) Social Interventions for HIV/AIDS Intervention with Microfinance for AIDS and Gender Equity. IMAGE Study. Rural AIDS and Development Action Research Project. South Africa.

*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.

Parker, Richard and Peter Aggleton (2003). "HIV and AIDS-Related stigma and discrimination: a conceptual framework and implications for action." *Socia Science and Medicine*, Vol. 57, issue 1, page 13-24.

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***The Importance of Cultural Competence in Developing and Implementing Interventions***

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989).

The Prevention Planning Group expands the definition of cultural competence to include the particular populations corresponding to its nine population-based Committees: People Living with HIV/AIDS, individuals involved in the criminal justice system, immigrants and migrants, gay men and men who have sex with men, individuals from communities of color, individuals who are substance user, women, and young people. While the Emerging Issues Committee examines various populations not represented by other PPG population-based Committees, as well as emerging issues, areas and policies that have not yet been addressed, its recent primary focus has been transgender individuals and individuals over 50 years of age.

**General Recommendations related to cultural competence:**

- The development of HIV Prevention materials, written or otherwise (e.g., oral, audio, visual), should be culture-specific to the target populations. In addition, materials should be available in languages spoken by those served.
- Translation services should be available as needed.
- Ensure that brochures and pamphlets are not so bland or so “blended” that they lose their intended effect on targeted, at-risk communities. This leaves many individuals feeling that HIV doesn’t exist in their community.
- Training is also needed that addresses the unique needs and expectations communities have around the confidentiality of HIV-related health information specifically, and confidentiality of health information more generally.
- Competence trainings that promote non-judgmental approach to sexual history-taking and an expanded understanding of sexual behavior (especially those that are perceived to linked to or have higher prevalence within the gay/bi/MSM community).
- Providers should have an appropriate understanding and practice appropriate usage of community identity labels & terminology as well as appropriate understanding and practice appropriate usage appropriate understand and usage of sexual vernacular. In additions, providers should be able to react and respond in an appropriate and non-judgmental way to clients/patients/consumers who engage in diverse sexual behaviors.

- There should be acknowledgment and understanding of the unique and specific needs of communities at risk. Most communities affected by the epidemic have nuanced expectations that many in public health don't understand. Some health departments don't understand the specific needs of heavily impacted sub-populations (i.e., LGBT people of color, incarcerated and formerly incarcerated individuals).
- Teachers and school administrators should be provided with training surrounding cultural competence, not only as it relates race/ethnicity, but also to sexual orientation and gender identity.
- Comprehensive sex & HIV education should be implemented in schools. Sessions should be planned to inform parents, many of whom did have HIV/AIDS education when they were in school.
- Agencies should utilize qualified peers in service delivery. This can help address some of the gaps that agencies experience around cultural competency (e.g., facilitating support groups).

**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.

The HIV epidemic is shaped by numerous factors, including geographical location, local social structures, cultural beliefs and activities, racial and gender stratification, laws, policies, and programs. Such factors are critical for understanding and influencing risk behavior. Research can contribute to a better understanding these factor's role as well as how ethnic, cultural, and geographic differences can influence the design of targeted interventions. Premarital sex, condom use, anal intercourse, and the use of injection drugs are known to have different meanings for people coming from different cultures. For example, some Hispanic/ Latino men, who engage in penetrative anal sex with other men, regard this behavior as reflecting machismo. In contrast, they may only regard men engaging in receptive anal sex as homosexual.

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.

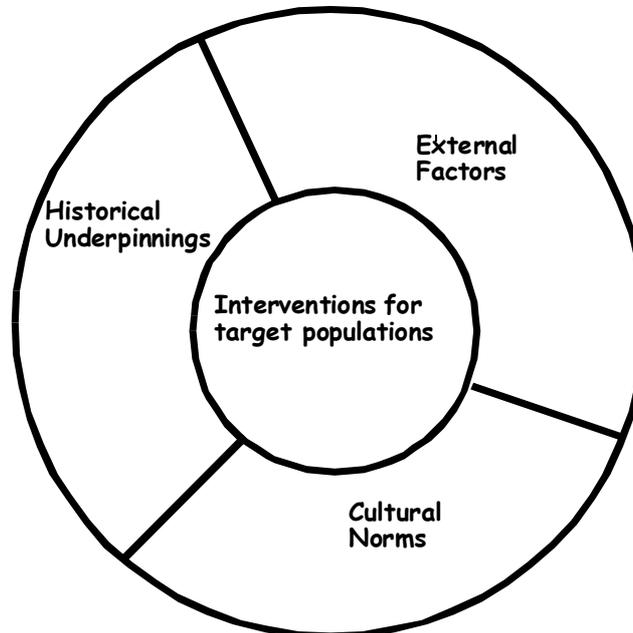
The following elements must be considered when implementing any HIV prevention intervention:

**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.

Below is 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.



For example, if an agency is examining the implementation of HIV prevention interventions for *African American/Black women*, the socio-cultural model might include the following:

**Cultural Norms:**

- Non acceptance by community
- African American/Black sexual Messages
- Familial norms
- Culturally-dictated hierarchy in male-female relationships
- African American/Black women's role in relationship

**External Factors:**

- Racism
- Discrimination
- Homophobia
- Trauma
- Stigma
- Poverty
- Societal factors
- Lack of access to health care/uninsured or underinsured
- Women portrayed as sex objects in the media

**Historical Underpinnings:**

- Issues related to slavery
- Mistrust of government
- Institutionalized racism
- Break up of families
- High incarceration rate of African American/Black men
- Sterilization of African American/Black women

When designing an intervention for the above example of African American/Black women, it is important to acknowledge the issues listed such as slavery and sexual messages in the media. Issues such as mistrust of the government, racism, trauma, stigma, discrimination and poverty must be factored into mix as well. Such issues need to be respected when considering appropriate models, settings and methods to deliver prevention messages.

If an agency is examining the implementation of HIV prevention interventions for *Native American communities*, the socio-cultural model might include:

**Historical Underpinnings:**

- Attempted genocide of all Native peoples
- Residual impact of the Residential Boarding School systems (“Kill the Indian, save the person”)
- Federal policies toward Native people, including Termination, Assimilation, Relocation
- Introduction of alcohol to Native communities
- Forced or attempted assimilation of Native peoples, including religious factors
- Introduction (accidental or intentional) of diseases
- Treaties being agreed to then later abrogated by federal and/or state authorities

- Compounded impact of historical traumas, much of which have not been identified or addressed by Native communities

**External Factors:**

- Poverty
- Racism (“the only good Indian is a dead Indian.”)
- Stereotyping of Native people (as drunkards, lazy, shiftless, rich from casinos, etc.)
- Impact of multiple epidemics & threats to health (diabetes, asthma, cancer, alcoholism, addictions, domestic violence, STDs, suicide, drunk driving deaths, isolation, poor self-esteem, among several other health problems)
- Exclusion from data reports (not being identified, Natives as an “other,” being “statistically insignificant,” being combined with other races or ethnicities, etc., no data = no funding = no programs)
- Governmental requirements to prove identity and tribal membership
- Difficulties crossing international borders despite treaty stipulations for unrestricted passage
- Influence of money & capitalistic economy on Native values
- Impact of mainstream education systems’ failure to adequately teach Native history from a Native perspective

**Cultural Norms:**

- Concept of sovereignty
- Value of traditional Native American teachings & ways of life
- Impact of multiple assimilation attempts results in some/many Native people being disconnected from their own culture, communities, & values
- Impact of health disparities is such that some problems have become accepted as the “norm” in some families or communities
- Pride in being Native American
- Many communities are split against each other internally among various communities
- Strength, power, and authority of women that is traditionally recognized but is often considered to be less important by some who have adopted mainstream American values
- Mistrust of government, organizations, and outsiders
- For many people, there is a “yearning” to connect with a healthy Native community (which may or may not be easily found)

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.

**Sociocultural Model changes since 2005** The PPG has examined changes in cultural norms, historical underpinnings and external factors since the last Comprehensive HIV Prevention Plan was developed in 2005. These changes will be taken into account when the PPG engages in

priority setting. A brief summary of some themes to take into account within each Sociocultural Model factor includes:

**External Factors:**

- There is a new administration in Washington, which will potentially yield HIV/AIDS – related policy changes.
- Presently there are anti-immigration sentiments in the U.S. which impact federal immigration policy. In addition, literacy issues in any language (including English) are present for immigrants.
- The downturn in the economy presents critical funding challenges especially in agencies with limited funding.
- Increased use of the Internet and other technology (i.e., text messaging and other cell phone apps) impacts the manner in which HIV prevention information and services are provided, although some do not have access to such technology.
- More and more, ageism exists.

**Cultural Norms:**

- The Federal government’s views on condom efficacy and religion’s views on condom use affect condom usage (or lack thereof).
- Moral factors in culture stemming from religion affect prevention efforts.
- There is a change in perception of risk for HIV, particularly amongst youth.
- Young people’s assumption that “it can’t happen to me” reflects a lack of safety nets and present mindedness of adolescents.
- Stigma related to culture re: children of gay or lesbian individuals

**Historical Underpinnings:**

- Stereotypes remain present in this country, including stereotyping of “risk groups”.
- Racism is a factor in all prevention efforts
- The country is at war on two fronts. In NYS, 9/11 and the global war on terror are significant issues affecting all communities?
- Historical issues of homophobia remain, affect the way the epidemic is perceived and, by extension, success of prevention efforts.

**Social Networks** Social networks are sets of social linkages or interactions between individuals. These linkages are usually defined in terms of particular social relationships, such as kinship ties, friendships, or commercial transactions. Social networks can be thought of as being either “egocentric” (the set of persons with whom an index person has relationships) or as “sociometric”. The set of linkages and persons in a given community or other social unit of research on social networks contributes to a better understanding of the course of the epidemic and can inform and improve HIV intervention research.

Social network analysis is an important tool for understanding HIV transmission because transmission occurs between individuals who make up a network. Some persons may form

bridges between what would otherwise be unconnected networks. Such persons play key roles in transmission within a large network. Other networks may be diffuse and loosely tied together. (adapted from *Assessing the Social and Behavioral Science Base for HIV/AIDS Prevention and Intervention: Workshop Summary* (1995) Institute of Medicine)

Research is needed on how and why networks change over time; on the effects of both sociometric and egocentric networks (and changes in these networks) on social norms, risk behavior, and HIV transmission; and on the use of networks as a strategy of interventions.

**“Virtual Binders”** In preparation for priority setting, each of the PPG’s nine population-based committees developed a “virtual binder” consisting of materials designed to assist in understanding the prevention needs of its population. Appendix X includes a list of the articles/reports/presentations/fact sheets contained within each of these “binders” and within a general binder for material applicable all populations.

**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 that 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 does not 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 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.

***Partner Services: An Evidence-based HIV Prevention Tool*** Partner services is not a new intervention, but recent scientific reviews have drawn renewed attention to its importance, and concluded it is a highly effective evidence-based intervention for HIV prevention. “Partner services reduce the spread of HIV by facilitating the confidential identification and notification of partners who may have been unknowingly exposed to HIV, providing them with HIV testing, and linking them to medical care, prevention programs, and other services.” (National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, August 2009.)

In 2007, the US Preventive Services Task Force (which uses standardized criteria to assess the strength of scientific evidence to support wide range of public health and preventive interventions) completed a review of Partner Counseling and Referral Services (PCRS) – which CDC now refers to as Partner Services (PS). The systematic review found sufficient evidence, according to *Guide to Community Preventive Services* rules, that provider referral partner notification identifies a high-prevalence target population for HIV screening.<sup>1</sup> (Task Force on Community Preventive Services. 2007; Hogben M, et al, 2007).

Meta-analysis findings included that the proportion of notified people (i.e. partners) contacted who were found to be newly HIV positive was 20%. The Task Force on Community Preventive Services recommended the use of provider-referral partner notification—in which a healthcare provider or other public health professional contacts and notifies partners who have been identified by an infected individual—on the basis of sufficient evidence of effectiveness in

increasing HIV testing and identification of previously undiagnosed HIV-positive individuals. The effectiveness of patient referral (i.e. self-notification by the patient) could not be determined, because too few studies of adequate quality were available.

In addition to its effectiveness, a recent research review on *Client and Provider Attitudes, Preferences, Practices, and Experiences with Partner Services for HIV* found a fairly high level of acceptability of partner services across studies (Passin, WF, et al). Recent research also provides support for acceptability of health department delivered Internet Partner Services. (Mimiaga MJ, et al). These findings contribute to CDC's updated recommendation that "On the basis of evidence of effectiveness and cost-effectiveness of these services, CDC strongly recommends that all persons with newly diagnosed or reported HIV infection... receive partner services with active health department involvement." (MMWR. October 30, 2008). CDC has also requested that partner services programs keep their respective HIV community planning groups (CPGs) informed of partner services activities and ensure that CPGs have access to analyses of current data, including potential implications for HIV prevention in the jurisdiction.

HIV Prevention in the United States: At a critical crossroads. National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Centers for Disease Control and Prevention. August 2009.

Task Force on Community Preventive Services. Recommendations to Increase Testing and Identification of HIV-Positive Individuals Through Partner Counseling and Referral Services. *Am Journal of Preventive Medicine* 2007;33(2S): S88.

Hogben M, McNally T, McPheeters M, Hutchinson, AB, Task Force on Community Preventive Services. The Effectiveness of HIV Partner Counseling and Referral Services in Increasing Identification of HIV Positive Individuals: A Systematic Review. *American Journal of Preventive Medicine* 2007;33(2S):S89-S100.

Passin WF, Kim AS, Hutchinson AB, Crepaz N, Herbst JH, Lyles,CM, et al. A Systematic Review of HIV Partner Counseling and Referral Services: Client and Provider Attitudes, Preferences, Practices, and Experiences. *Sexually Transmitted Diseases*, May 2006, Vol. 33, No. 5, p.320–328.

Mimiaga MJ, Fair AD, Tetu AM, Novak DS, VanDerwarker R, Bertrand T, Adelson S, and Mayer KH. HIV and STD Status Among MSM and Attitudes About Internet Partner Notification for STD Exposure. *Sexually Transmitted Diseases*, February 2008, Vol. 35, No. 2, p.111–116 .

Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection. MMWR. October 30, 2008 / Vol. 57.

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

**American Indian Community House (AICH)**

**Organization Web Site**

<http://aich.org/>

**Asian Pacific Islander American Health Forum**

**Organization Web Site:**

<http://www.apiahf.org/>

**Asian Pacific Islander Coalition on HIV/AIDS (APICHA)**

**Organization Web Site**

[www.apicha.org](http://www.apicha.org)

**The Black AIDS Institute**

**Organization Web Site**

[www.blackaids.org](http://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](http://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](http://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](http://www.cdc.gov/hiv/partners/ahp.htm#otherlinks)

**Fact Sheets**

[www.cdc.gov/hiv/pubs/facts.htm](http://www.cdc.gov/hiv/pubs/facts.htm)

**CDC National Prevention Education Network (NPIN)**

[www.cdcnpin.org/scripts/index.asp](http://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](http://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](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm)

**Center for Health and Behavioral Training**

**University of Rochester**

<http://www.urmc.rochester.edu/chbt/>

**Cicatelli Associates, Inc.**

**Organization Web Site**

[www.cicatelli.org/AboutCAI/home.htm](http://www.cicatelli.org/AboutCAI/home.htm)

**Harm Reduction Coalition**

**Organization Web Site**

[www.harmreduction.org](http://www.harmreduction.org)

**Trainings Offered**

[www.harmreduction.org/hrti/cur/index.html](http://www.harmreduction.org/hrti/cur/index.html)

**Henry J. Kaiser Family Foundation for educational information and training**

**Organization Web Site**

[www.kaisernetwork.org](http://www.kaisernetwork.org)

**NYS Department of Health**

**Expanded Syringe Access Demonstration Program**

[www.health.state.ny.us/nysdoh/hiv aids/esap/regover.htm](http://www.health.state.ny.us/nysdoh/hiv aids/esap/regover.htm)

**HIV Counseling and Testing**

[www.health.state.ny.us/nysdoh/aids/index.htm](http://www.health.state.ny.us/nysdoh/aids/index.htm)

**HIV Reporting and Partner Notification**

[www.health.state.ny.us/nysdoh/hiv aids/hivpartner/intro.htm](http://www.health.state.ny.us/nysdoh/hiv aids/hivpartner/intro.htm)

**Materials**

[www.health.state.ny.us/nysdoh/aids/edmat.htm](http://www.health.state.ny.us/nysdoh/aids/edmat.htm)

**Project WAVE**

[www.health.state.ny.us/nysdoh/hiv aids/projwave/index.htm](http://www.health.state.ny.us/nysdoh/hiv aids/projwave/index.htm)

**Statewide Training Calendar**

[www.health.state.ny.us/nysdoh/aids/training.htm](http://www.health.state.ny.us/nysdoh/aids/training.htm)

**National Development and Research Institutes, Inc. (NDRI)**

**Organization Web Site**

[www.ndri.org/](http://www.ndri.org/)

**Latino Commission on AIDS (LCOA)**

**Organization Web Site**

<http://www.latinoaids.org/>

**National Minority AIDS Council (NMAC)**

**Organization Web Site**

[www.nmac.org/](http://www.nmac.org/)

**Native American Community House (NACS)**

**Organization Web Site**

<http://www.nacswny.org/>

**University of California at San Francisco (UCSF)**

**Center for AIDS Prevention Studies**

<http://www.caps.ucsf.edu/doiit.php>

**HIV Insite**

<http://hivinsite.ucsf.edu/>

**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

2010-2015 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 2005. Activities comprising the NYS Regional Gaps Analysis took years to complete. Activities related to the PPG's African American/Black Initiative and focus on Communities of Color began were continued between 2005 and 2010. Committees examined cultural competence, social networks, revisited the socio-cultural model and developed "Virtual Binders" of information about populations at risk. By 2010, 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 PPG's Approach to Priority Setting

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

- **Four Aspects Considered by the PPG when setting HIV Prevention Priorities** (pages 1-2)
- **“Tiers”- A Useful Way to Organize the 2005-2010 NYS Priority Populations** (page 3)
- **2010-2015 NYS Priority HIV Prevention Populations** (page 4)
- **The Priority Setting Institute--October 2009** (pages 4-5)
- **Priority Setting Call-Ins--December and January 2010** (page 5)
- **Setting Intervention Priorities--January 2010** (pages 5-6)
- **Finalizing Intervention Priorities--February 2010** (page 6)
- **Considerations—March-May 2010** (page 6)

**Introduction** The NYS HIV PPG's approach to priority setting considered the following four aspects:

**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. In preparation for priority setting, and to more accurately reflect the present epidemiology of the epidemic in NYS, during the 2008-2009 Planning Cycle PPG members engaged in an exercise that re-ordered these transmission categories. The new hierarchical order and the definitions of these categories, are:

**1. MSM:** the CDC hierarchical category of men who have sex with men. \*

**2. Heterosexual:** the CDC hierarchical category of heterosexual transmission. \*

**3. IDU:** the CDC hierarchical category of (1) injection drug users, and (2) all those who fall in the CDC category of men who have sex with men/injection drug users.\*

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

\* For the each of the MSM, Heterosexual and IDU transmission categories, a portion of cases falling into the “no risk reported” CDC defined category (designated as “unknown” in the *New York State Surveillance Annual Report*) must also be considered.

**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 PPG’s “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 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.

After intervention priorities were set, population-based Committees had an opportunity to articulate “considerations” to take into account when implementing the prioritized intervention with at-risk communities. These considerations provide a wealth of information for the provider when planning for intervention implementation.

**“Tiers”- A Useful Way to Organize the 2010-2015 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 to 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”.

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.

The tiers are:

**Tier I: HIV Infected, especially persons of color** (an individual who has tested HIV positive)

**Tier II: HIV Status Unknown, especially persons of color** (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)

**Tier III: HIV Negative/presumed negative especially persons of color** (an individual who has tested negative and has a behavioral risk of HIV infection)

***2010-2015 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**

MSM

Heterosexual

IDU

Perinatal/Pediatric

**Tier II: HIV Status Unknown, especially persons of color**

MSM

Heterosexual

IDU

Perinatal/Pediatric

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

MSM

Heterosexual

IDU

Perinatal/Pediatric

*The Priority Setting Institute--October 2009* Few contemporary community PPG members participated in all the discussions/presentations/ document preparation which occurred since the development of the last *Comprehensive HIV Prevention Plan*. Indeed, only six present community PPG members were participants in the 2005 priority setting process. Therefore, to ensure a level playing field, the October PPG meeting was dedicated to holding a “Priority Setting Institute” to bring everyone up to speed and to practice the agreed-upon priority setting process. The Priority Setting Institute offered participants five “courses”:

**An Introduction to Priority Setting (PS), including “The Big Four”, Communities of Color and the Socio-Cultural Model**

This course provided an historical overview of PPG priority setting as well as the framework for priority setting, including an overview the four aspects the PPG was to consider when setting HIV prevention priorities.

**The Statewide Macroanalysis, Statewide Service Profile**

This course defined the Macroanalysis and the Statewide Service Profile, provided data from each of those reports and explained how to use them in priority setting.

**The RGA/Interventions**

This course provided an understanding of the concept of science-based interventions as well as an overview of the PPG’s sociocultural model and its relationship to the effective implementation of interventions in preparation for priority setting.

### **Epidemiologic data**

This course provided a description of the epidemiology of HIV/AIDS in NYS in preparation for priority setting.

### **Priority Setting Practicum**

This practicum provided participants with an opportunity to use what was learned in PS 201, 202, and 203 in a “practice priority setting” activity for the Transmission category/Tier pairing of Heterosexual, especially persons of color/HIV infected.

***Priority Setting Call-Ins-December and January 2010*** At its 2009-2010 Planning Cycle planning meeting, the Executive Committee developed a plan to ensure that members had up to date information to engage in a successful priority setting process. The primary components of this plan were four call-ins:

**1. Terminology** - to assist participants in understanding the terminology we use when talking about priority setting, as well as the acronyms we use in advance of the January meeting. A Priority Setting Glossary was developed and disseminated. (December 3, 2009, 19 member participants)

**2. NYC Comprehensive HIV Prevention Plan** - to provide an overview of the NYC Comprehensive HIV Prevention plan, and to understand their priority setting process. (December 9, 2009, 26 participants)

**3. Interventions** – AI staff familiarized participants with interventions presently funded by the PPG’s priority populations, including evidence-based interventions, Counseling and Testing and Partner Services. (January 15, 2010, 27 member participants)

**4. Summary** – to summarize the previous three calls as well as answer any further questions in preparation for Priority Setting. (January 21, 2010 21 member participants)

***Setting Intervention Priorities--January 2010*** At its January 2010 meeting, the PPG prioritized interventions for each of its 12 priority populations. To accomplish this, participants used knowledge gathered since the development of the last *Comprehensive HIV Prevention Plan*, all of which was summarized at the Priority Setting Institute and during the Priority Setting Call-Ins. 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.

To decide on the top three priority interventions for each population, the Nominal Group Technique was used.

***Finalizing Intervention Priorities—February 2010*** At its February Executive Committee meeting, the Executive Committee reviewed the complete listings of interventions the PPG prioritized for each population to: 1) as appropriate, “bundle” interventions and 2) eliminate duplication within each transmission group/“Tier” pairing.

The Executive Committee also decided on the appropriate terms by which interventions would be presented in the priority listings.

We 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.

The Executive Committee was careful not to “redo” or “second guess” the work of the full PPG or otherwise tamper with the PPG’s work. The clarifications provided by the Executive Committee reflected the priorities as identified by the PPG. For a full description of the PPG’s final Priority Interventions, see Chapter 6 (Effective Interventions for Priority Populations) of this *Comprehensive HIV Prevention Plan*.

***Considerations*** Once priority setting itself was complete, each population-based Committee developed specific considerations providers should take into account when implementing interventions for its population (or specific segment(s) of its population) in order for the intervention to be effective. This information forms the content for Chapter 7 (Considerations) of this *Comprehensive HIV Prevention Plan*.

