Pennsylvania
Community
HIV Prevention Plan

September 17, 2001

Robert S. Zimmerman, Jr., Secretary of Health

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The extraordinary efforts and hard work of the Pennsylvania HIV Prevention Community Planning Committee and staff of the Division of HIV/AIDS of the Pennsylvania Department of Health.

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Pennsylvania Department of Health
HIV Prevention Community Planning Committee

FOREWORD

In 1993 the Centers for Disease Control and Prevention (CDC), working closely with other governmental and non-governmental partners, issued guidance on HIV Prevention Community Planning to state, territorial, and local health departments. Since 1994 the Pennsylvania Department of Health's (DOH) Division of HIV/AIDS (Division) has conducted regular community-focused HIV prevention planning. The Department is committed to planning that incorporates both perspectives of groups at risk for HIV infection, for which it's programs are intended, and the views of HIV prevention services.

The Centers for Disease Control and Prevention initiated a five-year planning cycle commencing in calendar year 1999. Pennsylvania's HIV Prevention Community Planning Committee decided to divide that span into a three-year (1999-2001) and a two-year (2002-2003) Plan. This document represents the year 2002-2003 plan. Philadelphia has voting representation on the statewide Committee. However, it receives HIV prevention funding directly from the CDC and therefore has its own community planning group. A representative of the Division of HIV/AIDS regularly attends meetings of both committees.

The Division convenes the statewide Committee, selects meeting sties, provides meals and lodging, and assists members with travel arrangements. In addition, the Division provides technical assistance and staff support to the Committee and its subcommittees in the areas of AIDS Epidemiology, HIV antibody testing and counseling, other federal and state HIV-related activities, and any additional input the Committee needs. The Division also prepares the CDC funding applications that are consistent with the HIV Prevention Plan's objectives, recommended activities and interventions, and priorities. Finally, the Divison initiates and monitors subcontracts as determined in the application and coordinates with other state agencies as appropriate regarding the priority of the prevention plan objectives.

Pennsylvania's HIV Prevention Community Planning Committee is a group of individuals united for a common purpose. Members serve by virtue of their life experiences and expertise, not as representatives of any agency or organization. The Committee is charged with developing an HIV prevention plan that includes objectives and recommended interventions and related activities. In addition, the Committee reviews DOH's annual application to the CDC for HIV prevention funding to insure that the document concurs with the prevention plan. The Committee also provides input and recommendations to the Division of HIV/AIDS on other issues related to HIV prevention.

The Pennsylvania Prevention Project (PPP) at the University of Pittsburgh's Graduate School of Public Health facilitates the annual planning process. The PPP facilitates meetings of the Committee and its subcommittees and produces minutes. In addition, the PPP carry's out needs assessments and provides technical assistance to the Division and the Committee in behavioral science, prevention planning, program evaluation, and process evaluation of the annual planning procedure. Finally, the PPP monitors community-based demonstration projects based upon recommendations of the HIV Prevention Plan.

This document is based upon annual guidance provided by the Centers for Disease Control and Prevention. **Section I** reviews steps by the Committee and Division to meet the five core objectives of community HIV prevention planning for 2002 **Section II** presents the current AIDS Epidemiological Profile for Pennsylvania, and cross-program activities. **Section III** discusses priority populations and interventions. **Section IV** outlines overarching goals of the plan as well as specific goals, objectives and actions and addresses Coordination of HIV prevention services. **Section V** reports on the status of the Pennsylvania five-year strategic evaluation plan.

Pennsylvania Department of Health
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2001

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HIV PREVENTION COMMUNITY PLANNING

FIVE CORE OBJECTIVES OF HIV PREVENTION COMMUNITY PLANNING

There are 65 HIV prevention community planning jurisdictions funded by the Centers for Disease Control and Prevention. A set of five national core objectives has been developed to provide a framework in which those jurisdictions can be compared and in which concerns specific to HIV prevention community planning can be readily identified and addressed. Discussion of Pennsylvania's work toward the core objectives follows.

(1) Fostering the openness and participatory nature of the community planning process

Current Description: The Pennsylvania HIV Prevention Community Planning Committee for 2001 is composed of 40 voting members from across the Commonwealth (Appendix I). Joe Pease is the Co-Chair from the Division of HIV/AIDS and Reneé Hartford is the Community Co-Chair. One member represents the city of Philadelphia, three members are from the executive committee of the Young Adult Roundtable, and one member represents the Pennsylvania Integrated HIV Planning Council (Ryan White HIV/AIDS Regional Planning Coalitions). Two other members of the HIV Prevention Committee are voting members of the Integrated HIV Planning Council, and there are voting members representing the Pennsylvania Departments of Education and Corrections. In addition, consultants from the Health Department's Bureaus of Drug and Alcohol Programs, Epidemiology, Family Health, and its Division of HIV/AIDS regularly participate on the Committee.