# 6

## Effective Interventions for Priority Populations

**2010-2015 Priority Population/Intervention Pairings** According to the Goals, Objectives and Guiding Principles of the *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 2010-2015 priority population/intervention pairs, but also provides evidence for their choice. Below are the 2010-2015 priority populations, within Tiers, matched with prioritized interventions:

### **TIER I: HIV INFECTED, ESPECIALLY PERSONS OF COLOR**

#### **Transmission Category: MSM**

-Linkage to: primary care (including medications and STD screening); treatment adherence services; psychosocial and mental health services and mental health counseling (including counseling related to health status disclosure); case management (including support group services, housing, peer support)

- Interventions delivered to Individuals (IDI); Interventions delivered to Groups (IDG); Comprehensive Risk Counseling Services (CRCS) (including substance use treatment and substance use awareness; risk reduction counseling)

- Outreach, including internet and in high-risk venues; condom and other barrier distribution, including access to dental dams and lube; access to sterile syringes

#### **Transmission Category: Heterosexual**

- Health Education Risk Reduction (HERR)

- Linkage to: primary care (with linkage connections, i.e., child care); treatment adherence services; STI screening and Hepatitis B and C screening; psychosocial mental health services (including trauma informed services); supportive services, including emergency assistance

- Interventions delivered to Individuals (IDI); Interventions delivered to Groups (IDG); like Healthy Relationships and peer training; Comprehensive sex health education, including STD; HIV/AIDS and Hepatitis information.

- Integrated distribution of safer sex materials; condom and other barriers, including access to dental dams and lube

**Transmission Category: IDU**

- Syringe access; syringe exchange (including peer delivered syringe exchange) ESAP; Harm reduction counseling services, including opioid overdose prevention, Buprenorphine, nalaxone, combined with comprehensive harm reduction services; linkage to comprehensive health services including hepatitis services and pre-treatment services and mental health/psychiatric services
- Interventions delivered to Groups (IDG), e.g. like Safety Counts; Interventions delivered to Individuals (IDI) using harm reduction approach
- Sexual harm reduction education for IDUs

**Transmission Category: Perinatal/Pediatric**

- Linkage to: care, including pre-natal and other ancillary services, and outreach (CAPC); mental health counseling (family/individual; multi-generational including disclosure issues)
- Linkage to: supportive services (including treatment adherence); care coordination (including the primary caregiver); Case Management including disclosure issues
- Health Education/Risk Reduction (HERR) including: sexuality education, including school-based and issues of stigma; Interventions Delivered to Groups (IDG), e.g., Healthy Relationships; Interventions Delivered to Individuals (IDI)

**TIER II: HIV STATUS UNKNOWN, ESPECIALLY PERSONS OF COLOR**

**Transmission Category: MSM**

- Outreach, including internet and in high-risk venues; condom and other barrier distribution, including access to dental dams and lube; access to sterile syringes
- Social Marketing (including raising awareness re: STI screening/HIV testing)
- HIV Counseling, Testing and Referral (CTR); STI screening; Hepatitis B and C screening
- Health Education Risk Reduction (HERR) with specificity to gay men's issues

**Transmission Category: Heterosexual**

- HIV Counseling, Testing and Referral (CTR); STI screening; Hepatitis B and C screening with incentives
- Health Education Risk Reduction (HERR) education, including: sex health education around skills building; condom use and safer sex negotiation; substance use counseling services and referral
- Outreach, including internet and in high-risk venues; condom and other barrier distribution, including access to dental dams and lube; access to sterile syringes; Interventions delivered to Individuals (IDI) and Interventions delivered to Groups (IDG) by peers; Comprehensive Risk Counseling (CRCS)

**Transmission Category: IDU**

- Syringe exchange/ESAP harm reduction services/Buprenorphine/opioid overdose prevention  
Transitional case management

- HIV Counseling, Testing and Referral (CTR); STI screening; Hepatitis B and C screening

- Outreach; sexual harm reduction including provision of safer sex materials, including condom and other barriers, including access to dental dams and lube

**Transmission Category: Perinatal/Pediatric**

- HIV Counseling, Testing and Referral (CTR); STI screening; Hepatitis B and C screening

- Outreach (CAPC)/health education

- Comprehensive Risk Counseling Services (CRCS)

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

**Transmission Category: MSM**

- Outreach including internet and in high-risk venues; condom and other barrier distribution, including access to dental dams and lube; access to sterile syringes; peer delivered outreach

- HIV Counseling, Testing and Referral (CTR); STI screening; Hepatitis B and C screening, including expanded testing

- Social Marketing/Health Communication/Public Information

**Transmission Category: Heterosexual**

- Community outreach w/peer mentors/incentives

- HIV Counseling, Testing and Referral (CTR); STI screening; Hepatitis B and C screening with incentives

- Comprehensive sexuality education, including family planning and HIV/AIDS education

**Transmission Category: IDU**

- ESAP; Syringe Exchange; transitional case management; Buprenorphine; opioid overdose prevention; harm reduction approach; linkage to supportive services (and re-entry services if being released from a correctional institution) with coordination to ensure that people get needed services in the appropriate time frame and manner

- Interventions delivered to Groups (IDG); Interventions delivered to Individuals (IDI) with Harm Reduction approach; outreach utilizing peer mentors

- HIV Counseling, Testing and Referral (CTR); STI screening; Hepatitis B and C screening

**Transmission Category: Perinatal/Pediatric**

- HIV Counseling, Testing and Referral (CTR); STI screening; Hepatitis B and C screening, including late term and partner testing

- Interventions delivered to Individuals (IDI)/Interventions delivered to Groups (IDG) using peers, including condom distribution; education and negotiation; partner counseling, including sero-discordant couples

- Comprehensive Risk Counseling Services (CRCS), including condom distribution, education and negotiation

***Effectiveness of Priority Interventions*** The above priority interventions have each been proven to be effective with their paired populations. Each intervention is defined on the following pages, along with a brief description of findings confirming the intervention's effectiveness as well as sources for those findings. When studies are applicable to all priority populations, they are described as such. Findings specific to priority populations, as applicable, are also described. However, it is important to acknowledge that available literature does not necessarily include evaluation of these interventions on all communities at risk for, i.e., Asian and Pacific Islander communities and Native American communities. Very few such studies have been undertaken for these communities.

The PPG recognizes that, during the five years this *Comprehensive HIV Prevention Plan* is in effect, new interventions, including biomedical ones, will be developed and evaluated. Such cutting-edge interventions will be documented and examined in future *Plan Updates*.

Please keep in mind that this document is not an exhaustive literature search, and there may be many other citations relevant to each intervention/population pairing.

## Buprenorphine/Opioid Overdose Prevention/

**Definition Buprenorphine:** Buprenorphine is a medicine for treating heroin addiction. It blocks symptoms of withdrawal and craving and helps an individual to not use heroin.

Buprenorphine works a lot like methadone, but instead of getting it at a special clinic, a doctor prescribes it in the office and you can take it at home, which can make treatment easier.

**Opioid Overdose Prevention:** Naloxone (Narcan) is a prescription medicine that reverses an overdose by blocking heroin (or other opioids) in the brain for 30 to 90 minutes. Naloxone comes in pre-filled syringes and is administered by injection. Programs must register with the New York State Department of Health to operate an Opioid Overdose Prevention Program. Eligible providers are licensed health care facilities, health care practitioners, drug treatment programs, not-for-profit community-based organizations and local health departments. These programs train individuals how to respond to suspected overdoses including the administration of Naloxone.

### Priority interventions for:

IDU, especially persons of color

✓HIV Infected

✓HIV Status Unknown

✓HIV Negative/ Presumed Negative

### *Literature relevant to each of the above priority populations:*

►A needs assessment and expansion project identified and documented the areas in the Bronx in which injection drug users (IDUs) had limited access to and knowledge of harm reduction services as well as to provide a range of harm reduction services to IDUs and to test different methods of providing outreach. This collaboration represented an historic and important accomplishment for harm reduction services in the Bronx since it was the first time they worked together to expand services and reach communities that have been historically underserved. The large numbers of IDUs served, the array of services provided, and the sheer volume of different locations where contacts were made demonstrated the significance of the collaboration. The time it took to deliver these services was significant: 1,443 IDUs were provided services at 108 different locations. This project provides evidence that there is a clear and profound need to broaden the reach of harm reduction services to many communities in the Bronx, and those methods for reaching underserved IDUs are available and effective. (Barreras, 2007)

►An article in the *American Journal of Public Health* demonstrated that overdose prevention education with distribution of intranasal naloxone is a feasible public health intervention to address opioid overdose. (Doe-Simkins, 2009)

►Opioid overdose prevention programs, such as those in Baltimore, Md; Chicago, Ill; San Francisco, Calif; New York, NY; and several cities in New Mexico, have been effective in preventing opioid overdose fatalities and can be replicated. Outreach to IDUs regarding

emerging threats (i.e., fentanyl-laced heroin) saves lives, extends access to drug treatment, and offers opportunities to address other public health concerns among IDUs, including communicable diseases such as HIV, sexually transmitted diseases, and hepatitis. (Klein, et.al., 2007)

►A study showed that Naloxone administration by IDUs is feasible as part of a comprehensive overdose prevention strategy and may be a practicable way to reduce overdose deaths on a larger scale. (Piper, et.al., 2008)

►A study was done to determine whether primary-care-based buprenorphine/naloxone was associated with decreased HIV risk behavior. It concluded that primary-care-based buprenorphine/naloxone treatment is associated with decreased drug-related HIV risk, although additional efforts may be needed to address sex-related HIV risk when present. (Sullivan, et.al, 2008)

►Continuing treatment with buprenorphine-naloxone improved outcome compared with short-term detoxification. Further research is necessary to assess the efficacy and safety of longer-term treatment with buprenorphine for young individuals with opioid dependence. (Woody et al. 2008)

#### **Sources:**

Barreras, Ricardo E. (prepared by), ( 2007) Bronx Harm Reduction Needs Assessment and Expansion Project: Collaboration between Bronx's Harm Reduction Agencies (CitiWide Harm Reduction, New York Harm Reduction Educators, St. Ann's Corner of Harm Reduction), Funded by: Injecting Drug User Health Alliance (IDUHA) Supported by: *New York City Council & The New York City Department of Health and Mental Hygiene*

Doe-Simkins M, Walley AY, Epstein A, et al. (2009) Saved by the nose: Bystander-administered intranasal naloxone hydrochloride for opioid overdose. *American Journal of Public Health.* 99(5):788-791.

Klein, SJ., O'Connell, DA, Candelas, AR., Giglio, JG, and. Birkhead, GS. (2007) Public Health Approach to Opioid Overdose *American Journal of Public Health.* 97(4): 587–588.

Piper TM, Stancliff S, Rudenstine S, et al. (2008) Evaluation of a naloxone distribution and administration program in New York City. *Substance Use and Misuse.* 43(7):858-870.

Sullivan LE, Moore BA, Chawarski MC, et al. (2008) Buprenorphine/naloxone treatment in primary care is associated with decreased human immunodeficiency virus risk behaviors. *Journal of Substance Abuse Treatment.* 35(1):87-92.

Woody GE, Poole SA, Subramaniam G, et al. (2008) Extended vs. short-term buprenorphine-naloxone for treatment of opioid-addicted youth. *Journal of the American Medical Association.* 300(17):2003-2011.

## 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

### Priority intervention for:

MSM, especially persons of color

✓HIV Infected

IDU, especially persons of color

✓HIV status unknown

✓HIV Negative/ Presumed Negative

Perinatal/Pediatric, especially persons of color

✓HIV Infected

### Literature relevant to each of the above HIV positive 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.
- ▶A study to assess the prevalence of need and unmet need for supportive services and the impact of case managers on unmet need among HIV-infected persons showed that need and unmet need for supportive services among HIV-infected persons is high. Case management programs appear to lower unmet need for supportive services. (Katz et al. 2000)
- ▶A study to assess the effect of case managers on unmet need for supportive services and utilization of medical care and medications among HIV-infected persons showed that case management appears to be associated with fewer unmet needs and higher use of HIV medications in patients receiving HIV treatment. (Katz, et al. 2001)
- ▶Case management may be a successful method to improve adherence to antiretroviral therapy and biological outcomes among HIV-infected homeless and marginally housed adults (Kushel et al 2006).

**Sources:**

Gardner, LI, Metsch LR, Anderson-Mahoney, P, Loughlin, AM, del Rio, C, Strathdee, S, Sansom, SL, Siegal, HA, Greenberg, AE, Holmberg, SD (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.

Katz MH, Cunningham WE, Mor V, Andersen RM, Kellogg T, Zierler S, Crystal SC, Stein MD, Cylar K, Bozzette SA, Shapiro MF. (2000) Prevalence and Predictors of Unmet Need for Supportive Services Among HIV-Infected Persons: Impact of Case Management. *Medical Care*. 38(1):58-69.

Katz MH, Cunningham WE, Fleishman JA, Andersen RM, Kellogg T, Bozzette SA, Shapiro MF. (2001) Effect of case management on unmet needs and utilization of medical care and medications among HIV-infected persons. *Annals of Internal Medicine*. 16;135(8 Pt 1):610-2.

Kushel MB, Colfax G, Ragland K, et al. (2006) Case management is associated with improved antiretroviral adherence and CD4+ cell counts in homeless and marginally housed individuals with HIV infection. *Clinical Infectious Diseases*. 43(2):234-242.

***Literature specific to (substance using) MSM priority populations:***

A randomized controlled trial of a 15-session case management intervention was conducted with substance using gay and bisexual people living with HIV (PLWHIV) who had recently engaged in unprotected sexual risk acts recruited from four US cities: Milwaukee, San Francisco, New York and Los Angeles. The trial concluded that a case management intervention model, delivered individually, is likely to result in significant and sustained reductions in substance use among PLWHIV. (Wong et al. 2008)

**Source:**

Ibañez GE, Purcell DW, Stall R, Parsons JT, Gómez CA. (2005) Sexual risk, substance use, and psychological distress in HIV-positive gay and bisexual men who also inject drugs. *AIDS*. 19 Suppl 1:S49-55.

**Literature specific to IDU priority populations:**

►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. Subjects in the experimental arm were significantly less likely to continue drug injection independent of entering drug treatment, and were also more likely to enter drug treatment. Subjects in both arms who entered drug treatment were less likely to continue drug injection. Among subjects who continued drug injection, those in the experimental arm were significantly less likely to share needles. (Robles et al. 2004)

►Based on a review of published articles, the authors of a systematic and comprehensive review of peer-reviewed articles published between 1993 and 2003 conclude that at least some evidence is available for the effectiveness of some models of case management for substance users. These

effects are small or modest at best and do not differ significantly from those of most other interventions in the field of substance abuse treatment. As in the field of mental health care, obvious positive effects include reduced use of inpatient services and increased utilization of outpatient and community-based services, prolonged treatment retention, improved quality of life, high client satisfaction, and stabilization or even improvement of the situations of—often problematic—substance abusers. Retention in and completion of case management programs have consistently been associated with positive outcomes, but overall effects concerning clients' functioning are less consistent. Various authors have found significant effects over time for several drug-related outcomes, but often these did not differ from outcomes among clients receiving less intensive or even minimal interventions. Longitudinal outcomes are still unclear, but at least some studies have shown long-term effects if the intervention was sustained. (Vanderplasschen et al. 2007)

**Sources:**

Robles RR, Reyes JC, Colon HM, et al. (2004) Effects of combined counseling and case management to reduce HIV risk behaviors among Hispanic drug injectors in Puerto Rico: a randomized controlled study. *Journal of Substance Abuse Treatment*. ;27:145–152

Vanderplasschen W, Wolf J, Rapp R.C., and Broekaert E. (2007) Effectiveness of Different Models of Case Management for Substance-Abusing Populations *Journal of Psychoactive Drugs*. 39(1): 81–95

**Literature specific to Perinatal/Pediatric priority populations:**

► A study examined HIV case management (CM) outcomes in New York State. It supported CM models that provide intensive services to women with children; the provision of multiple services, in addition to CM, within a single agency; and the need for case manager training on how to work with clients to increase service utilization. (Lehrman et al 2002)

Lehrman SE, Gentry D, Yurchak BB, Freedman J. (2001) Outcomes of HIV/AIDS case management in New York. *AIDS Care*. 13(4):481-92.

**Comprehensive Risk Counseling Services (CRCS)**

**Definition** Comprehensive Risk Counseling Services (CRCS) is a client-centered prevention activity, which assists HIV seropositive and seronegative persons in adopting risk-reduction behaviors. CRCS is intended for persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV transmission and acquisition. CRCS provides intensive one-on-one prevention counseling and support. In addition, CRCS provides assistance in accessing needed medical, psychological, and social services that affect clients' health and ability to change HIV-related risk-taking behavior.

**Priority intervention for:**

MSM, especially persons of color  
✓HIV Infected

Perinatal/Pediatric, especially persons of color

- ✓HIV status unknown
- ✓HIV Negative/ Presumed Negative

Perinatal/Pediatric, especially persons of color

- ✓HIV Infected

**Literature relevant to each of the above priority populations:**

►A number of studies have shown that Comprehensive Risk Counseling Services (previously known as Prevention Case Management or PCM) can be effective in changing HIV-related risk behaviors (Choi, et al., 1994 and Kalichman, et al., 1996).

►An evaluation of a CRCS program in Wisconsin that combined individual risk reduction counseling and case management showed that participants had a significant reduction in risk transmission behaviors including unprotected vaginal intercourse, insertive anal intercourse, or syringe sharing with partners of negative or unknown HIV status (Gasiorowicz et al 2005).

**Sources:**

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

Gasiorowicz M, Llanas MR, DiFranceisco W, et al. (2005) Reductions in transmission risk behaviors in HIV-positive clients receiving prevention case management services: findings from a community demonstration project. *AIDS Education and Prevention*, (1 Suppl A):40-52.

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.

**Comprehensive Sexuality  
and Sex Education**

**Definition** 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:**

- Heterosexual, especially persons of color
- ✓HIV Infected
- ✓HIV Negative/Presumed Negative

**Literature relevant to each of the above priority populations:**

►A qualitative descriptive study in which participants were interviewed in a semi-structured format concluded that comprehensive sexuality education for early adolescents would help youths to be abstinent, would provide some protection from sexual abuse, and would prepare them to practice safer sex in the future. (Haglund, 2006)

► A randomized controlled trial evaluated an innovative culturally specific sexual health intervention-targeting, but not limited to, low-income African American women-in which HIV and sexually transmitted disease prevention strategies were combined with comprehensive sexuality education. The intervention was effective in improving sexual anatomy knowledge at both 3- and 9-month follow-up. For a subset of women engaging in unprotected sex at pretest, the intervention group reported an increase in positive attitudes toward the female condom at 9-month follow-up. Reasons for the weak treatment effect are discussed in the context of challenges inherent in conducting community-based research with high-risk populations and sensitive topics. (Robinson et al. 2002)

► Young people with HIV especially need appropriate sex education and support for dealing with sexuality and self-identity with HIV. Women and men with HIV need condoms, appropriate services for sexually transmitted infections, sexual dysfunction and management of cervical and anogenital cancers. Interventions based on positive prevention that combine protection of personal health with avoiding HIV/STI transmission to partners are recommended. HIV counseling following a positive test has increased condom use and decreased coercive sex and outside sexual contacts among discordant couples. HIV treatment and care have reduced stigma and increased uptake of HIV testing and disclosure of positive status to partners. High adherence to antiretroviral therapy and safer sexual behavior must go hand-in-hand. Sexual health services have worked with peer educators and volunteer groups to reach those at higher risk, such as sex workers. (Shapiro et al. 2007)

► 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).

**Sources:**

Haglund, K. Recommendations for sexuality education for early adolescents. (2006) *Journal of Obstetrics, Gynecology and Neonatal Nursing*. 35(3):369-75.

Robinson BB, Uhl G, Miner M, Bockting WO, Scheltema KE, Rosser BR, Westover B. (2002) Evaluation of a sexual health approach to prevent HIV among low income, urban, primarily African American women: results of a randomized controlled trial. *AIDS Education and Prevention*. 14(3 Suppl A):81-96.

Shapiro K, Ray S. (2007) Sexual health for people living with HIV. *Reproductive Health Matters*. 2007;15(29 Suppl.):67-92.

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.

## Condom and other Barrier Distribution

**Definition** Condoms (female and/or male), lubricant, and other harm reduction materials for reducing sexual risk for HIV are distributed to members of the community at easily accessed, well publicized sites or during outreach activities.

### Priority intervention for:

MSM, especially persons of color

- ✓HIV Infected
- ✓HIV Status Unknown
- ✓HIV Negative/Presumed Negative

Heterosexual, especially persons of color

- ✓HIV Infected
- ✓HIV Status Unknown

IDU, especially persons of color

- ✓HIV Status Unknown

Perinatal/Pediatric, especially persons of color

- ✓HIV Negative/Presumed Negative

### Literature relevant to each of the above priority populations:

►The condom is one of the only widely available and highly effective HIV prevention tools in the US. When used consistently and correctly, latex male condoms can reduce the risk of pregnancy and many sexually transmitted infections (STIs), including HIV by about 80-90%. Condoms, including female condoms, are the only contraceptive method that is effective at reducing the risk of both STIs and pregnancy. (NAID 2001, Holmes, et. al. 2004, Warner, et al. 2004, Weller, 2002)

►Authors assessed awareness and experience with the NYC Condom via surveys at seven public events targeting priority condom distribution populations during 2007. Most respondents (76%) were aware of NYC Condoms. Of those that had obtained them, 69% had used them. Six months after the NYC Condom launch, there were found high levels of awareness and use. (Burke et al. 2009)

►In 2005, the New York City Department of Health and Mental Hygiene (DOHMH) made free condoms available to organizations through a Web-based ordering system. DOHMH condom distribution increased from 5.8 million in 2004 to 17.3 million in 2006. Overall, managers reported making condoms available at 76% of high-priority venues, but only at 40% of gay bars. Among patrons who saw free condoms, 80% reported taking them; 73% of those who reported taking them also reported using them. A simple, Web-based ordering system dramatically increased condom distribution. In the venues sampled, the majority of patrons acquired and used free condoms when available and visible, suggesting that increasing free condom availability

may increase use. Special efforts are needed to ensure availability at gay bars. (Renaud et al. 2009)

**Sources:**

Burke RC, Wilson J, Bernstein KT, Grosskopf N, Murrill C, Cutler B, Sweeney M, Begier EM. (2009) The NYC Condom: use and acceptability of New York City's branded condom. *American Journal of Public Health*. 99(12):2178-80. Epub 2009 Oct 15.

Holmes KK, Levine R, Weaver M. (2004) Effectiveness of condoms in preventing sexually transmitted infections. *Bulletin of the World Health Organization*. ;82:454-461.

Renaud TC, Bocour A, Irvine MK, et al. (2009) The free condom initiative: Promoting condom availability and use in New York City. *Public Health Reports*. 2009;124(4):481-489.

Report from the NIAID. (July 2001). Scientific evidence on condom effectiveness for STD prevention.

Warner L, Hatcher RA, Steiner MJ. Male Condoms. In: Hatcher RA, Trussel J, Stewart F, et al. editors. (2004) *Contraceptive Technology*. New York: Ardent Media Inc.:331-353.

Weller S, Davis K. (2002) Condom effectiveness in reducing heterosexual HIV transmission. *Cochrane Database Systematic Review*; (1):CD003255

### **Expanded Syringe Access Program (ESAP)**

**Definition** Pharmacies registered in New York State's Expanded Syringe Access Program (ESAP) may sell or furnish up to 10 syringes at a time to adults, 18 years or older, without a prescription. Under this program, health care

facilities and health care providers (doctors and others who can prescribe syringes) may also furnish syringes.

**Priority intervention for:**

**IDU, especially persons of color**

✓HIV Infected

✓HIV Status Unknown

✓HIV Negative/Presumed Negative

**Literature relevant to each of the above priority populations:**

► A study surveyed pharmacy nonprescription syringe customers at their point of purchase. Sixty-two individuals purchasing nonprescription syringes in seven pharmacies located in NYC and Albany, NY, USA participated. The study concluded that pharmacy-based syringe access programs are essential in areas not served by syringe exchanges. (Battles et al. 2009)

Pharmacy-based syringe access is a viable harm-reduction alternative in the fight against blood-borne diseases, with ESAP now equaling the number of syringes being distributed by syringe exchange programs in New York State (Tesoriero, 2009).

**Sources:**

Battles, H.B., Rowe, K.A., Ortega-Peluso, C. and Tesoriero, J.M. (2009) Who Purchases Nonprescription Syringes? Characterizing Customers of the Expanded Syringe Access Program (ESAP). *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, May 12, 2009- Published online

Tesoriero, J.M., Battles, H.B., Klein, S.J., Kaufman, E., and Birkhead, G.S. (2009) Expanding access to sterile syringes through pharmacies: Assessment of New York's Expanded Syringe Access Program. *AIDS*, 23:1153-1162

## 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 Status Unknown

Heterosexuals, especially persons of color

✓HIV Infected

✓HIV Status Unknown

Perinatal/Pediatric, especially persons of color

✓HIV Infected

**Literature specific to MSM priority populations:**

► Findings suggest that health education risk reduction behavioral interventions reduce unprotected anal sex among MSM (Herbst et al. 2007, Johnson et al. 2008, Lyles et al. 2007).

► 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).

► 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).

**Sources:**

Herbst JH, Beeker C, Mathew A, et al. and the Task Force on Community Preventive Services. (2007) The effectiveness of individual, group, and community-level HIV behavioral risk-

reduction interventions for adult men who have sex with men: a systematic review. *American Journal of Preventive Medicine* 32(4 Suppl):S38-S67.

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.

Johnson WD, Diaz RM, Flanders WD, et al. (2008) Behavioral interventions to reduce risk for sexual transmission of HIV among men who have sex with men. *Cochrane Database Systematic Review* Jul 16(3):CD001230.

Lyles CM, Kay LS, Crepaz N, et al. (2007) Best-evidence interventions: findings from a systematic review of HIV behavioral interventions for U.S. populations at high risk, 2000-2004. *American Journal of Public Health* 97(1):133-143.

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.

**Literature specific to Heterosexual and Perinatal/Pediatric priority populations:**

►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.

The efficacy of brief HIV/sexually transmitted disease (STD) risk-reduction interventions for African-American women in primary care settings was studied. The study suggests that brief single-session, one-on-one or group skill-building interventions may reduce HIV/STD risk behaviors and STD morbidity among inner-city African American women in primary care settings. (Jemmott, 2007)

►Kelly, et al. (1994) 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 comparison conditions.

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

Jemmott LS, Jemmott JB, O'Leary A. (2007) Effects on sexual risk behavior and STD rate of brief HIV/STD prevention interventions for African American women in primary care settings. *American Journal of Public Health*, 97(6):1034-1040.

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.

### **HIV Counseling, Testing and Referral (CTR)**

**Definition** HIV 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 language-appropriate 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.

#### **Priority intervention for:**

MSM, especially persons of color

- ✓HIV Status Unknown
- ✓HIV Negative/ Presumed Negative

Heterosexual, especially persons of color

- ✓HIV Status Unknown
- ✓HIV Negative/ Presumed Negative

IDU, especially persons of color

- ✓HIV Status Unknown
- ✓ HIV Negative/ Presumed Negative

Perinatal/Pediatric, especially persons of color

- ✓HIV Status Unknown
- ✓HIV Negative/ Presumed Negative

#### **Literature relevant to each of the above priority populations:**

► Findings from a demonstration project indicate that offering rapid HIV testing in outreach and community settings is a feasible approach for reaching members of minority groups and people at high risk for HIV infection. The project identified venues that would be important to target and offered lessons that could be used by other CBOs to design and implement similar programs in the future. (Bowles et al. 2008)

►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.

►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).

►Four state health departments (Florida, Louisiana, New York, and Wisconsin) collaborated with jails to implement stand-alone voluntary rapid HIV testing programs. Conclusion from the study indicated that rapid HIV testing in jails identified a considerable number of previously undiagnosed cases of HIV infection and the authors recommended that rapid HIV testing be available to all incarcerated individuals, regardless of whether incarcerated individuals reported HIV risky behaviors. (Macgowan 2009)

►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).

**Sources:**

Bowles KE, Clark HA, Tai E, et al. (2008) Implementing rapid HIV testing in outreach and community settings: Results from an advancing HIV prevention demonstration project conducted in seven U.S. cities. *Public Health Reports*. 123(Suppl. 3):78-85.

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.

Macgowan R, Margolis A, Richardson-Moore A, et al. (2009) Voluntary rapid human immunodeficiency virus (HIV) testing in jails. *Sexually Transmitted Diseases*. 2009;36(2):S9-S13.

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.

**Literature specific to MSM priority populations:**

►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.

**Literature specific to Heterosexual priority populations:**

►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.

**Literature specific to IDU priority populations:**

►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): 409-426.

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.

**Literature specific to Perinatal/Pediatric priority populations:**

►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).

►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.

**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.

## Interventions Delivered to Groups (IDG)

**Definition** IDGs are health education and risk reduction interventions provided to groups of varying sizes. IDGs 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). IDGs use models that provide a wide range of skills-building activities, information, education and support, delivered in a group setting.

### Priority intervention for:

MSM, especially persons of color

✓HIV Infected

Heterosexual, especially persons of color

✓HIV infected

✓HIV Status Unknown

IDU, especially persons of color

✓HIV Infected

✓HIV Negative/ Presumed Negative

Perinatal/Pediatric, especially persons of color

✓HIV Infected

✓HIV Negative/ Presumed Negative

### Literature Relevant to HIV Positive Individuals in each of the above priority populations:

►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.

►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:**

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.

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.

**Literature specific to MSM priority populations:**

► 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).

► The evidence found in a review of interventions for adult men (aged 20 years or older, across a range of settings and populations) who have sex with men shows that individual-level, group-level, and community-level HIV behavioral interventions are effective in reducing the odds of unprotected anal intercourse (range 27% to 43% decrease) and increasing the odds of condom use for the group-level approach (by 81%). (Herbst, et al. 2007)

► 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).

► Many Men, Many Voices (3MV) is a group-level intervention that addresses behavioral and social determinants and other factors influencing the HIV/STI risk and protective behaviors of black MSM. Evaluation showed that participants reduced unprotected anal intercourse with casual sex partners as well as the number of male sex partners. (Wilton et al. 2009)

► The IDG Men of African American Legacy Empowering Self” (MAALES), is based on elements of the Critical Thinking and Cultural Affirmation (CTCA) intervention developed by Cleo Manago and the theory of Reasoned Action and Planned Behavior developed by Icek Ajzen and Martin Fishbein. It involves six two-hour group sessions held over a three-week period. To determine the intervention’s effectiveness, participants have been interviewed prior to participation, immediately after the intervention, and three months after completion. Participants were compared to a group of men who receive a standard HIV risk-reduction counseling session and are interviewed at similar intervals. Early evaluations and qualitative case studies report high levels of satisfaction and favorable outcomes. Participants overwhelmingly indicated that they

could relate to each other. Some participants started using condoms, and others reflected on their sexual behaviors. (Williams, et al. 2009)

**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.

Herbst JH, Beeker C, Mathew A, et al. (2007) The effectiveness of individual, group, and community-level HIV behavioral risk-reduction interventions for adult men who have sex with men: A systematic review. *American Journal of Preventive Medicine.*;32(4S):S38-S67.

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.

Williams JK, Ramamurthi HC, Manago C, Harawa NT. (2009) Learning from successful interventions: A culturally congruent HIV risk-reduction intervention for African American men who have sex with men and women. *American Journal of Public Health.* 99(6):1008-1012.

Wilton, L., Herbst, J. H., Coury-Doniger, P., Painter, T. M., English, G., Alvarez, M. E., et al. (2009). Efficacy of an HIV/STI prevention intervention for black men who have sex with men: Findings from the Many Men, Many Voices (3MV) Project. *AIDS and Behavior*, 13, 532-544.

**Literature specific to Heterosexual priority populations:**

► 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-Enquist, et al. 2001).

► A study examined the effect of gender-sensitive and culturally relevant HIV prevention film messages combined with self-efficacy and skill building exercises on self-reported safe sex behaviors, intentions, attitudes, and self-advocacy over time. Results showed that, despite the short duration of the intervention, participants self-reported significantly more use of safe sex behaviors and being prepared for sexual intimacy after the intervention. The study validated use of an approach originally intended for African American women with other women at risk for HIV. (DeMarco et al. 2009)

► 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)

►HORIZONS is a group-level, gender- and culturally tailored STD/HIV intervention for African American adolescent females seeking sexual health services. Evaluation showed that participants had a reduction in chlamydial infection and an increase in condom use. (DiClemente, et al. 2009)

►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)

►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)

►PROJECT S.A.F.E. is a three session cognitive-behavioral intervention designed to reduce STD infections among Hispanic and African American women designed to facilitate skill development to avoid infections while increasing awareness that STDs (including AIDS) disproportionately affect minority women. The intervention also helps build decision-making and communication skills, and encourages participants to set risk reduction goals. Participants gain mastery through role-play, group discussion, and behavioral skills exercises. Program participants showed a lower rate of infection as well as a better understanding of risky sexual behavior as compared to the control group. (Shain et al., 1999)

►The IDG Men of African American Legacy Empowering Self" (MAALES), is based on elements of the Critical Thinking and Cultural Affirmation (CTCA) intervention developed by Cleo Manago and the theory of Reasoned Action and Planned Behavior developed by Icek Ajzen and Martin Fishbein. It involves six two-hour group sessions held over a three-week period. To determine the intervention's effectiveness, participants have been interviewed prior to participation, immediately after the intervention, and three months after completion. Participants were compared to a group of men who receive a standard HIV risk-reduction counseling session and are interviewed at similar intervals. Early evaluations and qualitative case studies report high levels of satisfaction and favorable outcomes. Participants overwhelmingly indicated that they could relate to each other. Some participants started using condoms, and others reflected on their sexual behaviors. (Williams, et al. 2009)

**Sources:**

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.

DeMarco RF, Kendricks M, Dolmo Y, et al. (2009) The effect of prevention messages and self-efficacy skill building with inner-city women at risk for HIV infection. *Journal of the Association of Nurses in AIDS Care*. 2009;20(4):283-292.

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.

DiClemente, R. J., Wingood, G. M., Rose, E. S., Sales, J. M., Lang, D. L., et al. (2009). Efficacy of STD/HIV sexual risk-reduction intervention for African American adolescent females seeking sexual health services: A randomized controlled trial. *Archives of Pediatrics & Adolescent Medicine*. 163(12):1162-3.

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

Shain, RN, Piper, JM, Newton, ER, Perdue, SD, Ramos, R, Champion, JD, Guerra, FA (1999) A randomized, controlled trial of a behavioral intervention to prevent sexually transmitted disease among minority women. *The New England Journal of Medicine*, 340(2), 93-100.

Williams JK, Ramamurthi HC, Manago C, Harawa NT. (2009) Learning from successful interventions: A culturally congruent HIV risk-reduction intervention for African American men who have sex with men and women. *American Journal of Public Health*. 99(6):1008-1012.

**Literature specific to IDU priority populations:**

► 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).

► Group level interventions providing information, enhancing risk-reduction skills, and motivating behavior change through peer education training can reduce injection risk behaviors, although risk elimination might be necessary to prevent HCV transmission. (Garfein, et al. 2007)

► The Holistic Health Recovery Program is a 12-session, manual-guided, group level program for HIV-infected and HIV-negative injection drug users. The primary goals of Holistic Health Recovery Program are to promote health, improve quality of life, and harm reduction. It is based on the information-motivation behavioral skills model of HIV prevention behavioral. Evaluation showed that : participants decreased addiction severity, participants decreased risk behavior, participants had significant improvement in behavioral skills, motivation, and quality of life. (Margolin, et al., 2003)

► VOICES/VOCES was effective in lowering the rate of new STD infections among the men who participated (O'Donnell, et al. 1998).

►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)

**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.

Garfein RS, Golub ET, Greenberg AE, et al. (2007) A peer-education intervention to reduce injection risk behaviors for HIV and hepatitis C virus infection in young injection drug users. *AIDS*. 21(14): 1923-1932.

Margolin, A., Avants, S.K., Warburton, L.A., Hawkins, K.A. Shi, J. 2003. A randomized clinical trial of reduction intervention for HIV-positive injection drug users. *Health Psychology*, 22(2):223-228.

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.

**Literature specific to Perinatal/Pediatric priority populations:**

►A study sought to determine whether an HIV prevention program bundled with group prenatal care reduced sexually transmitted infection (STI) incidence, repeat pregnancy, sexual risk behavior, and psychosocial risks. According to intent-to-treat analyses, women assigned to the HIV-prevention group intervention were significantly less likely to have repeat pregnancy at 6 months postpartum than individual-care and attention-matched controls; they demonstrated increased condom use and decreased unprotected sexual intercourse compared with individual-care and attention-matched controls. Sub-analyses showed that being in the HIV-prevention group reduced STI incidence among the subgroup of adolescents. The conclusion was that HIV prevention integrated with prenatal care resulted in reduced biological, behavioral, and psychosocial risks for HIV. (Kershaw et al. 2009)

**Source:**

Kershaw TS, Magriples U, Westdahl C, et al. (2009) Pregnancy as a window of opportunity for HIV prevention: Effects of an HIV intervention delivered within prenatal care. *American Journal of Public Health*. 99(11):2079-2086.

## Interventions Delivered to Individuals (IDI)

**Definition** IDIs are health education and risk reduction 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.

### Priority intervention for:

MSM, especially persons of color

✓HIV Infected

Heterosexual, especially persons of color

✓HIV Infected

✓HIV Status Unknown

IDU, especially persons of color

✓HIV Infected

✓HIV Negative/Presumed Negative

Perinatal/Pediatric, especially persons of color

✓HIV Infected

✓HIV Negative/ Presumed Negative

### Literature Relevant to HIV infected individuals in each of the above priority 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.

►Positive Choice is an individual-level, interactive computer-based intervention to improve screening and counseling about ongoing sex risk and substance use among HIV-positive patients. Among HIV-positive clinic patients who reported unprotected anal or vaginal sex at baseline, a study showed that intervention participants were significantly less likely than comparison participants to report unprotected anal or vaginal sex at 3 months after the initial Video Doctor counseling session and at 3 months after the booster Video Doctor counseling session. Intervention participants also reported significantly fewer casual sex partners than comparison participants at 3 months after the booster Video Doctor counseling session. (Gilbert et al. 2008)

►Healthy Living is a 3-module/15-session intervention that is delivered one-on-one to people living with HIV. In a study, Healthy Living participants reported significantly fewer HIV transmission risk acts than the wait-list control participants at 8 months after the completion of all three modules. Across four assessments, Healthy Living participants reported significantly fewer HIV transmission risk acts than the wait-list control participants. (Healthy Living Team, 2007)

►Richardson et. al (2004) proved that brief provider counseling emphasizing the negative consequences of unsafe sex can reduce HIV transmission behaviors in HIV-positive patients presenting with risky behavioral profiles. *In the study*, patients who had two or more sex partners or at least one casual partner and who received consequences-framed messages were significantly less likely to engage in unprotected anal or vaginal sex. Research in this study was used to develop *Partnership for Health* which uses message framing, repetition, and reinforcement during patient visits to increase HIV positive patients' knowledge, skills, and motivations to practice safer sex.

***Sources:***

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.

Gilbert, P., Ciccarone, D., Gansky, S. A., Bangsberg, D. R., Clanon, K., McPhee, S. J., et al. (2008). Interactive "Video Doctor" counseling reduces drug and sexual risk behaviors among HIV-positive patients in diverse outpatient settings. *PLoS ONE*, 3(4), 1-10.

Healthy Living Project Team. (2007). Effects of a behavioral intervention to reduce risk of transmission among people living with HIV: The Healthy Living Project randomized controlled study. *Journal of Acquired Immune Deficiency Syndromes*, 44, 213-221.

Richardson J.L., Milam J, McCutchan A, et al. (2004) Effect of brief safer-sex counseling by medical providers to HIV-1 seropositive patients: a multi-clinic assessment. *AIDS*, 18:1179–1186.

**Literature specific to MSM priority populations:**

►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).

►The evidence found in a review of interventions for adult men (aged 20 years or older, across a range of settings and populations) who have sex with men shows that individual-level, group-level, and community-level HIV behavioral interventions are effective in reducing the odds of unprotected anal intercourse (range 27% to 43% decrease) and increasing the odds of condom use for the group-level approach (by 81%). (Herbst, et al. 2007)

►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:**

Dilley, J.W., Woods, W.J., Sabatino, J., et al. (2002). Changing Sexual Behavior Among Gay Male Repeat Testers for HIV: A Randomized, Controlled Trial of a Single-Session Intervention. *Journal of Acquired Immune Deficiency Syndromes*, 30: 177-186.

Herbst JH, Beeker C, Mathew A, et al. (2007) The effectiveness of individual, group, and community-level HIV behavioral risk-reduction interventions for adult men who have sex with men: A systematic review. *American Journal of Preventive Medicine*.;32(4S):S38-S67.

Patterson, T. L., Shaw, W. S., Semple, S. J. (2003). Reducing the sexual risk behaviors of HIV-positive Individuals: Outcome of a Randomized Controlled Trial. *Annals of Behavioral Medicine*, 25, 137-145.

**Literature specific to Heterosexual priority populations:**

► An evaluation of a brief, clinic-based, safer sex program administered by a lay health adviser for young heterosexual African American men newly diagnosed with a sexually transmitted disease (STD) concluded that it may be an efficacious strategy to reduce incident STDs among young heterosexual African American men. (Crosby et al. 2009)

► Elway, et al.'s (2002) review of studies of interventions to prevent transmission of sexually transmitted infections (STIs) and HIV in heterosexual men found that most interventions targeted specific groups of men (e.g., those attending STI clinics) rather than general populations, few were conducted with men alone, and most focused on behavioral and social psychological rather than morbidity outcomes. Successful interventions included on-site individual counseling and HIV testing, mass communications regarding risk reduction, and multiple-component motivation and skills education in STI clinics.

► Participants in both the Enhanced Counseling and Brief Counseling interventions of the Project Respect trial found that participants reported significantly more condom use at 3 and 6 months post intervention compared with participants who had experienced didactic messages (Kamb, et al. 1998).

► A study was conducted on a randomized clinical trial of two interventions: (a) a video made for this study and (b) an adaptation of Project RESPECT counseling. Four hundred black and Latina teenage women completed a questionnaire about their sexual behaviors and were randomly assigned to (a) see the video, (b) get counseling, (c) see the video and get counseling, or (d) receive usual care. At 3-month follow-up, those who saw the video and received counseling were 2.5 times more likely to have used a condom at last intercourse with their main partner than teens in the usual care group. These differences did not persist at 12-month follow-up. This suggests that a brief intervention can positively affect condom use in the short term. (Roye, et al. 2007)

**Sources:**

Crosby R, DiClemente RJ, Charnigo R, et al. (2009) A brief, clinic-based, safer sex intervention for heterosexual African American men newly diagnosed with an STD: A randomized controlled trial. *American Journal of Public Health*. 99(Suppl. 1):S96-S103.

Elway, A. R., G. J. Hart, et al. (2002). "Effectiveness of Interventions to Prevent Sexually Transmitted Infections and Human Immunodeficiency Virus in Heterosexual Men - A Systematic Review." *Archives of Internal Medicine* 162(16): 1818-1830.

Kamb, M.L., Fishbein, M., Douglas, J.M. Jr., Rhodes, F., Rogers, J., Bolan, G., Zenilman, J., Hoxworth T., Malotte, C.K., Iatesta, M., Kent, C., Lentz, A., Graziano, S., Byers, R.H., Peterman, TA. (1998). Efficacy of Risk-Reduction Counseling to Prevent Human Immunodeficiency Virus and Sexually Transmitted Diseases: A Randomized Controlled Trial. Project RESPECT Study Group. *Journal of the American Medical Association*, 280(13):1161–1167.

Roye C, Silverman PP, Krauss B. (2007) A brief, low-cost, theory-based intervention to promote dual method use by black and Latina female adolescents: A randomized clinical trial. *Health Education and Behavior*. 34(4):608-621.

**Literature specific to IDU priority populations:**

►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.

**Literature specific to Perinatal/Pediatric priority populations:**

*See interventions above specific to MSM/Heterosexual and IDU priority populations*

**Linkage to Care**

**Definition** Linkage to care requires that providers go beyond the initial process of referring individuals who are HIV infected to care by ensuring that they are fully involved in the process of finding and

maintaining HIV primary medical care and treatment adherence. This strategy involves the use of multiple interventions that address issues such as health literacy, readiness, health status perceptions, fear, stigma, missed appointments, and substance use and mental health issues. Agencies should not only ensure that clients are successfully linked to HIV care, but should also support clients with resources and knowledge about the care system and how to use it.

Adherence to antiretroviral therapy should be promoted per [hivguidelines.org](http://hivguidelines.org) and a “best practices” model to successfully improve quality of life and survival of people with HIV/AIDS. Interventions and services should be multifaceted, tailored for each patient, and delivered through a multidisciplinary team approach that includes the patient in collaborative treatment planning. Best practices and creative solutions can be employed to prepare individuals for and support them through the demands of therapy.

**Priority intervention for:**

MSM, especially persons of color

✓HIV Infected

Heterosexual, especially persons of color

✓HIV Infected

IDU, especially persons of color

✓HIV Infected

Perinatal/Pediatric, especially persons of color

✓HIV Infected

**Literature Relevant to each of the above priority populations:**

►A study provided an opportunity to adapt a patient navigation model first developed for cancer care to assess its effectiveness with HIV-infected disadvantaged populations, examining the effectiveness of these interventions in decreasing barriers to HIV primary medical care and improving health outcomes. A reduction in barriers, improvement in mediators, and improved health outcomes were observed over the 12-month intervention period. Structural barriers to HIV care and provider engagement were significantly associated with health outcomes. Based on study results, the authors proposed that an adapted navigation approach referred to as “HIV System Navigation” has promise for improving access to HIV care and warrants further development. (Bradford 2007)

►The Antiretroviral Treatment Access Study (ARTAS) assessed a case management intervention to improve linkage to care for persons recently receiving an HIV diagnosis. Evaluation showed that a brief intervention by a case manager was associated with a significantly higher rate of successful linkage to HIV care. Brief case management is an affordable and effective resource that can be offered to HIV-infected clients soon after their HIV diagnosis. (Gardner et al. 2005)

►A multisite, qualitative study examined the process by which persons living with HIV/AIDS (PLWHA) engage in primary HIV medical care for treatment. Perceptions of the client-provider relationship emerged as a central element of the process by which persons with HIV engaged – or remained – in care. Provider behaviors that were characterized as engaging, validating, and partnering facilitated engagement and retention in care; behaviors described as paternalistic served as barriers to care. Participants indicated that they desired a care partnership with an empathetic provider who had effective communication skills. These findings provide recommendations for health providers to engage and retain hard-to-reach PLWHA in timely and appropriate HIV care and services. (Mallinson et al. 2007)

►A paper examined factors associated with engaging socially marginalized HIV-positive persons in primary care using interview and chart review data. The sample was predominantly minority, and many reported drug and mental health issues as well as housing instability. It concluded that interventions that focus on decreasing structural barriers and unmet support services needs, addressing negative health beliefs and attending to drug use are promising public health strategies to engage marginalized HIV-positive persons in HIV primary care. (Rumptz et al. 2007)

►Medicaid insurance and a usual source of care were protective against delay after HIV diagnosis. After full adjustment, delay was still greater for Latinos and, to a lesser extent, African Americans compared with whites. (Turner et al. 2000)

►Following HIV diagnosis, linkage to outpatient treatment, antiretroviral initiation, and longitudinal retention in care represent the foundation for successful treatment. A retrospective cohort study of patients initiating outpatient care at the University of Alabama at Birmingham 1917 HIV/AIDS Clinic between January 2000 and December 2005 showed delayed linkage was observed in two-thirds of the overall sample and was associated with older age and African Americans. Attending all clinic visits (hazard ratio and lower initial CD4 counts led to earlier antiretroviral initiation. Worse retention in the first 2 years was associated with younger age, higher baseline CD4 count, and substance abuse. Results indicated that interventions to improve timely HIV diagnosis and linkage to care should focus on older patients and African Americans while efforts to improve retention should address younger patients, those with higher baseline CD4 counts, and substance abuse. These data inform development of interventions to improve linkage and retention in HIV care, an emerging area of growing importance. (Ulett et al. 2009)

**Sources:**

Bradford JB, Coleman S, Cunningham W. (2007) HIV system navigation: An emerging model to improve HIV care access. *AIDS Patient Care and STDs*. 21(Suppl. 1):S49-S67.