Methods used to obtain input from outside the Committee include consluting the nationally recognized Young Adult Roundtables which exist in nine communities (Camp Hill, Erie, Harrisburg, Lehigh Valley, Norristown, Pittsburgh, Reading, Williamsport, and York). According to process data obtained from Committee members over several years the Roundtables provide valuable information about youth and young adults. Three individuals from the Young Adult Roundtable Executive Committee are elected by their peers to be voting members of the HIV Prevention Committee. Liaison work between the Pennsylvania Prevention Project, the County and Municipal Health Departments, and the seven partnership members of the State Health Improvement Plan provides additional feedback from the local level to the HIV Prevention Committee. Finally, the Pennsylvania Prevention Project provides community leadership development and community-wide HIV prevention planning in Erie, and York where it is able to gather valuable HIV prevention information

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Recruitment and training The Committee observes the following procedures in recruiting new members. (1) The annual process evaluation of the Committee is conducted at its November meeting.

Process Evaluation 2000

- The most recent process evaluation was conducted on November 15, 2000 by facilitators not familiar with the Committee
- Questions based upon the Five Core Objectives of Community HIV Prevention Planning in which 56% (22) of the Committee participated.
- Anonymous Survey of all Committee members in December in which 44% (18) of the Committee responded.
- Committee reviews and approves a final draft.
- Membership Subcommittee utilizes information for recruitment of new members in 2001.
- Training & Development Subcommittee utilizes information to inform them of Committee development needs.

Mentor Job Description

(1) assists in clarifying the purpose of the annual plan, the functioning of the Committee and its subcommittees, and the roles of the Committee members, the facilitator, and co-chairs.
(2) acts as a role model for new members by demonstrating a commitment to participating, being on time, remaining for the duration of meetings, etc.
(3) assists in logistical matters such as, the location of meetings, making hotel reservations, making travel arrangements, reimbursement paper work, etc.
(4) clarifies and assists in seeking clarification of any issues raised at the meeting.
(5) attends the orientation, and reception.
(6) sits with the new committee member at the first regular meeting of the Committee.
(7) remains a mentor for the duration of the new Committee member's first year, or for as long as the new Committee member requests.

(2) The Membership Subcommittee meets via a telephone conference call in November to review the attendance of the current year's Committee members and to recommend removing any non-participating Individuals. Throughout the year, members who do not attend are sent materials distributed at meetings and letters asking them to communicate with the co-chairs if they are experiencing problems in attending. In addition, the Membership Subcommittee reviews information such as gender, race/ethnicity, HIV infection, and geography to determine gaps in representation on the Committee. (4) The Department of Health widely distributes applications for membership on the Committee. The known HIV/AIDS service universe is targeted as well as non-traditional venues such as Black Sororities, Hispanic or Latino(a) organizations, and leaders from the Asian and Pacific Islander community. In addition, the application is on the stophiv.com web site. (5) The Membership Subcommittee reviews applications and meets via a telephone conference call by the end of January to select new Committee members. (6) Individuals thus chosen, are notified by the Health Department and invited to a daylong orientation in March. Each is assigned a mentor, who is a current experienced Committee member. A reception is held during the evening of the same day to introduce new members to the rest of the Committee, staff of the Pennsylvania Prevention Project, and representatives of the Department of Health.

Subcommittees The Committee makes decisions using a modified consensus model: the majority rules if necessary, although every attempt is made to achieve consensus. The Training and Development Subcommittee spent considerable time guiding the Committee through the development of "Ground Rules" for discussions. In addition, modified Roberts Rules are utilized for motions and voting purposes.

Ground Rules for Discussion

- Those who wish to speak must be recognized by the Co-Chair or Facilitator
- No cross-talking or sidebar conversations.
- Respect time—no long oratories
- Verbal attacks are not acceptable
- Agree to disagree with respect
- Respect the other speaker and do not interrupt
- Members are encouraged to ask questions and seek clarification
- Create a "parking lot" during meetings to rest ideas or discussion items. Decision on each parking lot issue should be made before the end of discussion
- Recognize and respect others' physical limitations and capacities
- Do not simply reiterate; just agree
- Do not speak for others (i.e., use "I" statements)

Small group processes, including establishing subcommittees and work groups, present the most effective means for the Committee to reach decisions. Subcommittees are permanent, but work groups are generally convened for a fixed time period. Work groups have, for example been formed to focus on methods of reducing harm for injection drug users, recommendations on reporting HIV infection, and so forth. During this past year the Committee created a work group to examine the current subcommittees and make recommendations. The full Committee reviewed and refined those recommendations for final approval.

TABLE 1-1

SUBCOMMITTEE	ROLE
The following subcommittees meet on	**an as needed basis**
Community-Based Initiatives	Monitors and recommends initiatives to increase community involvement in prevention planning (e.g., community leadership development initiatives, community based technical assistance programs, and community demonstration projects)
Funding Guidelines	Monitors and makes recommendations regarding funding applications and contract guidelines (e.g., preparing CDC Continuation Grant Application, recommending allocations, and reviewing funding guidelines for prevention projects)
Membership	Monitors and makes recommendations regarding membership on the Committee and its subcommittees
The following subcommittees meet 3	**to 4 times per year on a regular schedule**
Counseling and Testing	Monitors and makes recommendations regarding issues relating to the HIV counseling and testing system; also evaluates the effectiveness of HIV counseling and testing
Prevention, Planning, and Evaluation	Monitors and makes recommendations regarding evaluation of the planning process, the prevention plan, and demonstration projects and; also assists in developing prevention standards and guidelines.
Priority Populations and Intervention	Examines and refines the process for developing priority populations and interventions
Training and Development	Examines requests for training and development to improve the skills and knowledge of the Committee (e.g., how and when to incorporate training and development into the Committees agenda, identifying and recommending consultants or training resources, etc.)
Youth Empowerment	Monitors and makes recommendations regarding issues affecting young people. Membership includes the Young Adult Roundtable co-chairs. Responsibilities include: encouraging representation and membership of young people on the

Youth Empowerment	Committee, liaison work with Young Adult Roundtables, other issues relating to HIV prevention and young people, needs assessment data for young people, and conveying information from the Young Adult Roundtables to the Committee and from it to the Roundtables.

(2) Ensure that the CPG(s) reflects the diversity of the epidemic in your jurisdiction and that expertise in Epidemiology, behavioral science, health planning and evaluation are included in the process.

At the end of June 30, 2001 the Pennsylvania Department of Health's HIV/AIDS Surveillance Quarterly Summary reported 25,256 diagnosed cases of AIDS, of which 53% (13,298) have died. A recent publication by the Institute of Medicine, No Time to Lose: Getting More from HIV Prevention, reports that the current epidemiological surveillance system, which is based primarily on AIDS case reporting and more recently on HIV case reporting in selected states (not Pennsylvania), does not provide a complete or accurate picture of HIV incidence. The present system merely tracks where the epidemic has been rather than where it is going. Nonetheless, at this time the demographics of diagnosed AIDS cases is the standard for generating diverse representation on the Committee. The following three tables present the current Committee's membership by both gender and race/ethnicity not including Philadelphia.

TABLE I-2

	Committee Members (40)	**Diagnosed Cases of AIDS in PA 1996-2000 (3,389)**
Men	37% (15)	78% (2,631)
Women	63% (25)	22% (758)

Not including Philadelphia

TABLE I-3

Race/Ethnicity	**Committee Members (40)**	**Diagnosed Cases of AIDS in PA 1996-2000 (3,389)**
White	48% (19)	41% (1,380)
Black	40% (16)	45% (1,524)
Hispanic/Latina	10% (4)	14% (472)
Asian-Pacific Islander	2% (1)	.38% (13) other

Not including Philadelphia

Pennsylvania's population can fluctuate greatly from region to region. According to the most recent statistics, there are 12,046,112 residents of the Commonwealth including Philadelphia. 88%-Caucasian, 9.7%-African American, 2.3%-Hispanic, and 1%-Asian and Pacific Islander. Many observers believe that the Hispanic and Latino/a populations are undercounted by the census.

TABLE 1-4 Total Pennsylvania Population by Race and Age

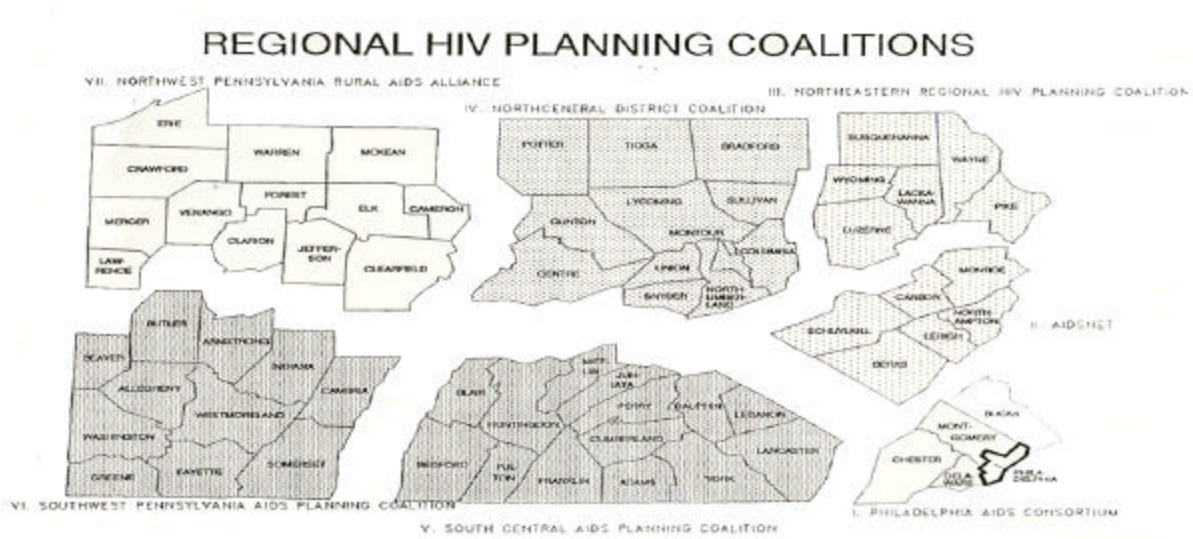
Age	Total percentage of population 12,046,112	Caucasian 88% (10,708,035)	African American 9.7% (1,171,088)	Hispanic and Latino 2.3% (289,808)
1-19 years	27%	26%	34%	41%
20-49 years	43%	42%	44%	45%
50+ years	30%	32%	22%	14%