Gardner LI, Metsch LR, Anderson-Mahoney P, Loughlin AM, del Rio C, Strathdee S, Sansom SL, Siegal HA, Greenberg AE, Holmberg SD; Antiretroviral Treatment and Access Study Study Group. (2005) Efficacy of a brief case management intervention to link recently diagnosed HIV-infected persons to care. *AIDS*. 19:423–431

Mallinson RK, Rajabiun S, Coleman S. (2007) The provider role in client engagement in HIV care. *AIDS Patient Care and STDs*. 21(Suppl. 1):S77-S84.

Rumptz MH, Tobias C, Rajabiun S, et al. (2007) Factors associated with engaging socially marginalized HIV-positive persons in primary care. *AIDS Patient Care and STDs*. 21(Suppl. 1):S30-S39.

Turner BJ, Cunningham WE, Duan N, Andersen RM, Shapiro MF, Bozzette SA, et al. Delayed medical care after diagnosis in a US national probability sample of persons infected with human immunodeficiency virus. *Archives of Internal Medicine*. 160:2614–2622

Ulett KB, Willig JH, Lin HY, et al. 2009) The therapeutic implications of timely linkage and early retention in HIV care. *AIDS Patient Care and STDs*. 23(1):41-49.

**Literature specific to Heterosexual priority populations:**

►A study examined a nonrandom sample of 60 HIV-positive women receiving case management and supportive services at New York City ASOs. Over 55% of the women interviewed reported high access to care, 43% reported the ability to access urgent care all of the time and 94% reported high satisfaction with obstetrics/gynecology (OB/GYN) care. The study results indicated that supportive services increase access to and satisfaction with both HIV and non-HIV-related health care. (Pillai, 2009)

**Sources:**

Pillai NV, Kupprat SA, Halkitis PN. (2009) Impact of service delivery model on health care access among HIV-positive women in New York City. *AIDS Patient Care and STDs*. 23(1):51-58.

**Literature specific to IDU priority populations:**

►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.

**Source:**

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.

**Literature specific to Perinatal/Pediatric priority populations:**

►Human immunodeficiency virus (HIV) infection during pregnancy is a condition that requires multidisciplinary care. Care must be rendered that is appropriate for both the mother and the fetus. Prevention of mother-to-child transmission of HIV is of paramount concern. To prevent transmission, universal testing for HIV infection in pregnant women is ideal. In the United States and other developed countries, great strides have been made toward decreasing the risk of HIV transmission to infants to <2% with use of a combination of highly active antiretroviral therapy during the ante partum period and during labor and delivery, scheduled cesarean section when appropriate, avoidance of breast-feeding, and 6 weeks of zidovudine prophylaxis for infants. The continuation of antiretroviral therapy after delivery depends on the needs of the mother with regard to treatment of her own health. (Anderson, 2009)

►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).

**Sources:**

Anderson BL, Cu-Uvin S. (2009) Pregnancy and optimal care of HIV-infected patients. *Clinical Infectious Diseases*. 48(4):449-455.

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.

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.

### Linkage to Mental Health Services

**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. For HIV positive populations, mental health services may include a disclosure component, a trauma-related component and/or a family/individual component.

**Priority intervention for:**

MSM, especially persons of color

✓HIV Infected

✓HIV Negative/ Presumed Negative

Heterosexuals, especially persons of color

✓HIV Infected

IDU, especially persons of color

✓HIV Infected

Perinatal/Pediatric, especially persons of color  
✓HIV Infected

**Literature Relevant to each of the above priority populations:**

► 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).

► A cross-sectional study identified variables predictive of sexual transmission risk behavior among an ethnically diverse sample of 256 HIV-positive adults (women and men who have sex with men; MSM) with childhood sexual abuse (CSA) histories. The study showed that trauma symptoms, shame, coping style, and substance use were significantly associated with sexual risk behavior among HIV-positive adults with histories of CSA, with models of prediction differing by gender and partner serostatus and, as a result, recommended that HIV prevention intervention for persons with HIV and CSA histories should address trauma-related behavioral difficulties and enhance coping skills to reduce sexual transmission risk behavior. (Sikkema, et al. 2009)

**Source:**

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.*

Sikkema KJ, Hansen NB, Meade CS, et al. (2009) Psychosocial predictors of sexual HIV transmission risk behavior among HIV-positive adults with a sexual abuse history in childhood. *Archives of Sexual Behavior.* 38(1):121-134.

**Literature relevant to all HIV positive priority populations:**

► Despite advances in HIV treatment, there continues to be great variability in the progression of this disease. A paper reviewed the evidence that depression, stressful life events, and trauma account for some of the variation in HIV disease course. It found substantial and consistent evidence that chronic depression, stressful events, and trauma may negatively affect HIV disease progression in terms of decreases in CD4 T lymphocytes, increases in viral load, and greater risk for clinical decline and mortality. More research is warranted to investigate biological and behavioral mediators of these psycho immune relationships, and the types of interventions that might mitigate the negative health impact of chronic depression and trauma. Given the high rates of depression and past trauma in persons living with HIV/AIDS, it is important for healthcare providers to address these problems as part of standard HIV care. (Leserman et al. 2008),

► Mental health treatment, whether behavioral or pharmacological in nature, effectively improves the mental health of PLWHA. Poor mental health is associated with HIV transmission risk behaviors, and a developing literature suggests that mental health treatment may reduce sexual risk behavior and improve adherence to HIV care and treatment, leading to a reduction in HIV transmission. (Sikkema 2009)

**Source:**

Leserman J. Role of depression, stress, and trauma in HIV disease progression. (2008) *Psychosomatic Medicine*, 70(5):539-545.

Kathleen J Sikkema Watt Melissa H., et al., Mental Health Treatment to Reduce HIV Transmission Risk Behavior: A Positive Prevention Model. *AIDS and Behavior*, 14:252–262

**Literature specific to MSM priority populations:**

►HIV prevention interventions for black MSM may benefit from incorporating screening and/or treatment for depression, allowing MSM who are depressed to respond more effectively to behavioral change approaches. (Reisner et al. 2009)

►The EXPLORE study evaluated a behavioral intervention to prevent HIV infection among MSM. It examined depressive symptoms, utilization of mental health care, substance use and HIV risk taking behaviors in YMSM aged 16-25 years compared with their older counterparts. Findings suggest the need for more appropriate and accessible mental health care and substance use services for YMSM. Additionally, HIV prevention work with this population should provide comprehensive education about HIV testing and risk reduction counseling that focuses on communication about serostatus and safety in sexual situations. (Salomon et al. 2009)

**Sources:**

Reisner SL, Mimiaga MJ, Skeer M, et al. (2009) Clinically significant depressive symptoms as a risk factor for HIV infection among black MSM in Massachusetts. *AIDS and Behavior*. 13(4):798-810.

Salomon EA, Mimiaga MJ, Husnik MJ, et al. (2009) Depressive symptoms, utilization of mental health care, substance use and sexual risk among young men who have sex with men in EXPLORE: Implications for age-specific interventions. *AIDS and Behavior*. 13(4):811-821.

**Literature specific to Heterosexual priority populations:**

►Study findings demonstrated that Seeking Safety treatment (SS), a trauma-focused cognitive group therapy targeting skills building and self-efficacy in the context of integrated trauma and substance abuse treatment, was significantly more effective in reducing HIV sexual risk for women with higher levels of unprotected sex when compared with a Women's Health Education curriculum which provided specific psycho education on HIV risk reduction. (Hien 2010)

►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:**

Hien, D. A., Campbell A., Killeen T., et al. (2010) The Impact of Trauma-Focused Group Therapy upon HIV Sexual Risk Behaviors in the NIDA Clinical Trials Network "Women and Trauma" Multi-Site Study. *AIDS and Behavior*. 14:421–430

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 (Supp. 2): S133-134.

**Literature specific to IDU priority populations:**

► 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).

**Source:**

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.

Also, see Hien, et. al (2010) under Heterosexual.

**Literature specific to Perinatal/Pediatric priority populations:**

► Maternal perinatal depression (PND) may interfere with effective perinatal HIV care. Preliminary results of a study suggest that rates of perinatal depression among HIV-infected women are substantial and conclude that pregnant HIV-infected women should be routinely screened and treated for PND. (Kapetanovic et al. 2009)

**Source:**

Kapetanovic S, Christensen S, Karim R, et al. (2009) Correlates of perinatal depression in HIV-infected women. *AIDS Patient Care and STDs*. 23(2):101-108.

**Linkage to Re-entry Services**

**Definition** Re-entry services are multi-step services that help to ensure a continuum of services for incarcerated individuals who are being released from incarceration. It addresses care, prevention and support

services needs of incarcerated individuals to ensure a coordinated transition from incarceration to community.

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

**Literature Relevant to the above Priority Population:**

► A study explored whether being met at the gate by a case manager is associated with more health-seeking behavior during the six months post-release among HIV-infected incarcerated individuals

transitioning from the facility to the community. Case managers documented whether clients were met at the gate upon release. Results indicated that clients who were met at the gate were more likely to participate in drug or alcohol treatment and not engage in sex exchange during the subsequent six months. Findings offer support for the importance of establishing early post-release contact with a case manager among HIV-infected ex-offenders. (Arriola, 2007)

► A study highlighted the need for coordination and collaboration between correctional facilities and community-based health care and human service providers that leads to a deliberative and planned transition from jail to service systems in the community. (Fontana, et al. 2007)

**Sources:**

Jacob Arriola KR, Braithwaite RL, Holmes NE, et al. (2007) Post-release case management services and health-seeking behavior among HIV infected ex-offenders. *Journal of Health Care for the Poor and Underserved*. 2007;18(3):665-674.

Fontana L, Beckerman A. (2007) Recently released with HIV/AIDS: Primary care treatment needs and experiences. *Journal of Health Care for the Poor and Underserved*. 2007;18(3):699-714.

### **Linkage to Supportive Services and Care Coordination**

**Definition** Supportive services include, but are not limited to, needs which may or may not be related to one's HIV status such as housing, home health care, counseling and substance use services. Care Coordination facilitates access to social support and medical services across different organizations and providers.

**Priority intervention for:**

Perinatal/Pediatric, especially persons of color  
 ✓HIV Positive

**Literature Relevant to the above Priority Population:**

► A paper described and compared three innovative methods for preventing perinatal HIV transmission. Each of these strategies was developed based on an in-depth assessment of the strengths and weaknesses of existing prevention approaches, and the needs of the populations they serve. Each program demonstrated improvements in indicators related to prevention of perinatal HIV transmission, such as increased utilization of prenatal care, increased prenatal testing rates, and decreases in perinatal HIV transmission. The case studies emphasized two key similarities among these programs: the value of collaboration between agencies providing care and services to HIV-infected and high-risk women of childbearing age, and the importance of maximizing opportunities for HIV testing and treatment. These strategies have demonstrated effectiveness in improving health outcomes and reducing perinatal HIV transmission. (Clark et al. 2006)

A Review of key indicators from the prevention of mother-to-child transmission database and reporting practices from January 2005 to June 2006 throughout 18 resource-limited countries showed that prevention of mother-to-child transmission services are integrated into maternal-child health services but adult and pediatric care and treatment programs often function

independently, without coordination or linkages. Integrating care into maternal-child health services and linking mother's HIV status to child are necessary for HIV-infected mothers and HIV-exposed children to receive appropriate follow-up and treatment. (Ginsburg et al. 2007)

**Sources:**

Clark J, Sansom S, Simpson BJ, Walker F, Wheeler C, Yazdani K, Zapata A. (2006) Promising strategies for preventing perinatal HIV transmission: model programs from three states. *Maternal and Child Health Journal*. 10(4):367-73. Epub 2006 Jun 3

Ginsburg AS, Hoblitzelle CW, Sripipatana TL, Wilfert CM. (2007) Provision of care following prevention of mother-to-child HIV transmission services in resource-limited settings. *AIDS*. 21(18):2529-32.

*See also Treatment Adherence, page 50 and Case Management, page 7.*

## Outreach

**Definition** Outreach activities are HIV/AIDS interventions that are client-engaging and generally conducted face to face (or in virtual environments such as the Internet) with individuals who are at high risk in the neighborhoods, areas or web sites 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 and at dating/hook-up sites on the internet.

**Priority intervention for:**

MSM, especially persons of color

- ✓HIV Positive
- ✓HIV Status Unknown
- ✓HIV Negative/Presumed Negative

Heterosexual, especially persons of color

- ✓HIV Status Unknown
- ✓HIV Negative/ Presumed Negative

IDU, especially persons of color

- ✓HIV Status Unknown
- ✓HIV Negative/ Presumed Negative

Perinatal/Pediatric, especially persons of color

✓HIV Infected

✓HIV Status Unknown

**Literature specific to MSM priority populations:**

- ▶A study focusing on examining the feasibility, acceptability, and efficacy of an Internet delivered HIV risk reduction program for rural men who have sex with men (MSM) was undertaken. The results provided support for the efficacy of Internet-based interventions to reduce risk of HIV infection. Results also support traditional research methods to evaluate HIV prevention programs delivered exclusively through the Internet. (Bowen et al. 2008)
  
- ▶A community level intervention for young gay men in Eugene, OR which used a variety of prevention activities, including outreach that was designed and run by peers showed lower rates of unprotected intercourse (Kegeles et al. 1996)
  
- ▶Hospers et al. (1999) evaluated a program in the Netherlands that trains volunteers to go into cruising areas to talk with MSM about the importance of safer sex and to provide risk reduction information, brochures, condoms and lube. A post-intervention survey of people who had at least one conversation with a volunteer and those who hadn't been approached but would have had a conversation if asked was conducted. The conversation group had significantly higher condom use for insertive and receptive anal intercourse. Of this group, men who had sex with only men increased condom use more than men who had sex with men and women.
  
- ▶An analysis compared the baseline risk profiles of participants in an HIV prevention intervention ('active recruitment') to their chat room peers who did not participate in the intervention ('passive recruitment'). Data were collected using an online brief risk assessment from MSM who were recruited within Internet chat rooms. Mean age was 30 years. Half self-identified as Black or African American, 29% as White and 64% as gay. Compared with participants, non-participants were more likely to report: spending higher mean number of hours in online chat rooms; using condoms inconsistently during anal intercourse with a man met online during the past 3 months; having had an sexually transmitted disease; being HIV seropositive; using methamphetamines during the past 30 days and using drugs to enhance sexual satisfaction during the past 30 days. Although risk among MSM who use chat rooms remains high, those at greater risk may be those who are less likely to engage in online HIV prevention interventions. (Rhodes et al. 2008)
  
- ▶In 2004, a team of registered nurses from the British Columbia Centre for Disease Control's Outreach/Street Nursing Program developed an online sexual health information and referral service on a Canadian website designed for men who have sex with men and are seeking social or sexual interaction. Over the next 18 months, two outreach nurses delivered care via the website for a total of six hours per week. The results of this pilot project indicated that providing online STI/HIV education is an effective tool for reaching an at-risk population. (Sandstra et al. 2008)

*See also: Arumainayagam et al. 2009, STI Screening/Hepatitis Screening*

**Sources:**

Bowen AM, Williams ML, Daniel CM, et al. (2008) Internet based HIV prevention research targeting rural MSM: Feasibility, acceptability, and preliminary efficacy. *Journal of Behavioral Medicine*.;31 (6):463-477.

Hospers, H.J., Debets, W., Ross, M.W., and Kok, G. (1999). Evaluation of an HIV prevention Intervention for Men Who Have Sex With Men at Cruising Areas in the Netherlands. *AIDS and Behavior*, 3: 359-366.

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.

Rhodes SD, Hergenrather KC, Yee LJ, Ramsey B. (2008) Comparing MSM in the southeastern United States who participated in an HIV prevention chat room-based outreach intervention and those who did not: how different are the baseline HIV-risk profiles? *Health Education Research*. 23(1):180-90. Epub 2007 Apr 5.

Sandstra IL, Gold F, Jones E, Harris P, Taylor D. (2008) Cyber outreach: ST/HIV education online. *Canadian Nurse*. 104(6):24-8, 30-1.

**Literature specific to Heterosexual priority populations:**

► A Mobile Access Project (MAP) to provide emergency medical help, peer counseling, condoms and clean needles, resource information and referral, and a place of respite and safety was initiated for sex trade workers in Vancouver, British Columbia, Canada. Over 90% of the 100 MAP clients reported that the van made them feel safer on the street. Sixteen percent of surveyed MAP clients recalled a specific incident in which the van's presence protected them from a physical assault and 10% recalled an incident when its presence had prevented a sexual assault. Distribution of needles and condoms has increased steadily since the implementation of MAP. Eighty percent of women surveyed at a drop-in center in the Downtown Eastside had received services from MAP. The peer-led Mobile Access Project has emerged as a viable harm reduction strategy for serving the immediate health and trauma-related needs of women engaged in street-level sex work. (Janssen et al. 2009)

**Source:**

Janssen PA, Gibson K, Bowen R, et al. (2009) Peer support using a mobile access van promotes safety and harm reduction strategies among sex trade workers in Vancouver's downtown eastside. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*. 86(5):804-809.

**Literature specific to IDU priority populations:**

► 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 Drug Users: A Review of Published Outcome Data. *Public Health Reports*, 113(Suppl 1):19-30.

Dickson-Gomez JB, Knowlton A, Latkin C. (2004, June) "Values and Identity: The Meaning of Work for Injection Drug Users Involved in Volunteer HIV Prevention Outreach." *Substance Use and Misuse*, 39(8):1259-86.

Latkin, C.A. (1998) Outreach in Natural Settings: The Use of Peer Leaders for HIV Prevention Among Injecting Drug Users' Networks. *Public Health Reports*, 113(Suppl 1): 151-9.

Neaigua, A., Sufian, M. et al. (1990) Effects of Outreach Intervention on Risk Reduction Among IDU. *AIDS Education and Prevention*, 2(4): 253-271.

***Literature specific to Perinatal/Pediatric priority populations:***

► 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).

►A qualitative study investigated the process of engagement in HIV medical care from the perspective of people living with HIV/AIDS (PLWHA). In-depth interviews were conducted with 76 participants in six cities. All participants were considered underserved because of histories of substance use, mental illness, incarceration, homelessness, or cultural barriers to the traditional health care system. Data analysis revealed that participants cycled in and out of care, a process that was influenced by (1) their level of acceptance of being diagnosed with HIV, (2) their ability to cope with the substance use, mental illness, and stigma, (3) their health care provider relationships, (4) the presence of external support systems, and (5) their ability to overcome practical barriers to care. The findings suggest that outreach programs can interrupt this cyclical process and foster sustained, regular HIV care for underserved PLWHA by conducting client-centered risk assessments to identify and reduce sources of instability and improve the quality of provider relationships; implementing strategies that promote healthy practices; creating a network of support services in the community; and supporting adherence through frequent follow-ups for medication and appointment keeping. (Rajabiun, et al. 2007)

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.

Rajabiun S, Mallinson RK, McCoy K, et al. (2007) “Getting me back on track”: The role of outreach interventions in engaging and retaining people living with HIV/AIDS in medical care. *AIDS Patient Care and STDs*. 21 (Suppl. 1):S20-S29.

### **Partner Counseling/ Education, including Sero- discordant Couples**

**Definition** Couple’s HIV/AIDS Counseling/ Education provides HIV health education/risk reduction and testing information counseling to partners together either in a group or individual format. Prevention counseling for serodiscordant couples has demonstrated

effectiveness in reducing the likelihood of transmission by supporting adoption of risk reducing behaviors, including consistent use of condoms, by enhancing communication skills and addressing issues related to intimacy.

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

#### **Literature relevant to the above priority population:**

►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).

**Sources:**

El-Bassel, N., Witte, S.S., Gilbert, L., et al. (2005) Long-term Effects of an HIV/STI Sexual Risk Reduction Intervention for Heterosexual Couples. *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

### **Sexual Harm Reduction Education**

**Definition** Harm reduction is a perspective and a set of practical strategies to reduce the negative consequences of behaviors by incorporating a spectrum of strategies from abstinence (sexual or drug-using) to safer use

of drugs and safer sexual practices. Harm reduction has been relegated by some to the realm of drug use, but it also applies to sexual behavior. A sexual harm reduction approach supports individuals in being sexual in ways which reduce the risk of contracting HIV, hepatitis B and C and other blood-borne and sexually transmitted infections.

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

**Literature relevant to the above priority populations:**

► Results from a 10-year prospective analysis of the ALIVE study and an analysis of the REACH studies spanning a 7-year period indicate that sexual risk factors for HIV infection are important in both female and male IDUs. These findings underscore the need for HIV interventions among drug users that incorporate sexual risk reduction. Based on the existing literature, a narrow focus on injection-related risks is an ineffective prevention strategy. Interventions that target specific subgroups of high-risk IDUs, such as men who have sex with men and inject drugs (MSM-IDUs), sex worker-IDUs and HIV-infected IDUs, deserve special attention. (Strathdee et al. 2003)

**Source:**

Strathdee SA, Sherman SG. (2003) The role of sexual transmission of HIV infection among injection and non-injection drug users. *Journal of Urban Health*. 80(4 Suppl 3):iii7-14.

### **Social Marketing**

**Definition** Social marketing is the use of marketing

principles to influence human behavior in order to improve health or benefit society, in this case prevent HIV transmission.

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

**Literature relevant to the above priority populations:**

► A study examined the reach and impact of a social marketing intervention to reduce HIV risk among heterosexually identified (HI) Latino men who have sex with men and women (MSMW). On average, 85.9% of the heterosexual respondents and 86.8% of the HI MSMW subsample reported exposure to the campaign. Responses to the campaign included having made an appointment for a male health exam that included HIV testing and using condoms. Campaign exposure was significantly associated with HIV testing behavior and intentions and with knowledge of where to get tested. The campaign reached its underserved target audience and stimulated preventive behaviors. Social marketing represents a promising approach for HIV prevention among HI Latinos, in general, and HI Latino MSMW, in particular. (Martínez-Donate et al. 2009)

► In 2002, the San Francisco Department of Public Health launched a social marketing campaign to increase testing for syphilis, and awareness and knowledge about syphilis among gay and bisexual men. Evaluation results strongly suggested that the Healthy Penis 2002 social marketing campaign was effective in increasing syphilis awareness, increasing knowledge around syphilis, and augmenting syphilis testing in the San Francisco gay and bisexual community. The high recall and recognition of Healthy Penis indicated it had a strong brand presence in the gay and bisexual community that presents an opportunity to incorporate or shift to other health messages as public health needs change for the target audience. For instance, future campaigns with the Healthy Penis brand can focus on health behavior messages related to herpes simplex virus, HIV, hepatitis C, or human papillomavirus. (Montoya, et.al., 2005)

A project examines HIV prevention media campaigns targeting African American gay and bisexual men through a content analysis and a cultural-critical approach. The researchers found that, among 40 social marketing campaigns, the primary tactics were educational and fear-based to promote HIV-related messaging to African American gay and bisexual men. (Speildenner, et.al., 2010)

***Sources:***

Martínez-Donate AP, Zellner JA, Fernández-Cerdeño A, Sañudo F, Hovell MF, Sipan CL, Engelberg M, Ji M. (2009) Hombres Sanos: exposure and response to a social marketing HIV prevention campaign targeting heterosexually identified Latino men who have sex with men and women. *AIDS Education and Prevention*. 21(5 Suppl):124-36.

Montoya, J. A., Kent, C. K., Rotblatt, H., McCright, J., Kerndt, P. R., & Klausner, J. D. (2005). Social marketing campaign significantly associated with increases in syphilis testing among gay and bisexual men in San Francisco. *Sexually Transmitted Diseases*, 32, 395–399.

Spieldenner, A. R., Castro, C. F. (2010). "Education and Fear: Black and Gay in the Public Sphere of HIV Prevention" *Communication Education* 59.3 July 6, 2010  
<http://www.informaworld.com/10.1080/03634521003606202>

### **Sterile Syringe Access**

**Definition** Access to sterile syringes can be accomplished through such services as syringe exchange programs or the legal sale of syringes in programs such as NYS's Expanded Syringe Access Program (ESAP).