The Commonwealth is divided into seven Ryan White HIV/AIDS Regional Planning Coalitions.

TABLE I-5 Membership of the HIV Prevention Committee for 2001 by Coalitions

Ryan White HIV/AIDS Regional Planning Coalitions	Committee Members by Region	Diagnosed AIDS Cases by Region 1996-2001 **
South Central	25% (10)	23% (789)
Southwest	17% (7)	21% (705)
AIDSNET	17% (7)	14% (463)
TPAC *	15% (6)	27% (925)
Northwest	10% (4)	6% (190)
Northeast	8% (3)	4% (131)
North Central	8% (3)	5% (186)

***** The Philadelphia AIDS Consortium (TPAC) includes Philadelphia, Montgomery, Delaware, Chester, and Bucks Counties. Philadelphia does not receive CDC prevention funds from the Pennsylvania Department of Health. The county of Philadelphia prepares its own grant application and HIV prevention plan in order to receive such funds directly. In addition, the Philadelphia CPG community co-chair is a voting member of the Pennsylvania HIV Prevention Community Planning Committee. A representative of the Division of HIV/AIDS is present at meetings of both groups.



Twenty-three percent (9) of the Committee's members represent the HIV-infected community. Of those nine, 67% are women, and 33% are men. One of the men and half of the women (3) are African-American. HIV-infected members represent Men who have Sex with Men, (MSMs who are African American, Caucasian, and rural); Injection Drug Users; bisexuals; female sexual partners; and the incarcerated.

(3) Ensure that priority HIV prevention needs are determined based on an epidemiologic profile and needs assessment.

Epidemiologic Profile Epidemiology studies the occurrence of infections or disease in a population. Ideally it can calculate how many people are newly infected with HIV, what subpopulations have been infected, and who might become infected. Epidemiology can help program planners target specific audiences for interventions and address risk behaviors that are most serious in a community.

The Epidemiological Profile derives from (1) AIDS surveillance data for Pennsylvania; (2) HIV seroprevalence surveys of defined populations (e.g., of childbearing women and of persons receiving publicly funded HIV counseling and testing); (3) state mortality data related to HIV; (4) statewide statistics on Sexually Transmitted Infections (STIs) and pregnancies, phenomena that provide surrogate information about populations participating in risk behaviors associated with HIV transmission; and (5) statewide estimates of HIV seroprevalence calculated by extrapolation from national estimates and with data from the HIV Seroprevalence Survey in Pennsylvania's Childbearing Women.

The inferences that can be made from such data enable those who plan prevention programs and healthcare to better determine which population-transmission groups and geographic areas should have priority in receiving resources for prevention and care. In the past separate profiles were generated for care and prevention planning in order to mirror the reality of separate funding for each activity. However, this update of the epidemiological profile recognizes the dense and often undifferentiated continuum that exits between prevention and care. The profile thus includes data relevant for an integrated approach to planning for prevention and care.

The Planning Committee continues to benefit from the expertise of the Department of Health's Bureau of Epidemiology, which compiles and updates the Epidemiological Profile and provides data pertinent to prioritizing target populations or risk-behavior groups. In 2000, the Bureau's HIV/AIDS epidemiologist assigned to work with the Planning Committee sought expert advice from a panel of nationally known communicable disease epidemiologists. This enabled him to devise a weighting-and-ranking system for epidemiological data used in the prioritization process for target populations.

In addition, the Committee began to educate itself about the basics of epidemiology. The above mentioned HIV/AIDS epidemiologist delivered a presentation on key terms and concepts at the groups meeting in May. Furthermore, information from the first

annual conference of the Center for AIDS Prevention Studies was disseminated to members. The Training and Development Subcommittee will explore methods to further illuminate Committee members relative to epidemiology. In addition, they will ensure that new Committee members are exposed to basic epidemiology during Orientation.

Needs Assessment The Department of Health and the Planning Committee have embarked on a major update of needs assessment data. Extensive needs assessments were conducted among a number of at-risk populations between 1994 and 1996, with periodic updates undertaken on a smaller scale in subsequent years.

Three statewide needs assessments have been completed or are currently in progress. The first targeted groups of injection drug users (rural, young, Latino, female, and long-term users) and was completed late in 2000. A second needs assessment targets men who have sex with men (young, African-American, Latino, injection drug using, rural, and white middle class) and is in progress. The third targets subgroups of heterosexuals at risk of HIV infection and is also in progress.

Purpose of Needs Assessments

1.) assess existing community resources for HIV prevention in order to determine the community's capability to respond to the epidemic;
2.) identify unmet HIV prevention needs within defined populations; and
3.) prioritize HIV prevention needs by defined high-risk populations.

CDC's Handbook for HIV Prevention Community Planning (1994)

Data is gathered through focus groups and individual interviews. Participants are asked about their knowledge of HIV/AIDS, HIV-related risks and barriers, their experience with prevention interventions, and psychosocial considerations like the impact cultural factors have on their ability to access prevention services.

The University of Pittsburgh's Pennsylvania Prevention Project (PPP) carry's out the needs assessments. Members of the Committee are involved in identifying target populations, developing questions, and conducting related activities.
Besides supporting statewide efforts to plan for HIV prevention findings, need assessments can assist local entities involved in developing and implementing HIV prevention interventions.

Because of stigmatization of HIV related behavior, many members of risk groups do not publicly identify with these groups. Thus random surveys that can be generalized to all risk group members can not be carried out. Therefore, qualitative assessments using focus groups and interviews are used. A sampling frame based on AIDS Epidemiology

is used so that the members of focus groups reflected people with AIDS in gender, race and ethnicity, and geographic place of residence.

The need assessments are qualitative in nature since they aim only to capture individual's perceptions. These assessments are not meant to be representative of all injection drug users, men who have sex with men, or heterosexuals in Pennsylvania. Instead, they seek to register in a detailed, structured manner the impression of some members from each of these groups.

To accomplish this, the staff of the PPP takes the following steps:

- review of the literature and of data from past needs assessments
- identification of sampling frame
- development of questions
- identification of methods
- development of budget
- application for approval to the institutional review board of the University of Pittsburgh
- identification and training of staff
- implementation of needs assessment
- analysis of data
- evaluation of project.

When the data are analyzed, common themes are identified with special attention given to what is known about each subgroup and existing gaps in knowledge. Information is grouped by the following categories: 1) epidemiological information, 2) Factors impacting a group's ability to recognize risk, change unsafe behavior, and maintain safe behavior, 3) HIV-related barriers to behavior change and their associated needs, and 4) strategies or interventions that have been used with relative effectiveness.

Developing questions for this needs assessment drew upon several sources of information. Specifically, questions were based on: 1) informational needs of the Committee, 2) topics identified through the literature search, 3) questions from past needs assessments, 4) discussions by the Committee about injection drug users, men who have sex with men, and heterosexuals, 5) dialogue between the Committee and the staff of the Pennsylvania Prevention Project, and 6) feedback from outside experts. The staff of the PPP drafted a set of questions for individual interviews and the focus groups based on the above sources of information. Local experts including, individuals who work with these populations, reviewed the draft. After considering the expert's suggestions, selected members of the Committee reviewed and modified the questions. Finally, they were reviewed by two individuals considered national experts in this field of HIV-related focus groups and by additional members of the Committee who represent work with the target groups.

A panel that included staff from the PPP, local experts, and Committee members discussed what methods of study are most appropriate for each subgroup. Subgroups that are marginalized and thus hard to reach (e.g., active injection drug users and commercial sex workers) were accessed using key-informant interviews. Interviews are more appropriate than focus groups for these subpopulations, since some individuals belonging to them might find it difficult to interact with their peers in a group situation. More accessible subgroups (e.g., women in jails, women in recovery) were studied using focus groups.

(4) Ensure that interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, cost effectiveness, social and behavioral science theory, and community norms and values.

Outcome Effectiveness As the Committee moves toward outcome-based methods of evaluating it will better understand the effectiveness of HIV prevention interventions in producing behavioral change. It is difficult to measure the direct effect of HIV prevention programs on keeping individuals HIV-negative; however, estimates may be made for reducing the cost of treating individuals for conditions related HIV infection. As resources permit, the Program Planning and Evaluation workgroup will continue to examine the intricacies of outcome effectiveness and to consider how best to incorporate it into the annual HIV prevention plan.