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

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

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

Also see *Expanded Syringe Access Program (page 13)* and *Syringe Exchange (page 47)*

#### **Literature relevant to each of the above priority populations:**

► Researchers targeted Harlem, NY (using the South Bronx for comparison), and disseminated informational material at community forums, pharmacist training programs, and counseling or outreach programs for IDUs. They compared cross-sectional samples in 3 target populations (pre-and post-intervention): community members (attitudes and opinions), pharmacists (opinions and practices), and IDUs (risk behaviors). Among community members and pharmacists, negative opinions of IDU syringe sales decreased in Harlem whereas there was either no change or an increase in negative opinions in the comparison community. Although pharmacy use by IDUs (N = 728) increased in both communities, pharmacy use increased significantly among black IDUs in Harlem, but not in the comparison community; syringe reuse significantly decreased in Harlem, but not in the comparison community. Targeting the individual and the social environment through a multilevel community-based intervention reduced high-risk behavior, particularly among black IDUs. (Fuller et al. 2007)

Fifty four percent of subjects in a recent study among IDUs in NYC reported receiving fewer syringes than their number of injections per month. This 'syringe gap' was the focus of the study in which 500 NYC IDUs who participate in SEPs were surveyed to determine whether program syringe coverage was adequate to support safer injecting practices. Inadequate syringe coverage was more frequently reported by younger and homeless injectors, and by those who reported public injecting in the past month (49% reported public injecting in the past month). (Heller, 2009)

**Sources:**

Fuller CM, Galea S, Caceres W, et al. (2007) Multilevel community-based intervention to increase access to sterile syringes among injection drug users through pharmacy sales in New York City. *American Journal of Public Health*. 97(1):117-124.

Heller, DI, Paone, D, Siegler, A, Karpati, A (2009) The syringe gap: an assessment of sterile syringe need and acquisition among syringe exchange program participants in New York City. *Harm Reduction Journal*, 6:1.

### STI Screening, Hepatitis Screening

**Definition** The presence of an STI other than HIV or Hepatitis is an indicator of risk for HIV infection because STIs and HIV are primarily transmitted in the same way (via sex). Perhaps more importantly, certain STIs, especially

ulcerative STIs, such as syphilis and herpes, may increase a person's biological risk for acquiring or transmitting HIV for several reasons, including that ulcers may serve as a point of exit or entry for HIV. STI and Hepatitis screening and treatment offer key opportunities for integrating HIV prevention activities because those at risk for STIs may also be at risk for HIV.

**Priority intervention for:**

MSM, especially persons of color

- ✓HIV Status Unknown
- ✓HIV Negative/ Presumed Negative

Heterosexual, especially persons of color

- ✓HIV Status Unknown
- ✓HIV Negative/ Presumed Negative

IDU, especially persons of color

- ✓HIV Status Unknown
- ✓HIV Negative/ Presumed Negative

Perinatal/Pediatric, especially persons of color

- ✓HIV Status Unknown
- ✓HIV Negative/ Presumed Negative

**Literature relevant to each of the above priority populations:**

►Two brief interventions to promote rapid HIV testing among STD clinic patients who initially declined testing were evaluated. The primary outcome was whether patients agreed to be tested for HIV. The evaluations concluded that brief interventions can increase rapid HIV testing acceptance among patients who are reluctant to be tested and that counseling guided by behavioral science theory is more effective than a well-designed information-based intervention. (Carey, et al 2008)

Carey MP, Coury-Doniger P, Senn TE, Venable PA, Urban MA. (2008) Improving HIV rapid testing rates among STD clinic patients: a randomized controlled trial. *Health Psychology*. 27(6):833-8.

**Literature specific to MSMs:**

► An assessment of the need to increase access to an outreach venue, the local sauna in Walsall, UK, frequented only by men who have sex with men, was undertaken. A case-notes review of the clients who attended the monthly outreach sessions at the sauna in the year 2007 was performed. Among the 287 men seen at the 12 outreach sessions, 37% had a sexually transmitted infection (STI). Of those tested positive, 88% had never had a previous STI. Twenty-one men had syphilis and a further six tested positive for HIV. Hepatitis B vaccination was completed for 41% of the clients seen. Those who tested positive for an STI said they would not have attended a conventional setting but accepted screening at the sauna. This confirmed the need to increase access at this outreach venue, and further funding has not been provided to have outreach sessions twice a month. (Arumainayagam et al. 2009)

► A study was done to describe trends in the occurrence and frequency of HIV testing among men who have sex with men (MSM) receiving care in four US sexually transmitted disease (STD) clinics and to define factors associated with HIV testing frequency and positivity concluded in MSM seen at these four STD clinics, the percentage of never previously HIV tested is decreasing and MSM are testing more frequently. (Helms et al. 2009)

► Sex practices that risk the transmission of STI were common within a high-risk sample, whereas awareness of risk and the need for testing was high but not universal. Frank discussion with doctors of patients' group sex behavior also enhanced decisions about adequate testing. Gay men in group sex networks are an appropriate priority for sexual health screening. (Prestage et al 2009)

**Sources:**

Arumainayagam J, Grimshaw R, Acharya S, et al. (2009) Value of targeting at-risk populations at outreach venues: findings from a local sauna. *International Journal of STD and AIDS*. 20(9):642-643.

Helms DJ, Weinstock HS, Mahle KC, Bernstein KT, Furness BW, Kent CK, Rietmeijer CA, Shahkolahi AM, Hughes JP, Golden MR. (2009) HIV testing frequency among men who have sex with men attending sexually transmitted disease clinics: implications for HIV prevention and surveillance. *Journal of the Acquired Immune Deficiency Syndromes* 1;50(3):320-6.

Prestage GP, Hudson J, Jin F, et al. (2009) Testing for HIV and sexually transmissible infections within a mainly online sample of gay men who engage in group sex. *Sexually Transmitted Infections*. 85(1):70-74

**Literature Specific to Heterosexuals**

► Diagnostic tests are important for screening and STI case management, as most infected individuals have mild or no symptoms and untreated STIs can lead to serious consequences such

as chronic pelvic pain, pelvic inflammatory disease, ectopic pregnancy, tubal infertility, cervical cancer and many adverse outcomes of pregnancy. Quality-assured STI testing is a critical component of an effective control program, as early identification and treatment of those who are infected can avert negative consequences and prevent onward transmission.

**Source:**

Peeling, R.W. (2006) Testing for sexually transmitted infections: a brave new world? *Sexually Transmitted Infections*. 82(6): 425–430.

**Literature specific to IDU populations:**

► An evaluation conducted of the integration of prevention services in an alternative sentencing drug rehabilitation program (alternative to incarceration) in San Diego CA concluded that alternative sentencing drug rehabilitation programs provide a venue to efficiently deliver integrated hepatitis and other prevention services. Considering the vast number of high-risk persons in drug rehabilitation, probation, parole, and incarcerated individual release programs, the authors posit that an opportunity exists to greatly expand hepatitis services. (Gunn et al. 2005)

► In 2000, the New York City Department of Health and Mental Hygiene integrated viral hepatitis services (vaccine and screening) into a publicly funded STD clinic. They evaluated integrated service delivery to high-risk IDUs at this clinic. The evaluation concluded that integrated hepatitis services appeared to attract IDUs to this STD clinic, where many also benefited from STD/HIV exams, testing, treatment, and referrals they may not have received otherwise. (Hennessy et al. 2007)

► The New York State Viral Hepatitis Integration Project demonstrated that syringe exchange programs (SEP) are ideal settings to reach high-risk IDUs. Eight hundred eight SEP clients accepted at least one hepatitis service, 692 clients attended at least one hepatitis related support group, and 59,668 fact sheets and brochures were distributed during the three year project. In addition, 832 doses of hepatitis A and 957 doses of hepatitis B vaccine were also provided during the project period. (NYSDOH AIDS Institute - Office of Program Evaluation, 2010).

**Sources:**

Gunn RA, Lee MA, Callahan DB, Gonzales P, Murray PJ, Margolis HS. (2005) Integrating hepatitis, STD, and HIV services into a drug rehabilitation program. *American Journal of Preventive Medicine* Jul. 29(1):27-33.

Hennessy RR, Weisfuse IB, Schlanger K. (2007) Does integrating viral hepatitis services into a public STD clinic attract injection drug users for care? *Public Health Report*. 122 Suppl 2:31-5.

NYSDOH AIDS Institute - Office of Program Evaluation (2010) Unpublished evaluation of the NYS Viral Hepatitis Integration Project.

**Literature specific to Perinatal/Pediatric populations:**

► Two million of the 15 million (13.3%) new cases of sexually transmitted infections (STIs) among persons 15 to 49 years old occur in pregnant women. Access to care and a provider's ability to assess

risk, screen, and treat STIs are critical factors in preventing adverse pregnancy outcomes. Significant variations in provider STI screening and treatment practices exist despite recommended guidelines. This article reviews issues related to screening and management of common STIs during pregnancy, with emphasis on the new 2006 US Centers for Disease Control and Prevention Sexually Transmitted Diseases Treatment Guidelines and recently revised recommendations for HIV testing of pregnant women in healthcare settings.

**Source:**

Johnson HL, Erbelding EJ, Ghanem KG. Sexually transmitted infections during pregnancy. (2007) *Current Infectious Disease Report*. 9(2):125-33.

## Syringe Exchange

**Definition** 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  
 ✓HIV Status Unknown  
 ✓HIV Negative/ Presumed Negative

**Literature relevant to the above priority populations:**

▶ 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.

Broner R, Kidorf M, King V, et al. (1998) Drug Abuse Treatment Success Among Needle Exchange Participants. *Public Health Report*, 113(10): 129-39.

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.

### **Treatment Adherence Services**

**Definition** Provision of counseling or special programs to ensure readiness for and adherence to complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.

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

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

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

**Literature relevant to the above priority populations:**

►Data from participants enrolled in Project MOTIV8, a randomized controlled trial to test the efficacy of novel behavioral adherence interventions, were analyzed to explore the potential impact of Modified directly observed therapy (mDOT) on health behaviors other than adherence. Participants were recruited from local HIV clinics from 2004-2008. Overall, participants reported a high level of satisfaction with the mDOT intervention. Qualitative data revealed that mDOT had a positive impact on participants' adherence to non-antiretroviral medications as well as their involvement and communication with health care providers. In addition, participants reported that the daily mDOT visits had indirect effects on their daily functioning, including improvements in their daily living activities (e.g., earlier awakenings, getting dressed, and cleaning their homes) and an increased level of community involvement. (Bradley-Ewing, et.al. 2008)

►An effectiveness study examined a telephonic nursing program to translate well-validated cognitive-behavioral and motivational interviewing adherence counseling into routine clinical care. It concluded that telephone counseling was associated with a relatively high percentage of participants reaching target antiretroviral therapy adherence levels and may be an effective method to disseminate psychologically based counseling into a broad range of care settings. (Cook, et al. 2009)

►Two hundred forty-nine patients who were referred for adherence services had baseline and follow-up data available for analysis. Participants who maintained an unchanged antiretroviral regimen experienced a significant increase in self-reported adherence and likelihood of reporting more than 95% adherence by 7-day recall. Improvements in plasma HIV viremia log copies were also demonstrated. The study demonstrated that the development of a multifaceted clinical program can have significant impact on medication adherence and viral burden in HIV infection. (Dieckhaus, et. al., 2007)

***Sources:***

Bradley-Ewing A, Thomson D, Pinkston M, et al. (2008) A qualitative examination of the indirect effects of modified directly observed therapy on health behaviors other than adherence. *AIDS Patient Care and STDs*. 22(8):663-675.

Cook PF, McCabe MM, Emiliozzi S, et al. (2009) Telephone nurse counseling improves HIV medication adherence: An effectiveness study. *Journal of the Association of Nurses in AIDS Care*. 20(4):316-325.

Dieckhaus KD, Odesina V. (2007) Outcomes of a multifaceted medication adherence intervention for HIV-positive patients. *AIDS Patient Care and STDs*. 21(2):81-91.

**Priority intervention for: Literature specific to Perinatal/Pediatric populations:**

►A study examined antiretroviral treatment use and adherence in HIV-infected pregnant and postpartum women participating in the Women and Infants Transmission Study (WITS-IV) in the US. Analyses indicated that medication adherence is more likely during pregnancy than postpartum in HIV-infected women, perhaps provoked by motivation to reduce vertical transmission and/or intensive ante partum surveillance. Further investigation is warranted to clarify factors implicated in women's decision-making process regarding ART medication adherence. (Mellins et al. 2008)

**Source:**

Mellins CA, Chu C, Malee K, et al. (2008) Adherence to antiretroviral treatment among pregnant and postpartum HIV-infected women. *AIDS Care*. 20(8):958-968.

# 7

## **Considerations to Take into Account when Implementing Priority Interventions**

**Introduction** This Chapter will provide useful guidance as to issues which must be taken into account when designing programs for specific target populations utilizing the recommended interventions as detailed in Chapter 6.

The PPG's Racial/Ethnic Committee updated overarching considerations to take into account when implementing all interventions for:

- ▶ African American/Black Communities
- ▶ Latino/Hispanic Communities
- ▶ Asian and Pacific Islander Communities
- ▶ Native American Communities

Overarching considerations to inform implementation of effective HIV prevention interventions when implementing all interventions were developed for the following subpopulations:

- ▶ Criminal Justice Populations
- ▶ Gay Men/MSM
- ▶ Immigrant/Migrant Populations
- ▶ Over 50 Populations
- ▶ Substance Using Populations
- ▶ Transgender Populations
- ▶ Women
- ▶ Young People

Finally, specific subpopulation-based considerations for each of the PPG's 2010-2015 priority population/intervention pairs (as detailed in Chapter 6) were developed as well for the following subpopulations:

- ▶ People Living with HIV/AIDS
- ▶ Criminal Justice Populations
- ▶ Gay Men/MSM
- ▶ Immigrant/Migrant Populations
- ▶ Substance Using Populations
- ▶ Women

The sections in this chapter covering these issues are:

- **Overarching Considerations to Inform Implementation of Effective HIV Prevention Interventions in Communities of Color** (pages 7-13)
  - African Americans/Blacks (pages 2-5)
  - Latinos/Hispanics (pages 5-7)

- Asian and Pacific Islanders (pages 7-10)
- Native Americans (pages 10-13)

- **Overarching Considerations to Inform Implementation of Effective HIV Prevention Interventions in specific Subpopulations**
  - Criminal Justice Settings (page 14-15)
  - Gay Men/MSM (pages 15-17)
  - Immigrants and Migrants (pages 17-18)
  - Over 50 Populations (pages 18-19)
  - Transgender Individuals (pages 19-21)
  - Women (page 21)
  - Young People (pages 21-22)
- **Considerations to Inform Implementation of the 2010-2015 HIV Prevention Priority Population/Intervention Pairings in Specific Subpopulations** (pages 22-60)

**Overarching Considerations to Inform Implementation of Effective HIV Prevention Interventions in Communities of Color** As was stated in Chapter 5, epidemiologic data confirm the fact that the HIV/AIDS epidemic in NYS continues to disproportionately impact communities of color. Since the PPG attached the phrase “especially persons of color” to each prioritized population, considerations to take into account when implementing priority interventions in these communities are overarching and should be considered for all priority interventions.

**Considerations to take into account when 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’ perception of governmental programs and traditional health care institutions. Be mindful of the impact of social, economic factors of oppression and historical events that have contributed to “mistrust” of governmental program and traditional health care institutions.
- ✓ Become familiar with current relevant policy and social issues such as the Health Care Reform Act and economic conditions that impact access to medical and health care and disease infection which disproportionately impacts communities of color.
- ✓ 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. Be mindful of cultural beliefs regarding respectful forms of communication (e.g., touching, eye contact, tone of voice, etc.)

- ✓ 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.
- ✓ Become familiar with the implications of non-traditional family structure that may impact on service delivery and the way the intervention can be delivered (e.g. generation gap varying opinions on sexual health). Be mindful of the lack of discussions around sexual health in communities of color and lack of understanding by medical providers regarding cultural beliefs around sexual health which can be hindered by the provider's cultural beliefs.
- ✓ Access culturally relevant information through web sites for resources, such as Urban League ([www.nul.org](http://www.nul.org)), QuiltEthnic ([www.quiltethnic.com](http://www.quiltethnic.com)), Black AIDS Institute ([www.blackaids.org](http://www.blackaids.org)) and effective interventions for African Americans/Blacks ([www.effectiveinterventions.org](http://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:** These "Considerations" 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 in 2005: 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).

These considerations were revised by the NYS HIV PPG's Racial/Ethnic Committee in May 2010.

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***Considerations to take into account when working with Latino/Hispanic Communities:***

- ✓ Become familiar with the history of Latinos/Hispanics and how historical events have played a role in shaping Latinos'/Hispanics' perception of governmental programs and traditional health care institutions. Be mindful of the impact of social, economic factors of oppression and historical events that have contributed to "mistrust" of governmental program and traditional health care institutions.
- ✓ 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 appropriate literacy levels for the targeted population.
- ✓ 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. 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).

- ✓ 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.

**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:** These considerations 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 these considerations in 2005: Ronald Gonzalez (Alianza Latina, Buffalo, NY) and Janet Foster (AIDS Institute, New York State Department of Health, Albany, NY).

These considerations were revised by the NYS HIV PPG's Racial/Ethnic Committee in May 2010.

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Francisco.

***Considerations to take into account when 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. Be mindful of the impact of social, economic factors of oppression and historical events that have contributed to “mistrust” of governmental program and traditional health care institutions.
- ✓ 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 miscommunication 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. . Be mindful of cultural beliefs regarding respectful forms of communication (e.g., touching, eye contact, tone of voice, etc.)
- ✓ 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.
- ✓ Recognize that among new immigrants there may be little or no existing support network. This situation may compel an individual to prioritize work over health services.
- ✓ 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. In some cultures, married women may not receive information without consent from their husband.
- ✓ 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. Be familiar with non-Western medical practices of diverse immigrant groups.
- ✓ 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 Transgender 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:** These "Considerations" 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 in 2005: Iline Chung-Eddie (Project Hospitality, Staten Island, NY) and Janet Foster (AIDS Institute, New York State Department of Health, Albany, NY).

These considerations were revised by the NYS HIV PPG's Racial/Ethnic Committee in May 2010.

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***Considerations to take into account when 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. Be mindful of the impact of social, economic factors of oppression and historical events that have contributed to “mistrust” of governmental program and traditional health care institutions.
- ✓ 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.
- ✓ 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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**Acknowledgments:** These “Considerations” are based upon experience working collaboratively with members of Native American communities in New York State. This list was prepared with benefit of guidance and insights provided by Native Americans and Native American service providers.

The following individuals reviewed and commented on this checklist in 2005: Cissy Elm (Onondaga, Snipe Clan), Ken Dunning (Onondaga, Beaver Clan), Pete Hill (Cayuga, Heron Clan), Shirley Farmer-Tyner (Oneida), Barbara Johnson (Onondaga, Snipe Clan) and Norine Borkowski, Native American Community Services.

These considerations were revised by the NYS HIV PPG’s Racial/Ethnic Committee in May 2010.

**Suggested Reading:**

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**Overarching Population-Specific 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. Many of the PPG’s Committees developed a list of overarching considerations to inform providers whenever they are implementing interventions targeted to their population.

***Overarching considerations in Criminal Justice settings:***

-Providers should understand the unique culture of corrections, including the Department of Correctional Services, Division of Parole, Division of Probation, County and City Jails, Juvenile Detention Centers and non-secure Youth Facilities.

-It is important to build good working relationships with correctional facilities to maximize access to incarcerated individuals.

-Include MSM issues in all interventions provided in correctional settings since incarcerated individuals may not be inclined to identify as MSM while incarcerated.

-Access to incarcerated individuals and facility program time limitations must be taken into consideration within criminal justice settings:

- DOCS programming: tailor group sessions to fit programming time frames;
- Facility schedule: Incarcerated individuals’ only free time may be in the evening.

-Correctional facility rules may not allow the distribution of safer sex materials during interventions, so be sure to provide verbal or written information about condoms, dental dams, lubricants, etc. Provide information on where to obtain supplies on the street.

-Many incarcerated individuals may have mental health issues which may impact their participation in services.

-When providing interventions in correctional settings, all materials to be used during the intervention must be approved for clearance by the individual correctional facility.

-Upon release / parole: the time the incarcerated individual has been incarcerated should be taken into consideration when planning linkages to care. Length of incarceration may play a significant role in whether the incarcerated individual / releasee is responsive to services, and/or whether interventions are successful or not.

-HIV infected individuals may not self identify in a correctional setting:

- Providers need to be sensitive to disclosure issues;
- Disclosure (lack of) may pose barriers / limitations for group interventions, support groups & other services.

-Issues of stigma for HIV infected individuals may be more intense in a correctional setting.

-Be sensitive to the fact that incarcerated individuals may have a lack of trust towards medical staff in corrections.

-There should be sensitivity towards issues of trauma.

-MSM may not self identify in a correctional setting:

- Providers need to be sensitive to disclosure issues;
- Disclosure (lack of) may pose barriers / limitations for support groups & other services.

-Be aware that clients may be engaged in facility treatment programs, like Comprehensive Alcohol and Substance Abuse Treatment (CASAT), Alcohol and Substance Abuse Treatment (ASAT) or Residential Substance Abuse Treatment (RSAT) in State correctional facilities which may contain conflicting messages regarding harm reduction and syringe exchange. DOCS' treatment programs are based on a cognitive therapy model and a relapse prevention model that encourages abstinence from drugs.

-Offer education for incarcerated individuals and parolees on legal implications and consequences on syringe exchange and ESAP programs.

-Some IDUs may not self-identify while incarcerated, especially in a group setting: Include information and resources regarding where to access syringe exchange, ESAP, etc. on the streets.

-Include Opioid overdose prevention and medication assisted treatment.

-Issues of stigma for HIV infected individuals may be more intense in a correctional setting.

-Be sensitive to the fact that incarcerated individuals may have a lack of trust towards medical staff in corrections.

-Syringe access programs and ESAP are not available during incarceration, so ensure that messages about harm reduction services in the community, like syringe exchange programs and ESAP, are incorporated in interventions provided in facilities.

### ***Overarching considerations for Gay Men/MSM***

-Epidemiological data confirms the fact that HIV/AIDS epidemic in NYS continues to disproportionately impact MSM communities of color, especially AA/Black Men. This needs to be considered when implementing priority interventions for this population.

-Be mindful of how stigma, historical events, homophobia and social and economic factors shape the perceptions of AA/Black MSM.

-Active involvement of AA/Black leaders in HIV prevention involving MSM has been severely lacking and has been ineffective due to inadequate mobilization, silent posturing, ignorance and homophobic reaction to the MSM population. We should be fostering real dialogue in communities of color to address negative perceptions of homosexuality.

-Interventions targeted for the MSM population are not relevant for MSM who are non-identified and who identify themselves as heterosexual.

-There is a definite need to identify and include MSM who self-report as “straight” but who have sex with men or are bi-sexual who are unconnected but would benefit by intervention messages and healthier behaviors.

-Consider an enhanced and renewed regional awareness and understanding of MSM populations. There are populations that are “hard to reach,” largely because they are not identified, or resist MSM identification due to stigma and other cultural issues. While this does mimic considerations of AA men, these considerations look at state level issues for the entire MSM community.

-The phenomenon of “safe sex fatigue” is an overarching consideration that requires revisiting prevention interventions and reconciling gay, MSM, as well as heterosexual populations to the existence of this reality.

-Recognize “health literacy” as significantly impacting the efficacy of interventions developed for the MSM population. Intervention design, implementation (individual) and environment are affected by health literacy components.

-Consider how previous sexual trauma may impact group intervention outcomes and impede MSM willingness to handle disclosure issues and may further stigmatize younger MSM (dual stigma).

-Impact of the Swiss report and how it has increased sexual risk-taking behaviors in MSM populations. There is the belief that an undetectable viral load translates into non-transmission of the HIV virus. Evidence shows that successful suppression of viral load is contingent upon continued ARV adherence and herein transmission is less likely.

-Consider messages that may be conflictual in faith-based provider intervention efforts for MSM populations. Greater communications are appropriate in achieving partnerships with faith-based organizations, their leaders and MSM communities of color.

-Consider the impact of “iatrogenic illness” (physician-induced/ health-provider-induced) on older MSM population where multiple co-morbidities prevail and possible drug interactions stem

from ARVs, prescriptions for diabetes mellitus (DM), high blood pressure( HBP), cardiovascular, mental disorders, over the counter medications( OTC) and supplements. This may serve to impede effective and continued primary care, treatment adherence and support services.

-Consider the impact of sero-sorting behaviors among Gay Men/MSM( defined by CDC as HIV positive men who have sex with other positive men and the same for negative, or strategic positioning, wherein the HIV positive partners are the receptive partner and the HIV negative partners are the insertive partners and this is a mechanism to try to reduce risks) especially without proper harm-reduction education programming. Many providers do not understand the practice.