Cost Effectiveness Cost effectiveness analyses are valuable in setting policies for HIV prevention and establishing criteria for applying interventions. Resources for HIV prevention are relatively scarce, and funding decisions must carefully weigh which interventions offer the greatest promise relative to their costs. Consequently, the Committee is strongly committed to preventing the largest number of new infections. According to No Time to Lose: Getting More from HIV Prevention published in 2001 by the Institute of Medicine, resources should be allocated to prevent as many infections as possible. The document also stresses that allocation must take into account the cost and effectiveness, besides estimates of HIV incidence. Evaluation should be a major component of decisions to allocate resources.

Social and Behavioral Science Theory According to the Center for AIDS Prevention Studies at the University of California San Francisco, basic behavioral science can explore the social, behavioral, and cultural influences that cause people to put themselves at risk for HIV infection. Behavioral science cannot tell service providers what to do, but it can suggest new ways of thinking about programs. Specifically behavior change theory provides a framework for understanding other behaviors that put them at risk for HIV infection. Therefore, behavior change theory can help craft an intervention informing each component as the intervention is designed. In other words, formal theory consists of principles and methods that have already proven useful in some areas of disease prevention and behavior change. Theories can give HIV program planners a framework for the goals of an intervention or help explain aspects of risk-taking behavior. Hence, the Committee believes that using relevant behavioral theories to design HIV prevention interventions can help improve programs and save

valuable time and resources. To this end the Training and Development Subcommittee will continue to explore theoretically grounded interventions for HIV prevention to present to the Committee.

Community Norms and Values The Committee is very diverse, consisting of people from small and large communities throughout Pennsylvania. Since 2000 it has regularly conducted discussions about priority populations (e.g., men who have sex with men, men who have sex with men who are injection drug users, and injection drug users) based on the various community norms and values represented at the meeting table. In addition, the continued work of the Pennsylvania Prevention Project in community-wide planning and community leadership development insures that the Committee is aware of HIV prevention interventions and local norms and values.

Prioritization All jurisdictions receiving CDC funding must establish priority target populations and associated interventions for preventing HIV infection. Pennsylvania's model for prioritization continues to be developed both with more refined HIV/AIDS epidemiological data and with adjustment data from behavioral surveys, needs assessments, and social indicators. The Priority Populations and Interventions Subcommittee will utilize gap analysis data from the uniform data collection system to be implemented in 2002. Once completed the priorities will be fully developed and implemented. By the time that a new five-year plan is required in 2003, the entire system for prioritizing populations and interventions in Pennsylvania will have been tested and well established.

Prioritization entails looking at "macro" data information about the major risk populations/transmission groups while considering race/ethnicity within them Prioritization also entails looking at "micro" data, (the geographic breakdowns of relevant information, the demographics of transmission groups and the life circumstances of individuals within them, such as homelessness, sex work, and imprisonment). Only macro data has been incorporated into Pennsylvania's model for prioritization. The Priority Populations and Interventions Subcommittee has focused its efforts on ranking transmission groups and has not yet developed a formal process for prioritizing interventions.

The Committee continues to work on the following three **AIMS** for implementing the model for prioritization established in the previous planning cycle. **AIM 1:** Rank and prioritize across and within target populations/transmission groups based on data already available (e.g., HIV/AIDS epidemiological data, relative size of target populations, and data indicating needs, including public funds currently allocated to each group and number of factors that are barriers to prevention). **AIM 2:** Rank and prioritize subgroups within target population/transmission groups based on the above factors, but blend in more objective data on the needs of each (e.g. gap analysis data, presence of social factors such as homelessness, incarceration, substance abuse that correlate with HIV risk, access issues or barriers to resources for prevention such as cultural language and customs or living in a rural area). **AIM 3:** Rank and prioritize HIV prevention interventions for each target population/transmission group.

At this time, the weight to be given to life experiences is likely best considered at the local level. Local agencies and regional coalitions probably best understand the life circumstances of individuals within their purview, and these agencies are most qualified to consider such circumstances when they conduct their local or regional prioritization.

(5) Foster strong, logical linkages (i.e., connections) between the community planning process, the comprehensive HIV prevention plan, the application for funding, and allocation of HIV prevention resources.

In 2000 a Linkages Work Group was established to address the linkages between the Committee's HIV prevention Plan allocation of resources and the department of health grant application for procurement of HIV prevention services. Upon recommendation of the subcommittee the Committee adopted the Marco, Inc. format and instrument suggested in Chapter Five: "Evaluation Linkages Between the Comprehensive HIV Prevention Plan and Resources Allocation" within the 1999 Resources for Evaluating CDC HIV Prevention Programs. Crucial to the completion of tables is the continued need for uniform HIV prevention data collection. Uniform collection of information from HIV prevention activities sponsored by three of the major HIV prevention sponsors, namely, the state's county and municipal county health departments, the Ryan White HIV/AIDS Regional Planning Coalitions, and the Council of Spanish Speaking Organizations of the Lehigh Valley will not produce viable data until 2003. Currently the prevention sponsoring groups have changed their forms so that they data that they collect are uniform. Staffs of the Health Department and Spanish Speaking Council have been trained in recording and transmitting counseling and testing data to a central location. Data from the Health Department is already being transmitted and their data are being cleaned. Spanish Speaking Council providers have been trained and are beginning to gather data using the new instrument. Ranking and prioritizing HIV prevention interventions for each target population/transmission group will not take place until 2002.

Section II
EPIDEMIOLOGICAL PROFILE

EPIDEMIOLOGICAL PROFILE UPDATE

In the 2000 and 2001 planning years, the Epidemiologic Profile of HIV/AIDS in Pennsylvania was updated to include more data on the epidemiological analyses of disease. In the absence of information on recently HIV infected cases; these additional data suggest and describe more fully the likelihood of new HIV infections in various geographic areas and in certain population-transmission groups. These data also describe the likelihood of growth in the population that is living with HIV/AIDS in Pennsylvania.

This year's update is meant to provide planners for HIV/AIDS prevention and care greater access to empirical data that they can use to develop relevant interventions and services in Pennsylvania. Therefore, the update extends the analysis conducted and presented in the 1999 Epidemiologic Profile of HIV/AIDS in Pennsylvania: An Empirical Resource of Prevention and Care Planning as well as the Year 2000 Update.

Summary of the initial 1999 analysis indicates:

Summary by Mode of HIV Transmission:

- Among males and females, in Philadelphia and the rest of the state (excluding Allegheny County), the proportion of new AIDS cases probably infected through IDU and heterosexual contact is increasing (for women heterosexual contact w/IDU is second to IDU).
- In Allegheny County, among both sexes there is a notable increase in the proportion of infections due to IDU (and possibly due to heterosexual contact w/HIV+ males of unspecified risk for women).
- MSM as a proportion of male AIDS cases has declined consistently in Philadelphia and Allegheny Counties and the rest of the state, BUT has remained overwhelmingly predominant in Allegheny County.
- A cascade of sub-epidemics is occurring. This cascading effect involves females of childbearing age who are IDUs or who have heterosexual contact with HIV-positive men (IDUs or of unspecified risk). Such women transmit HIV to their children.

Summary by Race/Ethnicity:

- The proportion of AIDS cases diagnosed each year among racial/ethnic minorities is increasing, especially among African-Americans, followed by Latinos/as. The proportion for African-Americans has more than doubled in the 10-year period from 1987 through 1997 and has been consistently observed across the state
- HIV prevalence data suggest that racial/ethnic minorities (mainly African- Americans and Latinos/as) collectively constitute the predominant pool of infected persons; they are, therefore, the main potential sources of new HIV infections.
- The proportion of new AIDS cases that are white has declined significantly from over 70% in 1992 to under 50% in 1997, however, they still constitute a large proportion of new AIDS cases each year.
- Data suggests that the proportion of racial/ethnic minorities among new HIV infections has been increasing; this is supported by evidence on African- Americans in particular, who appear to have the greater rate of increase in AIDS cases coupled with a large source population of persons living with HIV, comparable to Latinos/as.
- Data suggests that these groups are disproportionately affected by the HIV/AIDS epidemic.

Summary by Sex/Gender:

- The proportion of female AIDS cases among all cases is increasing; over 80% of female AIDS cases were of childbearing age (13-44 years) in each successive year over the past 10 years.
- Black women as a proportion of female AIDS cases of childbearing age have increased to over 60%, while Latina and white women appear to have declined to 18% each.
- The proportion of AIDS cases probably infected through IDU is increasing among both males and females across the state.
- Among AIDS cases in women of childbearing age (13-44), there are increases in the proportions of those probably infected through IDU (to just over 50%) and by heterosexual transmission (to about 40%).
- The proportion of female adolescent and female young adult (13-24 years) AIDS cases is increasing; STI data suggest that the potential for heterosexual transmission of HIV to female adolescents (15-19 years) is also increasing.
- Female AIDS cases of childbearing age are now mostly African-American (over 60%) and consist mainly of IDUs, and heterosexuals (mostly sex with IDU males or HIV-positive males of unspecified risk) Over 70% of such cases (5 year average, 1992-6) are directly or indirectly associated with IDU.
- The leading *maternal risk factors* for perinatally-infected AIDS cases are IDU, and sex with IDUs or HIV-positive males with no specified risk; over 65% (5 year average, 1992-6) of perinatal transmission was directly or indirectly associated with IDU.
- HIV prevalence data suggest that males and IDUs are the predominant pools for sources of new HIV infections; transmission appears to be cascading from male IDUs to their sexual partners, who are mostly women of childbearing age; childbearing women who are IDUs and those who are sexual partners of IDUs (and of HIV-positive males of unspecified risk) appear to be increasingly placing their offspring at risk of HIV infection through perinatal transmission.