-Consider the impact of erectile dysfunction drugs when combined with ARVs, party drugs and amyl nitrates. The consequent interventions may compromise safe sex behaviors of MSM.

-Providers need to enhance comfort-levels when addressing and talking about “sex” with MSM populations. Too many intervention opportunities are missed and the interaction would be the best intervention to increase safe sex practices and reduce high-risk behaviors in MSM.

-Because interventions tend to be brief and time-limited, consideration of adding a peer-mentoring component would expand interventions, prolong the MSM behavioral outcomes and enhance statistical significance of findings. It would also be cost-effective.

***Overarching considerations for Immigrants and Migrants:***

-Child care and parenting issues need to be addressed

-Materials and services should be gender-specific

-Provide transportation, nutrition and other types of supportive services/assistance whenever possible

-Linguistically and culturally competent materials, staff, translation services, etc. are crucial

-Services need to be available to the community (services going to where the community is located/where they live/where they work). I.e. mobile services, services available during the late evening and early morning hours

-Legal requirements should be kept to a minimum regardless of immigration status to ensure access to services.

-Clearly communicate that services are available regardless of immigration status

- Keep providers and community at large abreast and informed regarding changes to immigrations laws (i.e. lifting of the HIV Ban)
- Provide legal support with respect to immigration
- Outreach should begin with broad health focus and build trust before engaging in HIV prevention education.
- Preservation of confidentiality is paramount
- Ensure that staff who are providing services are reflective of the community who are seeking services
- Linkages to out of state services for immigrants and migrants are important to ensure continuity of care.

### ***Overarching considerations for Over 50 Populations***

- For some individuals over 50 there is a lack of mobility
- Some individuals over 50 are not aware of available HIV and other prevention-related services
- There is a general lack of knowledge about HIV and STDs in this population
- A lack of access to transportation and services is a barrier to access to services
- There may be a lack of training and resources for staff providing services to this population
- Capacity building for consumers/providers on clinical guidelines is needed
- Many in this population cannot comfortably discuss sexuality/sex (different generation)
- Many over 50 individuals are living below or at the poverty level which means that HIV prevention is not the most important issue they need to deal with
- Language barriers, including a lack of knowledge of sexual risk reduction terminology must be considered
- English is a second language for many which means that those individuals may be unable to read or understand English
- Stigma, including ageism, is an issue for this population
- Depression may be an issue with this population and must be considered

- Seniors suffer from many other chronic diseases which may mean that HIV may often not get diagnosed because health care providers think that symptoms are caused by something else
  - Educational materials are generally not tailored to seniors so they don't feel it pertains to them
  - Senior women who are postmenopausal suffer from lack of lubrication and can have tears and abrasions after having sex.
  - Use of performance enhancing drugs to increase sexual performance (Viagra, Cialis etc.) may put seniors at risk. When dispensing these drugs physicians do not discuss HIV/STD testing nor do they conduct it
  - There is a lack of social marketing campaigns targeting this population
  - Seniors and their caregivers do not perceive that they are at risk for HIV/STDs
  - Many over 50 individuals have little or no access to healthcare services
  - STD and HIV screenings should be incorporated into routine check-ups for individuals over 50
  - Many over 50 individuals believe that condoms are only for contraception. They don't use condoms because this is not an issue anymore for them.
  - Many providers do not consider that seniors are sexually active and therefore do not address HIV/STD issues with them.
  - Many in this age group are not computer literate or do not have access to computers
  - There is a lack of awareness that partners of HIV negative or presumed negative individuals still need screening for HIV and STDs
  - Many seniors caring for grandchildren and childcare issues for seniors may interfere with treatment
  - Peer education—seniors educating seniors —should occur more often. Individuals over 50 do not identify with young adults.
  - Age sensitivity is crucial—younger providers need to understand intergenerational issues
  - More women in the senior population are likely to have multiple partners
- Overarching considerations for Transgender Individuals***
- Isolation is a real issue for transgender individuals

- Stigma (transphobia) is an issue for this population
- There is a lack of accurate HIV/STD information within this population
- Many trans individuals are living below or at the poverty level
- There is a need for capacity building for consumers/providers on clinical guidelines
- There may be a lack of training and resources for staff providing services to this population
- Language barriers exist for this population, particularly a lack of general knowledge by providers about gender terminology
- Transgender individuals lack role models and lack visibility
- There is lack of family support for transgender individuals
- Issues of violence must always be considered when providing services to transgender individuals
- Injection use/use of hormones may mean sharing of needles. There is a lack of information about ESAP, dispensing and disposing of dirty needles and availability of sharps containers.
- In some cases individuals who are transgender may have multiple sex partners
- There are high rates of substance use, certain cancers and mental illness in this population
- Educational materials are not tailored to transgender individuals
- There is a lack of competency and sensitivity on the part of medical providers to transgender issues
- Transgender individuals mistrust the medical community and may resist obtaining medical care
- There is a need to identify competent, culturally sensitive providers and the need to establish a directory listing them
- There is a lack of information regarding gender identity/sexual orientation among peers and providers
- There is a lack of social marketing campaigns targeting this population

- There is a lack of community awareness of cultural norms and cultural values for this population
- This population experiences high rates of unemployment which creates economic pressure
- There is a lack of connection to the LGBT community
- Lack of perceived risks which is reinforced by not belonging to the group(s) initially identified at risk for HIV
- Lack of awareness that partners of HIV negative or presumed negative need screening for HIV and STDs
- Overdose prevention for transgender individuals must be available
- There is very little transgender-related information for and about youth

### ***Overarching considerations for Women***

-Women are seeking intimate and meaningful relationships with their partners. Strong needs, a desire for intimacy and partnership can correlate with risk taking behaviors. The need for love, wanting to belong must be addressed with strategies for women to get their needs met in healthier ways. We must also consider the impact that social media and Internet dating have on how women establish levels of intimacy and sexual relationships.

### ***Overarching Considerations for Effective Delivery of HIV Prevention Interventions with Young People***

**-Communication:** When delivering HIV Prevention Interventions to young people, taking into account the ways in which young people communicate with each other, and how adults communicate with young people assists will make an intervention more effective. Providers should stay abreast of technology trends, and identify ways to integrate these trends into their interventions. One of the most effective ways to stay ahead of the technology trends is to stay involved with your target population, young people, through focus groups or by inviting tech-savvy young people to offer staff technical assistance and training about the newest trends. Additionally, providers will want to consider the changing ways in which they require young people to self-identify in regards to race, ethnicity, sexual orientation and gender identity/expression. Respect for the self-identity of a young people is paramount to effectively engaging that young people in an intervention. A nonjudgmental approach is an essential best practice in working with you. Additionally, staff should be aware of how their non-verbal communication (body language, tone, facial expression) conveys a perspective or opinion on the information being provided by the young person.

**-Inclusion:** Providers will be more effective in delivering interventions to a target population of young people when they work to make their environment inclusive and welcoming of their target populations. This includes understanding and teaching staff about the differences between sexual behavior and sexual identity, and allowing a space for young people to self-identify at different places along the sexuality spectrum as they grow more familiar and comfortable with themselves. Further, integrating the concepts of universal risk reduction and comprehensive sexual health education into prevention activities helps to ensure that all young people feel included in the process.

**-Youth Empowerment:** Integrating the principals of Positive Youth Development<sup>1</sup> has been shown to make optimal sexual health interventions with young people more effective and more engaging for youth. Specifically, providers should identify meaningful roles for youth to be involved in planning, delivering and evaluating interventions and in promoting the rights of young people around confidentiality, disclosure and accessing healthcare. Agencies should also work to ensure that staffing of their youth programs reflects the target population of young people with regard to sexual orientation, gender identity, race, ethnicity and cultural background. For more information on youth empowerment and other topics related to the sexual health of young people, The New York State Department of Health has published, *Guiding Principals for Sexual Health Education for Young People: A Guide for Community Based Organizations*<sup>2</sup>, which organizes principles and resources in a well-referenced guide.

**-Accessibility:** Providers should work to ensure that the spaces where they deliver interventions are accessible to young people. Accessibility goes beyond the physical location of a program. It also includes creating a safe, supportive environment where the staff have cultural competency around issues of youth, culture, race, ethnicity, sexual orientation and gender identity/expression. While many interventions require specific amounts of time that a young person is engaged, it is expected that low-threshold engagement should also be available, with limited expectations for disclosure of identity to receive services.

**-Partnership/Coalition Building:** Providers should actively engage in formal and informal partnerships with the other aspects of their community that serve young people. These include schools, local health departments, groups comprised primarily of young people and other community organizations. Partnership builds the expertise of the provider in engaging young people and assists in identifying new young people to deliver the intervention to.

**-Competency:** Providers and staff should work to develop competency in the myriad issues that affect HIV prevention with young people in the areas described above. Providers should also stay abreast of current issues and trends among young people and consider how these issues and trends play out in their specific community. One of the most effective means of developing competency, is to directly involve young people in the provision of training and technical assistance. Organizations providing HIV testing with youth must consider implementing Youth

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<sup>1</sup> <http://www.actforyouth.net/?ydManual>

<sup>2</sup> <http://www.nyhealth.gov/publications/0206.pdf>

Development principles in their testing programs and should follow the Recommendations for Best Practices fro HIV Counseling & Testing With Youth.

**Priority Intervention-specific Population-Based Considerations** Some Committees felt that there were very specific considerations for particular priority interventions. Those considerations are detailed below, organized by Tier and Transmission Category.

**TIER I: HIV INFECTED, ESPECIALLY PERSONS OF COLOR**

**A. Transmission Category: MSM**

- ✓ **Linkage to: primary care (including medications and STD screening); treatment adherence services; psychosocial and mental health services and mental health counseling (including counseling related to health status disclosure); case management (including support group services, housing, peer support)**

**People Living with HIV/AIDS**

- Age, ethnicity, religious beliefs and customs, language and literacy must be considered particularly to those in rural communities.

- Integrate existing and new technologies to more effectively promote linkage among primary care, treatment adherence, mental health services and supportive services (e.g., support groups, peer services, housing and legal services), especially in rural communities.

- Messages about services should utilize the “language” of the specific communities. For example, expecting to capture the attention and interest of MSM who don’t identify as gay with gay-themed messages is unrealistic.

- Special consideration must be given in messaging services to young people who are HIV-positive.

- Special consideration should be given in developing prevention messages for HIV-infected individual over 50.

**Criminal Justice Populations:**

-Provide linkage to peer support/escort/mentor services that may encourage releasees to keep appointments.

-Consider providing LGBT sensitivity training for all staff.

- Transitional Planners should have access to MSM/LGBT resources, such as *Connections and the Job Search*. This is a resource published by the NY Public Library’s Correctional Services Program and distributed to many of the NYS DOCS facilities. A PDF version is available online at [www.nypl.org/help/community-outreach/correctional-services-program](http://www.nypl.org/help/community-outreach/correctional-services-program).

**Gay Men/MSM:**

-Ensure that referrals are made to appropriate clinical—and supportive services—providers. Key themes include services that are aware of the influence of homophobia; stress, substance use; (mis)assumptions about who sleeps with whom and what is done sexually; respectful language (including utilization of relationship status rather than marital status); creating a welcoming office environment (including what is visible in the waiting room). Openness to and acceptance of gay men as patients/clients should be visibly apparent. Cultural competence/humility is essential. Candid discussion regarding sexuality and sexual behavior needs to be fostered. Stigma remains a barrier.

-Transportation is a particularly challenging issue in linking individuals to care in rural and suburban regions of the state. It is also an issue in many urban settings as well. There may also be individuals seeking care outside of their geographic communities to safeguard anonymity/confidentiality. This may have ramifications for one's health insurance coverage.

-Identifying and linking to primary care and social services for MSM/gay youth may be particularly challenging, because so few providers have attained the competence necessary for dealing with this population. Some youth may be legally emancipated; others not. In the latter case, parental involvement may be a barrier to the appropriate delivery of confidential services. Disclosure is an issue with respect to HIV status as well as sexuality.

-Patient/client self-advocacy should always be supported to help bridge the clinical/services divide.

**Substance Using Populations:**

-All services need to be culturally based services to effectively serve all users regardless of gender

-Agencies need to be harm reduction focused

-Provide low threshold services e.g. proper cleaning of needles , food, employment

-Support services for active users

-Opportunities for active users

**Women:**

-MSM should be provided with an opportunity and safety to discuss sexual relations with women and importance of HIV/health status disclosure

-Health providers should be trained to discuss the needs of MSM as it pertains to relationships w/women

-MSM should be provided with an opportunity to safely discuss sexual relations with women and the importance of HIV/health status disclosure.

- ✓ **Interventions delivered to Individuals (IDI), Interventions delivered to Groups (IDG), Comprehensive Risk Counseling Services (CRCS) (including substance use treatment and substance use awareness, and risk reduction counseling)**

**People Living with HIV/AIDS**

- Need to identify “safe” environments in which to deliver interventions.

- “Safe” environments should have access to online social networking sites and utilize current and new video and digital technologies to promote health education.

- Need to be aware of the stigma surrounding IDU, especially those with co-existing mental health issues, when developing and delivering CRCS.

**Gay Men/MSM:**

-Bio-behavioral interventions, whose components may include antiretroviral therapy and treatment adherence, have roles in all of these intervention classes (IDIs, IDGs, CRCS). Viral load (and perhaps CD4s), including monitoring, impacts transmission.

-Sexual harm reduction needs to be central to our approach. We need to minimize harm in the context of informed sexual choices. The choice not to engage in condom-protected sex does not preclude worthwhile HIV prevention. There may be dissonant/discordant prevention messages. Unprotected sex may have consequences for STI transmission as well as for HIV evolution.

-Culturally and appropriate interventions and messaging for sub-populations of HIV-positive MSM need to be fostered. These sub-populations include youth, those over-50, those with disabilities, those whose language is other than English, those whose sexuality is self-defined in different ways, those with mental health issues, those using substances, the homeless, etc.

**Immigrant/Migrant Populations:**

-IDI's and GLI's should not be limited to business hours. They should be made available during after work/evening hours as well.

**Substance Using Populations:**

-Peer driven services to address: isolation, behavior, depression One on One peer counselor

**Women:**

-Curriculum/discussions should not shy away from the fact that MSM do engage in SW as part of their sexual behaviors

-Interventions should acknowledge that some MSM have sex with both men and women. Interventions can explore issues of disclosure of sexual practices to HIV status

-Interventions should explore how MSM sexual practices and/or behaviors impact female partners.

✓ **Outreach, including internet and in high-risk venues, condom and other barrier distribution, including access to dental dams and lube, access to sterile syringes**

### **People Living with HIV/AIDS**

- Consider peer delivered services and online services.

- Available online services should include existing social networking sites and promote opportunities that allow HIV-infected individuals to access services regardless of their geographic location.

- Consider the on-going needs of providers, especially evolving technologies which assist in meeting the needs of their clients.

- Consider more effective monitoring of outreach contracts to ensure the work is being done.

- Consider outreach services with greater flexibility to reach potential clients “where they are.” Flexibility may promote more efficient delivery of services.

-See the previous notes regarding stigma and safe environments

### **Criminal Justice Populations:**

-Include incarcerated peer educators in outreach activities conducted in city, county and State correctional facilities.

### **Gay Men/MSM:**

-With respect to the internet, there is a wide variety of sites which gay men and other MSM visit. Agencies should carefully research which sites are most popular locally and for which sub-populations. Internet outreach should always be done in a respectful, honest way consistent with recently promulgated internet outreach guidelines.

-Venue-based outreach also requires considerable community intelligence so that it is done in locations and at hours when it is most likely to be productive. The outreach should be conducted in a way that is respectful of the norms of the various settings. Agencies may need to work closely with venue owners/operators to ensure so there is a shared understanding of what the outreach will entail—and that it is not disruptive of either business or the enjoyment of the men these places. There is extraordinary diversity in the venues for which outreach may be appropriate.

-Individuals have preferences with respect to condom attributes and brands. To the degree possible, there should be a number of options as to which particular products are available so that the likelihood of barrier utilization is maximized. If there is any uncertainty as to what products are preferred, the question should be asked. Asking the question shows respect. Off-label use of the “FC” condom should be an option for gay men, and program staff should be candid—and knowledgeable—in presenting it. The term Female Condom is inherently problematic. An alternative is the “insertive condom.” Guidance on the use of the insertive condom in the rectum should be developed, promulgated and incorporated in outreach, even in the absence of FDA approval.

**Immigrant/Migrant Populations:**

-Evening activities and monthly workshops at a variety of settings including offsite such as churches. Confidentiality and other topics of interest to the population should be discussed

-Culturally and linguistically appropriate marketing strategies including: radio, videos, written brochures (telenovelas) and at a basic reading level and posters which are part of a general health message.

**Substance Using Populations:**

-Peer navigation to engage consumers effectively and substantively

-Don't exclude hetero-sexual venues- many do not identify with gender roles and traditional relationships-particularity with substance users.

**B. Transmission Category: Heterosexual**

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

**People Living with HIV/AIDS:**

-Consider including specific information about barrier protection.

-Address the myths about transmission.

-Promote discussion about fear around HIV-status disclosure.

-Address fear of potential rejection after HIV-status disclosure.

-Acknowledge that HIV-related stigma impacts discrete communities differently and in different layers.

**Criminal Justice Populations:**

-Include incarcerated peer educators in HERR activities conducted in city, county and state

correctional facilities.

- Consideration should be given to Educators with similar life experiences i.e. race, ethnicity, gender, sexual orientation, as prison population.

-For County jails: support formerly incarcerated Educators to return to facility to deliver HERR.

**Gay Men/MSM:**

-There are men who have sex with men who identify as heterosexual. Even among those who do not identify as heterosexual, there may be some who prefer to be perceived as such. HERR messages and materials for both men and women should reflect this reality, and references to same-sex sexual relations should be acknowledged as a reality to be respected. There also needs to be awareness that some men who have sex with men are also having sex with women.

-There is a fluidity of sexual identities and gender of individuals with whom one has sex.

-HERR, even for “heterosexuals” need to be inclusive of behaviors and individuals which do not fit traditional heterosexual notions.

-Safer sex fatigue should not be seen solely in the context of MSM; it is relevant to all populations, including those who are heterosexually defined.

-Sexual risk reduction options need to be addressed in a comprehensive and culturally appropriate manner. The content and the framing of the message need to be inclusive.

-Reduction in viral load (treatment initiation and adherence) and reduction in exposure episodes (number of partners; reducing direct exposure to fluids) are sexual harm reduction strategies.

-Serosorting is a sexual harm reduction strategy. Partner and self serostatus knowledge and honest communication are factors. STI transmission is also a relevant consideration.

-Health literacy. There must be attention to language—including translation issues.

**Immigrant/Migrant Populations:**

-Support groups that maintain confidentiality should be established which stress risk reduction. The support group facilitator should be linguistically and culturally sensitive to the needs of the immigrant/migrant population(s).

**Substance Using Populations:**

-Peer navigation has therapeutic value

-Clients should be in primary care and thinking about connection to peer navigation

-Be educated and promote Harm Reduction

-Use low threshold services with stages of change model

-Assume everyone is using

-Secondary prevention is important

**Women:**

- Gender dynamics need to be addressed and discussed as a factor that impacts male and female relationships. The role of culture is important.

-Cultural norms must be considered in the development of messages and curriculum

- Include anal sex in discussions of sexual activities and understand that some women engage in these activities both for their pleasure as well as a way to increase intimacy with their partner. For some women this sexual practice is engaged in to prevent pregnancy and/or preserve their virginity.

-Consider that women are seeking intimacy which makes disclosure and condom use and safer sex negotiation more challenging

✓ **Linkage to: primary care (with linkage connections, i.e., child care); treatment adherence services; STI screening and Hepatitis B and C screening; psychosocial mental health services (including trauma informed services); supportive services, including emergency assistance**

**People Living with HIV/AIDS**

-Provide safe space, especially space that is safe for and friendly toward children.

-Promote more family-centered services and care.

-Linkages need to be “of quality” and based on long-standing relationships.

-Linkages must be provided in a timely manner.

**Criminal Justice Populations:**

-Consideration must be given to services available in within correctional facilities (city, county and state) .

- Service providers must be knowledgeable of all available services within these facility setting.

**Gay Men/MSM:**

-For HIV-positive over-50 individuals, health care providers need to have an awareness of multiple morbidities, including those which are age-associated.

-Socio-economic disparities—particularly in communities in color—negatively impact linkage to care.

-Linkage to care to be of value requires attention to the quality of care coordination/case management. Quality indicators should be patient-centered and related to health outcomes.

-Patient-centered care should minimize patient burden. Centralized care options (one-stop or few-stop) should be promoted.

**Substance Using Populations:**

-Peer retention through incentive and low threshold services

-Assessment for pain management especially for those actually using meth, cocaine services

-Non-traditional hours should be offered to reach those w families working or are not available for services during business hours.

**Women:**

-There must be a cultural sensitivity and awareness for women of color and their historical experiences that influence how they define themselves and cope with stress

-Consider transportation needs and childcare needs

-Consider women's readiness to deal with mental health related issues

✓ **Interventions delivered to Individuals (IDI); Interventions delivered to Groups (IDG), like Healthy Relationships and peer training; Comprehensive sex health education, including HIV/AIDS information**

**People Living with HIV/AIDS:**

-Consider providing incentives to promote attendance and retention.

-Acknowledge different levels of literacy and comprehension.

-Consider transportation barriers that may present themselves, in both rural and urban locations.

-Consider referrals to community specific resources – CAPC, LTI, etc.

**Criminal Justice Populations:**

-Consider risk of stigma associated with intervention participation within correctional settings.

PLWHA's may not self identify:

- Providers need to be sensitive to disclosure issues;
- Disclosure (lack of) may pose barriers / limitations for individual and/or group level

interventions & other services.

-Provider access, time and space limitations must be taken into consideration within criminal justice settings

- DOCS programming: tailor group sessions to fit programming time frames;
- Facility schedule: Incarcerated individuals' only free time may be in the evening.

**Gay Men/MSM:**

-The socio-cultural model can and should influence the updating/adaptation of IDIs and IDGs. Interventions should periodically be revisited and updated to ensure relevance and appropriateness.

-Consumer-advisory boards or other consumer input must inform the choice of interventions as well as how they are implemented. This input must be real, not nominal.

**Substance Using Populations:**

-Peer driven services –in order to be receptive to intervention they must be stabilized

-Provide crisis services before the intervention

-Offer: Crisis services

Incentives

Ancillary services

**Women:**

-Interventions should be provided in locations that are accessible and convenient to women

- There must be an understanding of how women assess trust in their partners. Some women develop trust in their partners based on their current needs.

- Include **males** and females in couples in interventions.

- Interventions should be provided in locations that are accessible and safe for women

✓ **Integrated distribution of safer sex materials, condom and other barriers, including access to dental dams and lube**

**People Living with HIV/AIDS:**

-Consider providing incentives to promote attendance and retention.

-Acknowledge different levels of literacy and comprehension.

-Consider transportation barriers that may present themselves, in both rural and urban locations.

-Consider referrals to community specific resources – CAPC, LTI, etc.

**Criminal Justice Populations:**

-Correctional facility rules may not allow the distribution of safer sex materials during interventions, so be sure to provide verbal information about condoms, dental dams, lubricants, etc.

**Gay Men/MSM:**

-We need to adjust our language regarding the “female condom.” This terminology is a barrier. This is an insertive condom and should be understood as an option for all genders and for anal as well as vaginal insertion.

-Community distribution of safer sex supplies should always be tailored to individual needs/preferences.

**Substance Using Populations:**

-Creative Presentations and interactive presentations are most effective

-Normalize Risk Awareness and Protection

**Women:**

-Determine comfort levels of women to discuss sexual activities with their partners

- Recognize that women are often not empowered to implement use of barrier methods; think creatively on how women can be more effective in safer sex negotiation.

**C. Transmission Category: IDU**

✓ **Syringe access, syringe exchange (including peer delivered syringe exchange: /ESAP / Harm reduction counseling services, including opioid overdose prevention, Buprenorphine, nalaxone, combined with comprehensive harm reduction services, linkage to comprehensive health services, including Hepatitis services and pre-treatment services and mental health/psychiatric services**

**People Living with HIV/AIDS**

-Consider efforts to address and remove the stigma that surrounds and impacts HIV-positive persons who may also be substance users.

-Provide information in quick, yet informative sessions, to promote attendance and retention.

-Provide services in spaces the community identifies as safe and friendly.

**Gay Men/MSM**

-We need to focus on the quality of syringe access as well as its integration with other services including housing and health care. Quality measures should include its impact on co-morbidities, such as overdose and HCV , as well as cancer, diabetes, etc.

-Treatment on demand must be more of a reality throughout the State, and that treatment should be tailored for various populations (including gay men/MSM) and substances (including methamphetamine). Reimbursement (including Medicaid and private insurance) can limit appropriate, timely access to treatment.

-More training for and funding of opioid overdose prevention would foster the expansion of overdose programs. These are services which can be integrated into harm/risk reduction services with a peer orientation.

-Physicians and other clinicians can be better trained in drug user health. The NYS HIV Guidelines on HIV and Substance Use is a starting point.

-These are services which are not well-distributed throughout the state.

**Immigrant/Migrant Populations:**

-Establishing Syringe Exchange programs in non-traditional settings (i.e. mobile vans)

**Substance Using Populations:**

-Peer delivered services street distribution using HIV peers reflective of target population

-Utilize current social networks

-Provide ancillary services to engage users e.g., acupuncture

-Provide low threshold services

-Use a Harm Reduction model

-Provide incentives

-Safe Injecting Facilities are the safest environment to deliver the IDU Health Package

**Women:**

- Services should be women-centered and include skills-building, childcare and transportation services.

-Programs should be located in areas where at risk women can be found

-Programs should empower women to share information with their drug using partners.

-The intervention should destigmatize drug use amongst women and emphasize self care.

✓ **Interventions delivered to Groups (IDG), i.e. like Safety Counts; Interventions delivered to Individuals (IDI) using harm reduction approach**

**People Living with HIV/AIDS:**

-Promote public education to address and reduce public stigma around IDU.

**Criminal Justice Populations:**

-Not all DEBIs are suitable in correctional settings (like Safety Counts) and they may not be adaptable for that setting.

**Gay Men/MSM:**

-Harm reduction models benefit from peer implementers. Peers have a role in program design, in defining outcome measures and in program evaluation. Impact on the peers is one of the outcome measures.

-Mentoring and social networks can be intervention extenders, and in some cases central to the intervention.

**Substance Using Populations:**

-Provide peer delivered services

**Women:**

-Services must be women-centered include skill-building, child care, transportation service.

-Programs should be located in areas where at risk women can be found

-Program should empower women to share information w/their drug using partners

-Intervention should distinguish drug use amongst women and emphasize self care

- Include sexual harm reduction in the overall HIV prevention plan for women.

✓ **Sexual harm reduction education for IDUs**

**People Living with HIV/AIDS:**

-Promote harm reduction models

-Utilize messages that are non-judgmental and accurate

**Gay Men/MSM:**

-Hepatitis prevention as well as HIV prevention needs to be incorporated in sexual harm reduction (as well as injection-related harm reduction).

-Health literacy (including with respect to drug interactions). There must be attention to language—including translation issues.

**Substance Using Populations:**

-Provide peer delivered services

**Women:**

-The dynamics of sexual partnership and role of sex in the relationship must be considered/addressed;

-Make inclusive of the overall HIV prevention plan

**D. Transmission Category: Perinatal/Pediatric**

✓ **Linkage to: care, including pre-natal and other ancillary services, and outreach (CAPC); mental health counseling (family/individual, multi-generational including disclosure issues)**

**People Living with HIV/AIDS:**

-Utilize clean, comfortable spaces that are family friendly.

-Utilize locations that are easily accessed.

-Acknowledge that children can create additional responsibilities: e.g., child care issues, snacks and meals.

-Promote intergenerational dialogue around disclosure.

**Gay Men/MSM:**

-Disclosure should be facilitated and encouraged among young MSM who are positive in a culturally sensitive and appropriate way. The providers have a role in fostering an environment in which this can take place.

**Substance Using Populations:**

-Social and cultural sensitivity is important

-Have a non-judgmental attitude

-Help female clients deal with Child Protection Services

-Social marketing should focus on removing the stigma's of being HIV+, teen pregnancies, and active substance use

**Women:**

-Cultural issues should be considered in the development of interventions

✓ **Linkage to: supportive services (including treatment adherence); care coordination (including the primary caregiver); Case Management including disclosure issues**

**People Living with HIV/AIDS:**

-Acknowledge the impact that child care may have when providing referrals for coordinated care.

-Explore barriers, such as inadequate transportation, and the effect they may have on linkage agreements.

**Gay Men/MSM:**

-Disclosure should be facilitated and encouraged among young MSM who are positive in a culturally sensitive and appropriate way. The providers have a role in fostering an environment in which this can take place.

**Substance Using Populations:**

-Provide transportation, food/drink, and child care to lower threshold

✓ **Health Education/Risk Reduction (HERR) including: sexuality education, including school-based and issues of stigma, Interventions Delivered to Groups (IDG), i.e., Healthy Relationships, and Interventions Delivered to Individuals (IDI)**

**People Living with HIV/AIDS:**

-Include secondary prevention as means to promote family health and inter-generational dialogue.

-Provide safe spaces for group interventions to be delivered.

-IDI must be age and culturally appropriate.

**Gay Men/MSM:**

-Much has been done with respect to young women and contraception and abstaining from sex. Men, however, are often pushed to have sex, because it is "manly."

-Our approach needs to be broadened to include comprehensive sexuality education inclusive of STD and HIV prevention, and the diversity of sexuality.

**Substance Using Populations:**

-A group approach is important to break the isolation, and create a support network

-Trauma Informed Care

**TIER II: HIV STATUS UNKNOWN, ESPECIALLY PERSONS OF COLOR**

**A. Transmission Category: MSM**

- ✓ **Outreach, including internet and in high-risk venues, condom and other barrier distribution, including access to dental dams and lube, access to sterile syringes**

**People Living with HIV/AIDS**

-Consider addressing the stigma that keeps some reluctant to engage with outreach efforts.

-Consider highlighting the risks to one's health of engaging fear and denial.

-Promote trust building in outreach-based relationships.

-Must have easy access to sexual health harm reduction supplies. Need to be aware of cultural and religious issues when promoting use.

**Criminal Justice Populations:**

-Include incarcerated peer educators in outreach activities conducted in city, county and state correctional facilities.

**Gay Men/MSM:**

-With respect to the internet, there is a wide variety of sites which gay men and other MSM visit. Agencies should carefully research which sites are most popular locally and for which sub-populations. Internet outreach should always be done in a respectful, honest way consistent with recently promulgated internet outreach guidelines.

-Venue-based outreach also requires considerable community intelligence so that it is done in locations and at hours when it is most likely to be productive. The outreach should be conducted in a way that is respectful of the norms of the various settings. Agencies may need to work closely with venue owners/operators to ensure so there is a shared understanding of what the outreach will entail and that it is not disruptive of either business or the enjoyment of the men these places. There is extraordinary diversity in the venues for which outreach may be appropriate.

-Individuals have preferences with respect to condom attributes and brands. To the degree possible, there should be a number of options as to which particular products are available so that the likelihood of barrier utilization is maximized. If there is any uncertainty as to what products are preferred, the question should be asked. Asking the question shows respect. Off-label use of the "FC" condom should be an option for gay men, and program staff should be candid—and knowledgeable—in presenting it. The term Female Condom is inherently problematic. An alternative is the "insertive condom." Guidance on the use of the insertive condom in the rectum

should be developed, promulgated and incorporated in outreach, even in the absence of FDA approval.

**Substance Using Populations:**

-Repeat outreach

**Women:**

- Recognize that some MSM are also MSWM; reduce the stigma of the Down Low; reframe men's sexuality to include their relationships with women.

-Messages should address responsible sexual exploration

-Share risk reduction strategies that includes female partners.

✓ **Social Marketing (including raising awareness re: STI screening/HIV testing)**

**People Living with HIV/AIDS:**

-Consider a format like HIV Talk Radio to promote awareness.

-Consider STI & HIV as part of general health promotion activities.

-Consider community norms around language when developing interventions.

**Criminal Justice Populations:**

-Social marketing campaigns may be limited within correctional settings

- Awareness materials, i.e. Hot Line Poster, must be approved by facility administration.

**Gay Men/MSM:**

-There are several populations of MSM which are inadequately represented in social marketing campaigns. Among them are persons over 50, gay men/MSM with disabilities; Transgender gay men/MSM, etc.

**Immigrant/Migrant Populations:**

-See Overall Considerations page 17.

**Substance Using Populations:**

-Provide incentives to encourage testing – bills boards, palm-cards, PSA with statistics reality issue realistic social marketing blunt to the point

**Women:**

- Address men returning home from prison and engaging in unprotected sex with their female partner.

-Provide women with incarcerated partners with HIV education and include information that partners may have engaged in sex while incarcerated.

-Encourage men to disclose their sexual experiences while incarcerated

-Normalize HIV testing and knowing HIV status before engaging in unprotected sex with women

-Encourage men to engage in safer sexual practices with female partners

✓ **HIV Counseling, Testing and Referral (CTR); STI screening, Hepatitis B and C screening**

**People Living with HIV/AIDS:**

-Consider the impact that fear and denial has on particular communities.

**Criminal Justice Populations:**

-Balance care coordination with city, county and state correctional facilities, Parole and Service Delivery

- Learn which other service providers are in the facility

-Ensure that a process is in place for providing test results when incarcerated individuals are transferred or discharged prior to receiving their confirmatory test results.

**Gay Men/MSM:**

-These public health interventions should be better integrated by co-location and not siloing their implementation.

-Serosorting without CTR is not sexual harm reduction.

**Substance Using Populations:**

-Provide incentives to encourage substance users to test

**Women:**

-Educate MSM and their female partners about their HIV risks

-Include in screening and assessment activities disclosure of sexual risk histories

-Discuss and normalize sexuality and experimenting responsibly

-Train providers to have conversations with patients about sexual practices and offer testing as part of medical care

✓ **Health Education Risk Reduction (HERR) with specificity to gay men's issues**

**People Living with HIV/AIDS:**

- Consider the stigma many MSM experience.
- Consider where the best locations are to reach this group of MSM.
- Need to build trust before delivering this intervention.
- Consider including issues of specific to gay men's health, e.g., comprehensive anal health.

**Criminal Justice Populations:**

- Disclosure of sexuality within a correctional setting
  - Incarcerated individual's sentence / time should be considered when planning HERR with specificity to gay men's issues. Sentence /time may be a determining factor to disclosure.

**Gay Men/MSM:**

- There is a fluidity of sexual identities and gender of individuals with whom one has sex.
- Motivational interviewing and individually-tailored personal prevention plans are valuable tools for facilitating risk reduction.

**Substance Using Populations:**

- Provide peer delivered services targeted at risk behaviors with any population (navigators)

**Women:**

- Discuss/explore topics that pertain to what it means to be sexual with women; how/if that impacts their identification as gay men; what their notions/ideas about Down Low are

**B. Transmission Category: Heterosexual**

✓ **HIV Counseling, Testing and Referral (CTR); STI screening, Hepatitis B and C screening with incentives**

**People Living with HIV/AIDS:**

- Do an "open house" with incentives to promote participation and retention.
- Messaging should be community friendly and acknowledge community characteristics that are unique.
- Provide incentives that promote healthy living and healthy products.

**Criminal Justice Populations:**

-Balance care coordination with city, county and state correctional facilities, Parole and Service Delivery

- Learn which other service providers are in the facility

-Consider that incentives cannot be given in facility.

- Know what can be approved by facility (if anything).

-Ensure that a process is in place for providing test results when incarcerated individuals are transferred or discharged prior to receiving their confirmatory test results.

**Immigrant/Migrant Populations:**

-Incentives such as gift and food certificates, phone cards should be used

**Substance Using Populations:**

-Normalize testing

-Employ a consistent message around knowing your status about testing

**Women:**

-Many women utilize GYN services as their primary care providers and that relationship/venue can be fostered and included when discussing CTR services

-Encourage couple testing

-Unconventional hours & variety places outside of neighborhoods.

-Educate and encourage providers including physicians and allied health professionals to offer routine HIV testing.

- ✓ **Health Education Risk Reduction (HERR) education, including: sex health education around skills building, condom use and safer sex negotiation; substance use counseling services and referral**

**People Living with HIV/AIDS:**

-Consider utilizing speakers' bureaus that draw on community strength and experience.

-Acknowledge unique needs of heterosexual populations.

-Consider promoting "family dialogues" to deliver messages around skills building and negotiations.

-Consider multiple venues to promote easy access and safety.

**Criminal Justice Populations:**

-Include incarcerated peer educators in HERR activities conducted in State correctional facilities.

- Consideration should be given to educators with similar life experiences i.e. race, ethnicity, gender, sexual orientation, as prison population.

-For County jails: support formerly incarcerated educators to return to facility to deliver HERR.

**Gay Men/MSM:**

-The HIV-prevention needs of women partners of incarcerated men should be better addressed. Conjugal visits in criminal justice settings at the very least should include the availability of condoms.

-Serosorting is a sexual harm reduction strategy. Partner and self serostatus knowledge and honest communication are factors. STI transmission is also a relevant consideration.

**Immigrant/Migrant Populations:**

-Those conducting the HE/RR message must be aware of the lack of awareness and limited ability migrant/immigrant women to negotiate some of these skills

**Substance Using Populations:**

-Provide incentives

**Women:**

- Recognize that some women are sharing partners and that some women do not choose to be in an exclusive relationship.

-Address the real challenges to change sexual behaviors in established relationships; set realistic step by step goals

-Partners need to be part of the intervention

- Assess past traumas that might affect women's risky behaviors.

-Implement negotiation of condoms to include use of eroticism

-The highest risk women are not always easily/readily accessible. Innovative strategies should be developed to identify these women

- Interventions should be offered in locations that are convenient, safe and accessible.

- ✓ **Outreach, including internet and in high-risk venues, condom and other barrier distribution, including access to dental dams and lube, access to sterile syringes, Interventions delivered to Individuals (IDI) and Interventions delivered to Groups (IDG) by peers, Comprehensive Risk Counseling (CRCS)**

**People Living with HIV/AIDS:**

- Consider relationship building based on trust.
- Consider unique ways of raising awareness, especially with faith communities.
- Promote inter-agency collaborations to most effectively and efficiently utilize resources.
- Establish peer training that acknowledges the importance of building trust in relationships.

**Criminal Justice Populations:**

- Include incarcerated peer educators in Outreach, and IDG activities conducted in State correctional facilities.
- Include incarcerated peer educators in outreach and IDG activities conducted in State correctional facilities

**Gay Men/MSM:**

- Venue-based outreach requires considerable community intelligence so that it is done in locations and at hours when it is most likely to be productive. The outreach should be conducted in a way that is respectful of the norms of the various settings. Agencies may need to work closely with venue owners/operators to ensure so there is a shared understanding of what the outreach will entail—and that it is not disruptive of either business or the enjoyment of the men these places. There is extraordinary diversity in the venues for which outreach may be appropriate. There is also a great deal of diversity in the individuals who may frequent these venues, including with respect to their sexual identity and sexual practices.
- Individuals have preferences with respect to condom attributes and brands. To the degree possible, there should be a number of options as to which particular products are available so that the likelihood of barrier utilization is maximized. If there is any uncertainty as to what products are preferred, the question should be asked. Asking the question shows respect. Guidance on the use of the insertive condom in the rectum should be developed and promulgated and incorporated in outreach, even in the absence of FDA approval.

**Immigrant/Migrant Populations:**

- Skills building messages should be provided in the context of a support group with immigrants/migrants taking the role of women in their native culture into consideration as well as domestic violence concerns.

**Substance Using Populations:**

-Employ messages that reach broad audiences with strong social marketing venues, PSAs Pom Card e.g. subway bases, bus hospitals, laundry mats

-Target over 50 populations

**Women:**

-Discuss cultural and gender triggers that may make women more comfortable to negotiate safer sex and emphasize the importance of partner involvement in safer sex—that actives also need to be designed to involve the male partners

- Organize and conduct small group activities such as gender specific safer sex parties and presentations

-Conduct small group discussions to talk about women issues and needs.

**C. Transmission Category: IDU**

✓ **Syringe exchange/ESAP harm reduction services/Buprenorphine/opioid overdose prevention, transitional case management**

**People Living with HIV/AIDS**

-Promote public education around IDU-related stigma

-Consider more unique ways to promote the awareness of SEP and ESAP programs.

-Promote broader public education around the health needs of IDU.

**Gay Men/MSM:**

-We need to focus on the quality of syringe access as well as its integration with other services including housing, health care. Quality measures should include its impact on co-morbidities, such as overdose and HCV , as well as cancer, diabetes, etc.

-Treatment on demand must be more a reality throughout the State, and that treatment should be tailored for various populations (including gay men/MSM) and substances (including methamphetamine). Reimbursement (including Medicaid and private insurance) can limit appropriate, timely access to treatment.

-More training for and funding of opioid overdose prevention would foster the expansion of overdose programs. These are services which can be integrated into harm/risk reduction services with a peer orientation.

-Physicians and other clinicians can be better trained in drug user health. The NYS HIV Guidelines on HIV and Substance Use is a starting point.

-These are services which are not well-distributed throughout the state.

**Substance Using Populations:**

-Keep the threshold to services as low as possible

-Substitution Therapy (i.e., methadone, buprenorphine)-- outside of NYC there are often long waiting lists, more treatment spots are needed

-Syringe access: many places don't have syringe exchange; expand ESAP and implement regional mobile PDSE teams in rural communities (ice cream truck model)

-Safe Injecting Facilities are the safe environment to deliver the IDU Health Package

**Women:**

-Services must be women-centered include skill-building, child care, transportation service.

-Programs should be located in areas where at risk women can be found

-Programs should empower women to share harm reduction information w/drug using partners

-Interventions should destigmatize drug use amongst women and promote self care

✓ **HIV Counseling, Testing and Referral (CTR); STI screening, Hepatitis B and C screening**

**People Living with HIV/AIDS:**

-Provide safe space and respectful atmosphere.

-Address the stigma that prevents IDUs from accessing services.

**Criminal Justice Populations:**

-Ensure that a process is in place for providing test results when incarcerated individuals are transferred or discharged prior to receiving their confirmatory test results.

**Gay Men/MSM:**

-Update, testing in substance abuse treatment programs for HCV and HIV is not generally taking place unless there are symptoms. This is a lost opportunity for prevention, case identification, support and early initiation into treatment. There may be receptivity by individuals in treatment to ascertain their HCV status. This receptivity may be leveraged to introduce HIV testing as well.

**Substance Using Populations:**

-Incentives should be used

-One Stop Shopping: catch them while you can.. HIV-STI-HEP screening at the same time, in one spot

✓ **Outreach, sexual harm reduction including provision of safer sex materials, including condom and other barriers, including access to dental dams and lube**

**People Living with HIV/AIDS:**

-Promote access in friendly and safe environments.

-Make sure services can be accessed at “non-AIDS identified” locations.

-Promote dialogue with drug stores selling these to provide easier access.

**Criminal Justice Populations:**

-Include incarcerated peer educators in outreach activities conducted in city, county and state correctional facilities.

**Gay Men/MSM:**

-Injection drug users in New York may now be more likely to become infected through sexual contact rather than through a contaminated syringe. Sexual harm reduction needs to be a specific focus for this population.

-Individuals have preferences with respect to condom attributes and brands. To the degree possible, there should be a number of options as to which particular products are available so that the likelihood of barrier utilization is maximized. If there is any uncertainty as to what products are preferred, the question should be asked. Asking the question shows respect. Guidance on the use of the insertive condom in the rectum should be developed and promulgated and incorporated in outreach, even in the absence of FDA approval.

**Substance Using Populations:**

-Provide socially/culturally sensitive outreach

-Provide bi-lingual outreach

-Use peer workers and a non-punitive approach

-Role Playing should be employed

**D. Transmission Category: Perinatal/Pediatric**

✓ **HIV Counseling, Testing and Referral (CTR); STI screening, Hepatitis B and C screening**

**People Living with HIV/AIDS:**

-Provide safe, clean and comfortable environment for service delivery.

-Acknowledge and address community issues related to stigma.

**Criminal Justice Populations:**

-Ensure that a process is in place for providing test results when incarcerated individuals are transferred or discharged prior to receiving their confirmatory test results.

**Gay Men/MSM:**

-We have a population that was not tested at birth that is coming into sexual activity and risk—sexual or otherwise. There is a need for testing for all of these infections. The STI rates are particularly high in this population and we need to be particularly aware for them of the STI/HIV connection. Annual STI screening and at-exposure screening should be promoted. Partner services are critical.

**Women:**

- Ongoing provider training and patient education regarding the importance of first and third trimester testing.

**✓ Outreach (CAPC)/health education**

**People Living with HIV/AIDS:**

-Messages may need to be more general and promote health generally – HIV would be only one component.

**Criminal Justice Populations:**

-Include incarcerated peer educators in outreach activities conducted in city, county and state correctional facilities.

**Gay Men/MSM:**

-Venue-based and internet outreach require considerable community intelligence so that it is done in locations and at hours when it is most likely to be productive. The outreach should be conducted in a way that is respectful of the norms of the various settings. Agencies may need to work closely with venue owners/operators to ensure so there is a shared understanding of what the outreach will entail---and that it is not disruptive of either business or the enjoyment of the men these places. There is extraordinary diversity in the venues for which outreach may be appropriate.

-Texting and viral messages through new/social media should be tailored for the populations through a peer-delivered approach.

**Substance Using Populations:**

- Be non-judgmental, culturally sensitive and bi-lingual
- Utilize female peer workers

✓ **Comprehensive Risk Counseling Services (CRCS)**

**People Living with HIV/AIDS:**

- Same as under “Outreach” above and include the stigma that attaches to risk behaviors around CRCS.

**Substance Using Populations:**

- Discuss sexual risk during pregnancy: protect your baby and yourself from STIs and HIV
- Educate about the link between STIs and HIV transmission

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

**A. Transmission Category: MSM**

- ✓ **Outreach including internet and in high-risk venues, condom and other barrier distribution, including access to dental dams and lube, access to sterile syringes, peer delivered outreach**

**People Living with HIV/AIDS**

-Consider ways to establish relationships based on trust in the communities to be served.

-Consider unique ways of raising awareness.

-Consider providing “easy to follow” directions about service locations and service venues.

**Criminal Justice Populations:**

-Include incarcerated peer educators in outreach activities conducted in city, county and state correctional facilities.

**Gay Men/MSM:**

-Outreach interventions must consider how the phenomenon of “safer sex fatigue” impacts efforts to decrease risky behaviors and increase condom use. Some MSM have adopted a complacent attitude and project perceptions of HIV as not being a health threat among HIV-uninfected persons.

-This intervention will become more effective if it is peer-driven and if the peers reflect ethnically and geographically the individuals and communities being targeted. Providers need to work closely with POL-types who are stakeholders in the community setting and venue.

-Barrier utilization will be maximized when the products distributed are known, accepted, trusted and when sufficient options are available.

-With respect to the internet, there is a wide variety of sites which gay men and other MSM visit. Agencies should carefully research which sites are most popular locally and for which sub-populations. Internet outreach should always be done in a respectful, honest way consistent with recently promulgated internet outreach guidelines.

-Some internet sites may contribute to/reinforce less safe behaviors.

-Venue-based outreach also requires considerable community intelligence so that it is done in locations and at hours when it is most likely to be productive. The outreach should be conducted in a way that is respectful of the norms of the various settings. Agencies may need to work

closely with venue owners/operators to ensure so there is a shared understanding of what the outreach will entail---and that it is not disruptive of either business or the enjoyment of the men these places. There is extraordinary diversity in the venues for which outreach may be appropriate.

**Immigrant/Migrant Populations:**

-Peers/promotores should be trained in becoming group facilitators and conduct trainings and information sessions to other agencies and staff as well as to members of the target population

**Women:**

-Develop risk reduction strategies to include female partners.

**✓ HIV Counseling, Testing and Referral (CTR); STI screening, Hepatitis B and C screening, including expanded testing**

**People Living with HIV/AIDS**

-Consider the cultural and religious needs of the communities to be targeted.

-Consider providing an atmosphere of “friendliness” and “approachability.”

**Criminal Justice Populations:**

-Balance care coordination with city, county and state correctional facilities, Parole and Service Delivery

- Learn which other service providers are in the facility

-Ensure that a process is in place for providing test results when incarcerated individuals are transferred or discharged prior to receiving their confirmatory test results.

**Gay Men/MSM:**

-Serosorting without CTR is not sexual harm reduction.

-Serosorting practices may have some HIV-negative MSM accepting the idea that they will eventually seroconvert to HIV, and thus they avoid safer sex.

-CTR intervention ( in addition to STI screening, Hep B/C screening and expended testing) needs to consider the sexual and drug histories of MSM. Providers need to be effectively trained in taking sexual and drug histories. When trauma is identified referrals must be made with appropriate linkage to mental health services.

**Substance Using Populations:**

-Incentives should be provided.

**Women:**

-Encourage testing for themselves and female partners

✓ **Social Marketing/Health Communication/Public Information**

**People Living with HIV/AIDS**

-Materials/campaigns should be community specific, promote community health of which HIV is only one part.

-Consider outreach with campaigns targeting internet forums & chat rooms.

-House/bath parties and circuit parties.

**Criminal Justice Populations:**

-Social marketing campaigns may be limited within correctional settings

- Awareness materials, i.e. Hot Line Poster, must be preapproved by facility administration.

**Gay Men/MSM:**

-Social marketing should always consider the community intelligence with respect to specific diverse populations, among which are MSM living hand-to-mouth.

-This intervention should consider shifts in gay community norms about sex, including unprotected sex. There are internet sites which are responsive to—and perhaps encouraging of—choices not to have protected sex.

-There are several populations of MSM which are inadequately represented in social marketing campaigns. Among them are persons over 50, gay men/MSM with disabilities, Transgender gay men/MSM and gay commercial sex workers.

-Social marketing and public information messages have to be tolerant, while still clearly promoting healthy sexuality. There may be diversity and apparent dissonance in some of the messaging, given the complexity of in which safer sex choices are made. An example of apparent dissonance is promotion of pre-exposure prophylaxis while still encouraging condom use.

-An explicit messaging focus must be on keeping HIV-negative gay men and other MSM negative. This may entail highlighting personal and community-level responsibility.

-Texting and viral messages through new/social media should be tailored for the populations through a peer-delivered/peer-oriented approach.

**Substance Using Populations:**

-Use direct marketing about such subjects as relationships, unprotected sex

-Employ social situation marketing

**Women:**

-Raise awareness regarding how MSWM impacts women and encourage safer sex with all sexual partners

-Target prevention messages about MSMW to women in a factual, learning and non judgmental manner

**B. Transmission Category: Heterosexual**

✓ **Community outreach w/peer mentors/incentives**

**People Living with HIV/AIDS**

-Build trust-based relationships.

-Provide incentives that promote health and healthy living.

-Make sure outreach can be conducted in safe, yet “high traffic” areas.

**Criminal Justice Populations:**

-Consider in-facility outreach activities:

- Include incarcerated peer educators in outreach activities conducted in city, county and state correctional facilities.

-Consider that incentives cannot be given in facility.

- Know what can be approved by facility (if anything).

**Gay Men/MSM:**

-Outreach interventions must consider how the phenomenon of “safer sex fatigue” impacts efforts to decrease risky behavior and increase condom use. Some heterosexuals have adopted a complacent attitude and project perceptions of HIV as not being a health threat among HIV-infected and presumed uninfected persons

-Outreach in non-traditional venues requires solidly heterosexual messages and concomitant outreach peer involvement with outreach activities being linguistically and culturally competent.

-Individuals have preferences with respect to condom attributes and brands. To the degree possible, there should be a number of options as to which particular products are available so that

the likelihood of barrier utilization is maximized. If there is any uncertainty as to what products are preferred, the question should be asked. Asking the question shows respect. Guidance on the use of the insertive condom in the rectum should be developed and promulgated and incorporated in outreach, even in the absence of FDA approval.

**Substance Using Populations:**

-It would be helpful to universalize/normalize behaviors such as: the face of HIV...could be you!

-Target over 50 populations!

**Women:**

-Organize small group activities, such as safer sex parties and presentations;

- Organize and conduct small group activities such as gender specific safer sex parties and presentations.

-Recognize that women may not respond to HIV specific messages. Interventions may need to link HIV issues to other issues of interest to women

✓ **HIV Counseling, Testing and Referral (CTR); STI screening, Hepatitis B and C screening with incentives**

**People Living with HIV/AIDS**

-Consider community needs around culture and language.

-Make more service provisions and referrals and delivered “in a safe, friendly” place.

**Criminal Justice Populations:**

-Balance care coordination with city, county and state correctional facilities, Parole and Service Delivery

- Learn which other service providers are in the facility

-Consider that incentives cannot be given in facility.

-Know what can be approved by facility (if anything).

-Ensure that a process is in place for providing test results when incarcerated individuals are transferred or discharged prior to receiving their confirmatory test results.

**Gay Men/MSM:**

-Creative CTR incentives including helping people feel better about themselves and respecting primary and non-primary partners.

-Guidelines for HIV and STI screening should include annual screening for all sexually active individuals with presumed negative serostatus, especially when they have multiple partners or are partnered with someone who does.

-Settings in which CTR services take place must be positively health-oriented and client-centered rather than focusing on crisis management or illness per se. The focus should be self-efficacy.

**Substance Using Populations:**

-Integrate testing into primary care services

**Women:**

-Recognize that some women are sharing partners and that some women do not choose to be in an exclusive relationship.

-Discuss cultural and gender triggers that may make women more comfortable to negotiate safer sex and emphasize the importance of partner involvement in safer sex—that actives also need to be designed to involve the male partners.

**✓ Comprehensive sexuality education, including family planning and HIV/AIDS education**

**People Living with HIV/AIDS**

- Include providers who are experts in family-centered care.

-Respect community norms and traditions.

**Criminal Justice Populations:**

-Include incarcerated peer educators in all Health Education/Risk Reduction activities, including sexuality, family planning, and HIV/AIDS education conducted in city, county and state correctional facilities.

- Consideration should be given to educators with similar life experiences i.e. race, ethnicity, gender, sexual orientation, as prison population.

-For County jails: support formerly incarcerated educators to return to facility to deliver Health Education/Risk Reduction, including sexuality, family planning, and HIV/AIDS education.

**Gay Men/MSM:**

-HIV prevention needs of heterosexual men and women require an understanding of socio-cultural attitudes and beliefs about sex, sexual orientation and intimacy. HIV prevention should also be informed by the understanding that there is a tendency for African American women to remain sexually committed to their African American male partners who are incarcerated. This dynamic puts African American women, who may already engage in risky sexual behavior, at heightened risk for STD/HIV infection in cases where African American men have multiple partners who are female and possibly same-sex partners if incarcerated.

-Sex workers (male and female) should not have condoms on their person held against them as indicative of prostitution.

-We should be fostering dialogue in communities of color to address negative perceptions of homosexuality.

**Immigrant/Migrant Populations:**

-Using theatre/arts, educational DVD's that are both entertaining and educational at the same time.

**Substance Using Populations:**

-Provide educational presentation in doctor's office waiting rooms

-Target High schools

**Women:**

-Services must be women-centered include skill-building, child care, transportation service.

-Programs should be located in areas where at risk women can be found

-Program should empower women to share information with their partners.

-Interventions should destigmatize drug use amongst women and promote self care.

-Intervention should distinguish drug use amongst women and emphasize self care

**C. Transmission Category: IDU**

✓ **ESAP, Syringe Exchange, transitional case management, Buprenorphine, opioid overdose prevention, harm reduction approach, linkage to supportive services (and re-entry services if being released from a correctional institution) with coordination to ensure that people get needed services in the appropriate time frame and manner**

**People Living with HIV/AIDS:**

- Promotional efforts must be targeted to communities in high need-based on "epi-data."

-Need to acknowledge and address the stigma attached to IDU.

-Promote locations that are convenient and easily accessed by those with no personal transportation.

**Criminal Justice Populations:**

-See overarching considerations for Criminal Justice populations, pages 14-15.

**Gay Men/MSM:**

-Opioid overdose prevention training for responders is cost-effective and requires expansion and training of MSM as responders for MSM IDU.

-There is a challenging need for access to mental health treatment for this population and sub-populations including MSM.

-Treatment on demand must be more a reality throughout the State, and that treatment should be tailored for various populations (including gay men/MSM) and substances (including methamphetamine). Reimbursement (including Medicaid and private insurance) can limit appropriate, timely access to treatment.

-We need to focus on the quality of syringe access as well as its integration with other services including housing, health care. Quality measures should include its impact on co-morbidities, such as overdose and HCV , as well as cancer, diabetes, etc.

-Physicians and other clinicians can be better trained in drug user health. The NYS HIV Guidelines on HIV and Substance Use is a starting point.

**Substance Using Populations:**

-Keep the threshold to services as low as possible

-Substitution Therapy (i.e., methadone, buprenorphine)--outside of NYC there are often long waiting lists, more treatment spots are needed

-Syringe access: many places don't have syringe exchange; expand ESAP and implement regional mobile PDSE teams in rural communities (ice cream model)

-Safe Injecting Facilities are the safe environment to deliver the IDU Health Package

**Women:**

-Women should be assisted in the referral of drug using partner to ESAP and to other Harm Reduction services

✓ **Interventions delivered to Groups (IDG)/Interventions delivered to Individuals (IDI) with Harm Reduction approach, outreach utilizing peer mentors**

**People Living with HIV/AIDS:**

- Acknowledge and address the stigma attached to IDU among multiple communities.

**Gay Men/MSM:**

-Given the relatively brief nature of IDI and IDG interventions, positive behavior change effected through these interventions could be expanded/extended with the implementation of a peer-mentoring component where high-risk behaviors of MSM-IDU could be monitored and harm-reduction needs specific to MSM-IDU populations could be addressed, as could social system contributors.

**Substance Using Populations:**

-Incentives should be used

-Multi session interventions with a clear scenario would be most effective

-Repeat Safer Sex and Safer Drug Use messages

-Trauma Informed Care

**Women:**

-Women view the shared drug experience as part of the intimacy and trust in the relationship

-Help women separate the drug use behaviors from their relationships

- Some women might view shared drug experiences as part of intimacy and trust in their relationship.

✓ **HIV Counseling, Testing and Referral (CTR); STI screening, Hepatitis B and C screening**

**People Living with HIV/AIDS**

-Promote CTR through public awareness campaigns.

-Acknowledge and address the stigma attached to communities of Injection Drug Users.

**Criminal Justice Populations:**

-Ensure that a process is in place for providing test results when incarcerated individuals are transferred or discharged prior to receiving their confirmatory test results.

**Gay Men/MSM:**

-IDU negative population should be annually screened for HIV, STI, Hepatitis B and C especially for MSM who engage in high-risk behavior and for those using meth. This could be tied to incentives when behavioral change is targeted with treatment outcomes of increased condom use and reduced unprotected intercourse.

**Substance Using Populations:**

-Incentives should be used

-One Stop Shopping: catch them while you can.. HIV-STI-HEP screening at the same time, in one spot

**D. Transmission Category: Perinatal/Pediatric**

✓ **HIV Counseling, Testing and Referral (CTR); STI screening, Hepatitis B and C screening, including late term and partner testing**

**People Living with HIV/AIDS**

- Provide comprehensive services, but realize that HIV-specific focus may keep some away.

-Be willing to address fear and denial with family and individuals.

**Criminal Justice Populations:**

-Ensure that a process is in place for providing test results when incarcerated individuals are transferred or discharged prior to receiving their confirmatory test results.

**Gay Men/MSM:**

-CTR should focus on life skills training and consistent effective condom negotiation.

-CTR should strengthen interpersonal skills of partners and encourage disclosure surrounding past and current sexual partners and partner sex-orientation.

✓ **Interventions delivered to Individuals (IDI)/Interventions delivered to Groups (IDG) using peers, including condom distribution, education and negotiation, Partner counseling, including sero-discordant couples**

**People Living with HIV/AIDS:**

- Provide a safe, clean and comfortable space for service delivery.

-Distribute safer sex materials with a knowledge and appreciation of community norms.

**Gay Men/MSM:**

-Texting and viral messages through new/social media should be tailored for the populations through a peer-delivered approach.

-Healthy relationships focus and peer involvement to improve ability to make informed decisions.

✓ **Comprehensive Risk Counseling Services (CRCS), including condom distribution, education and negotiation**

**People Living with HIV/AIDS:**

- Provide a safe, clean and comfortable space for service delivery.

-Distribute safer sex materials with a knowledge and appreciation of community norms.

-CRCS must be culturally and linguistically appropriate.

**Gay Men/MSM:**

-Providers should focus on strengthening social support systems.

-Reproductive health services and discussion of contraception and barrier utilization needs to be integrated with sexual history and drug usage.

-Collaboration between social worker and case manager in addressing multi-generational disclosure issues.

## **Chapter 7 Index**

The NYS HIV/AIDS Prevention Planning Group developed this index specifically to assist the reader in finding information about a specific racial or ethnic group or a particular population in Chapter 7 (Considerations to Take into Account when Implementing Priority Interventions).

### **African American/Black communities**

Chapter 7, pages 2-5, 15.

### **Hispanic/Latino/Latina communities**

Chapter 7: pages 5-7

### **Asian and Pacific Islander communities**

Chapter 7: pages 7-10

### **Native American communities**

Chapter 7: pages 10-13

## **Population specific references:**

### **People Living with HIV/AIDS**

Chapter 7: pages 25, 27, 28, 29, 31, 32, 33, 34, 36, 37, 38, 40, 41, 42, 43, 44, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62

### **Criminal Justice Populations**

Chapter 7: pages 25, 28, 29, 31, 32, 34, 36, 40, 41, 42, 43, 44, 45, 46, 48, 49, 50, 52, 53, 54, 55, 56, 57, 59, 60, 61

### **Gay Men/MSM**

Chapter 7: pages 16-17, 26, 27, 28, 30,31, 33, 34, 35, 36, 37, 38, 40, 41, 42, 43, 45, 46, 47, 48, 49, 50, 52, 53, 54, 55, 56, 57, 59, 60, 61, 62

### **Immigrant/Migrant Populations**

Chapter 7: pages 18-19, 27, 29, 30, 36, 41, 44, 45, 46, 53, 58

### **Over 50 Populations**

Chapter 7: pages 19-20

### **Substance Using Populations**

Chapter 7: pages 26, 27, 29, 30, 32, 33, 34, 35, 36, 37, 38, 39, 41, 42, 43, 44, 45, 47, 48, 49, 51, 53, 54, 56, 57, 58, 59, 60, 61

**Transgender Populations**

Chapter 7: pages 20-22

**Women**

Chapter 7: pages 23, 26, 27, 31, 32, 33, 34, 35, 36, 37, 38, 41, 42, 43, 44, 45, 47, 48, 50, 53, 54, 55, 56, 57, 58, 59, 60

**Young People**

Chapter 7: Pages 22 to 24

**Heterosexual**

Chapter 7: pages 28-39

## 8

**Provider Needs**

The *2010-2015 NYS Comprehensive HIV Prevention Plan* provides guidance as to what HIV prevention interventions would be most effective in reducing HIV transmission for populations most at risk in NYS. Although important information needed for the implementation of appropriate, culturally competent, science-based HIV prevention interventions is included, the PPG and the DOH recognize that:

- ✓ 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.
- ✓ The needs of providers need to be considered, so that technical assistance, capacity building and other agency-specific needs could be met.

This Chapter provides a very brief summary of what providers may need to be able to successfully develop and implement the prioritized interventions as detailed in this *Comprehensive HIV Prevention Plan*. The lists below were developed as a result of an exercise engaged in by the PPG and could be considered a “wish list”. These needs should not necessarily be considered gaps since, in many cases, they are already present within programs or required by funders. Although each provider within the State has its own unique needs, most will naturally fall within the categories below. 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.

**Funding-related provider needs:**

- Increased HIV prevention funding in general
- Providers should expand their funding streams to include to include non-governmental funding streams
- Paperwork and bureaucracy should be streamlined
- Specific funding:
  - to address HIV-related stigma/discrimination
  - for training
  - for test kits

to “market” testing (STD, HCV or Hep-C)  
for marketing the agency, HIV prevention information and provide awareness to  
the community

- Examine the possibility of cash advances for agencies
- Flexibility in designing programs that respond to a particular Request for Applications (RFAs) but are most appropriate for target populations
- When reviewing an agency’s budget, include direct service staff so they may understand the fiscal side of the program
- Provide flexibility in use of funding
- Additional resources to support home grown interventions.
- Ability to apply for non-restrictive funds for innovative programming
- Interagency collaboration to optimize funding

**Agency oversight-related provider needs:**

- Agencies should be mindful of hiring practices, understanding that the people they are serving want to see people who look like them in the place that they are going to. This helps to provide grassroots credibility.
- Service providers should be mindful of public relations
- Providers should be accountable to those they serve to ensure clients’ needs are being met. All agencies must have a client grievance protocol in place.
- Consistent policies and procedures should exist in all agencies
- Administrative support
- Clinical supervision for staff to address stress management and to keep them healthy and able to do their jobs
- It could be helpful if Management of larger agencies could assist smaller grassroots organizations in starting up their services and sharing best practices so that there may be more agencies who can implement effective interventions

**Technical Assistance (TA)-related provider needs:**

- Cultural diversity/competency training on an ongoing basis (including trainings meeting the needs of subpopulations such as young people); sensitivity training (i.e., sexual orientation issues, homophobia, trans issues, stigma, etc.) on an ongoing basis
- Sexuality education for staff
- Health literacy training for staff
- Workshops on cutting-edge HIV prevention issues; access to cutting-edge, accurate updated research; access to information about clinical trials
- Dissemination of best practices, relevant reports, articles and other printed materials between providers
- Cross training between staff with different functions within the organization so that staff have an understanding of the functions of the rest of the agency
- Workshops/training re: health care reform and other laws/policies impacting service providers

- Workshops to increase capacity building skills for staff (i.e., grant-writing training); management training/capacity building
- More trainings surrounding evidence-based interventions, including DEBIs
- Trainings to provide an understanding of criteria specific to funding sources (i.e., CDC, NIH, etc.)
- Professional development opportunities to enhance job-related skills; training, capacity building
- Support and technical assistance for integrating HIV/STD/Hepatitis services to discuss best practices and other technical assistance needs
- Quarterly meetings for prevention-funded agencies to discuss best practices and other technical assistance needs

### **Program-related provider needs:**

- Utilization of more peers in programming
- Public relations for service providers--a lot of people don't understand what resources are available in their communities and what different providers provide, so having a public relations campaign that really informs about area resources and where people can go for their providers would be helpful.
- An effective, identified, referral system to support screening (i.e., mental health, substance abuse) of clients
- A community needs assessment, to better what the target community needs, not only by using data and statistics but actually talking to clients, in particular, persons living with HIV and AIDS including community forums/listening sessions to elicit and understand community needs
- Technology (internet, social network sites, texting, etc.) can be useful to agencies
- Become aware of and learn to utilize technology so that tools like Skype, internet chat rooms and Facebook can be effectively and appropriately utilized.
- Better support to promote programs such as ESAP. In certain communities there is little information for pharmacies to participate.
- Flexible program hours based on the needs of clients
- Support for implementing innovative HIV prevention strategies
- Utilization of consumer advisory boards
- Comprehensive needs assessments re: geography, provider/resources available, including the contexts related to those needs
- Interpretation and translation services
- More mobile services
- Social networking
- Better resources and social networking platform to connect upstate and downstate service providers, for example AIDS Nurses for AIDS Care and the Ryan White Network
- Additional resources to support home-grown interventions
- Childcare
- Expanded transportation access
- Clinical supervision addressing boundaries, retention, burnout

- More prevention supplies
- Mobile vans for a greater reach, particularly in rural parts of the State

**Miscellaneous needs:**

- More community openness about HIV using media campaigns, media coverage on public transportation, newspaper articles, etc.
- Co-locate psychiatric/mental health staff in CBOs
- Revise CDC transmission risk categories (in particular the NIR category)
- More prevention activities within rural areas of the state

# 9

## Useful Acronyms, Words and Phrases

**Introduction** The PPG has identified numerous acronyms, words and phrases that frequently are used in HIV prevention work. The following definitions have been gathered and/or developed by PPG members.

### Useful Acronyms

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

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

<b>NA/AN</b>	Native American/Alaskan Native
<b>OASAS</b>	Office of Alcoholism and Substance Abuse Services
<b>OCFS</b>	Office of Children and Family Services
<b>OMD</b>	Office of the Medical Director
<b>OMH</b>	Office of Mental Health <i>also</i> Office of Minority Health
<b>OPER</b>	Office of Program Evaluation & Research
<b>OPWDD</b>	Office for Persons with Developmental Disabilities
<b>PLWA</b>	Persons Living With AIDS
<b>PLWHIV</b>	Persons Living With HIV
<b>PNAP</b>	Partner Assistance Program (statewide)
<b>PPG</b>	Prevention Planning Group
<b>PPU</b>	Prevention Planning Unit
<b>R/E</b>	Racial/Ethnic
<b>RFA</b>	Request for Applications
<b>RFP</b>	Request for Proposals
<b>RGA</b>	Regional Gaps Analysis
<b>SAMHSA</b>	Substance Abuse Mental Health Services Administration
<b>SASDC</b>	Statewide AIDS Service Delivery Consortium
<b>SED</b>	State Education Department
<b>SEP</b>	Syringe Exchange Program <i>also</i> Special Emphasis Panel
<b>SGL</b>	Same Gender Loving
<b>SOC</b>	Stages of Change Behavioral Science model

<b>SOFA</b>	State Office for the Aging
<b>STD</b>	Sexually Transmitted Disease
<b>STI</b>	Sexually Transmitted Infection
<b>TA</b>	Technical Assistance
<b>TG</b>	Transgender

### **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.

**AIDS-Related Stigma or AIDS Stigma:** refers to prejudice, discounting, discrediting, and discrimination directed at people perceived to have AIDS or HIV, and the individuals, groups, and communities with which they are associated

**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 to describe 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.

**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 the 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.

**HIV/STI integration:** Making both STI screening and HIV testing more accessible to prevent new infections and facilitate entry into care and services for individuals already infected. Screening and testing also provides an opportunity to discuss risk behaviors.

**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).

**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).

**Internet Interventions:** The internet is used as a virtual meeting place for discussing, and sometimes promoting, behaviors that place one at risk for HIV and STDs. Innovative programs use the internet as a means to promote safer sex behaviors, raising awareness regarding HIV and STDs and providing one-on-one information to individuals seeking guidance online.

**Interventions Delivered to Groups (IDGs),** sometimes called Group Level Interventions (GLIs) are health education and risk reduction interventions provided to groups of varying sizes. They 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.

**Interventions Delivered to Individuals (IDIs),** sometimes called Individual-level Interventions (ILIs): health education and risk-reduction counseling provided to one person at a time. They 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.

**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.

**Same Gender Loving:** a term originally coined by community activist Cleo Manago in the early 1990s for African American Gay, Lesbian and Bisexual use. It is often used by those who prefer to distance themselves from terms and behaviors that they see as associated with traditional Gay culture. The term is also considered by some to be a better description of the emotional connections between gay men and women than the "Gay" identity. Although the term was first established to separate from a "Gay, white establishment", its actual meaning is not race-specific.

**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 while the other has

not.

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

**Sexual Harm Reduction:** an approach to reducing the harm associated with the sexual behaviors of injection drug users.

**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. Social Marketing is commonly used in public health and other social change campaigns.

**Social Networks/Social Networking:** Enlisting persons who are HIV/STI infected or HIV negative and at high risk to recruit in their social, sexual and drug using networks to seek HIV/STI counseling and testing. The enlisted persons, or "recruiters," are coached by CBO staff on strategies for discussing risk, the importance of testing, and engaging in care. Recruiters help peers connect to testing and engaging in care. Recruiters help peers connect to testing and in some instances accompany peers to testing.

**Sociocultural Model:** see Chapter 4.

**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** are 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.

**Transgender** is an umbrella term that refers to people whose gender identities or expressions differ from those typically associated with the sex they were assigned at birth.

**Transmission categories** In describing HIV/AIDS cases, same as exposure categories; how an individual may have been exposed to HIV, such as sexually (through MSM or heterosexual contact, injection drug use, perinatal).

**Youth Development Approach** focuses on young people's assets (capabilities, strengths) and not solely on their deficits (negative behaviors, problems). Programs that use a youth development approach work with young people to help them realize their fullest potential.