Summary by Age:

- Each year the proportion of diagnosed AIDS cases probably infected in the age range of 30 - 50 is increasing (i.e. ages 40 - 60 at AIDS diagnosis) with a $\pm$ 10 year incubation period assumed. This increase has been consistently observed across the state.
- Trends of AIDS incidence for those probably infected as adolescents or young adults (13-24 years) may be stabilizing; however, the small numbers in this group limit the possibility of interpreting AIDS trends as a reflection of HIV incidence trends among its members.
- Data on recent gonorrhea and syphilis infections were examined for indications of the likelihood of recent HIV infections among adolescents (15-19 years). Higher incidences of gonorrhea and primary syphilis among adolescents, especially females, suggest that the likelihood of recent HIV infections may be increasing in this age group.
- HIV prevalence data suggest that the age group 20- 44 years (followed by > 45 years) constitutes the predominant pool of infected persons, who are the main potential sources of new HIV infections.

1) Changes over time in estimated prevalence of HIV in the general population and in geographic distribution of such prevalence in Pennsylvania:

- The likelihood of death after 1994 is decreasing, and the percentage of cases that are still alive at the end of follow-up in each year of diagnosis after 1994 is greater than 50% and increasing. This suggest that median survival time for a larger proportion of cases cannot e reliably estimated since many of them have not been followed-up for a period that would correspond to the expected survival time for recently diagnosed cases.

- Observed survival time after diagnosis with AIDS is improving consistently with each successive year of the statewide cohort. The number of newly diagnosed AIDS cases increased with the increase observed in overall survival time and plateaued in the same year.

- Observed survival time after diagnosis with AIDS is improving consistently with each successive two-year interval of diagnosis for all planing coalition areas and for the statewide cohort. The statewide cohort's overall median number of months survived after diagnosis with AIDS increased from 8.33 in 1983-84 to 41.73 in 1993-94. Increasing survival time may result in an increase in the numbers of persons living with HIV/AIDS. An increase in the number of persons living with HIV/AIDS may increase the likelihood of new infections or re-infections.

2) Summary of the Geographic Distribution of AIDS Prevalence in Pennsylvania:

- The estimated prevalence rate remained consistently higher in Philadelphia compared to the rest of the state or to other health districts.

- The Southeastern Health District appears to have the next highest estimated prevalence, and to slightly exceed the estimate for the state in 1997. These results do not show any marked deviation from prevalence observed by the sero-survey of childbearing women.

3) Detailed Breakdown of the Geographic Distribution of AIDS Prevalence in Pennsylvania including Philadelphia:

Table II-1 Persons Living with AIDS: Rate per 100,000 in Each Coalition Area

NE	AIDSNET	TPAC	SC	SW	NW	NC
1-29	45-60	196	45-60	30-44	1-29	30-44

Table II-2 Persons Living with AIDS: Rate per 100,000 by Race/Ethnicity

NE			**AIDSNET**		**TPAC**		**SC**	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
White	122	18.48	258	22.78	1,844	68.95	486	26.79
Black	48	697.67	159	589.72	4,528	595.27	291	375.60
Hispanic	29	436.42	325	473.94	851	561.88	198	198.96
SW			**NW**		**NC**		Cases as of 03/31/00	
	Number	Rate	Number	Rate	Number	Rate		
White	517	20.43	124	13.78	112	17.44		
Black	356	174.54	56	185.54	127	1221.39		
Hispanic	38	176.24	22	260.11	34	482.27		

Table II-3 Persons Living with AIDS: Rate per 100,000 by Gender

NE			**AIDSNET**		**TPAC**		**SC**	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Male	169	52.03	544	89.71	5,569	315.57	742	77.50
Female	30	8.47	200	31.24	1,681	86.49	238	23.54
Total	199	29.31	744	59.68	7,250	195.51	980	49.79
SW			**NW**		**NC**		Cases as of 03/31/00	
	Number	Rate	Number	Rate	Number	Rate		
Male	794	59.94	164	35.60	217	65.58		
Female	122	8.35	41	8.47	58	17.14		
Total	916	32.89	205	21.70	275	41.08		

Ryan White HIV/AIDS Regional Planning Coalitions: NE—Northeast, AIDSNET, TPAC—The Philadelphia AIDS Consortium, SC—South Central, SW—Southwest, NW—Northwest, and NC—North Central. See also map of coalitions on page 6.

4) The Geographic Distribution of Recent Changes in AIDS Incidence in Pennsylvania:

- Analysis of recent changes in the epidemic indicates that 14 high outcome counties have had high average annual rates of increase in new AIDS cases (>+15% and between 1992 & 1997, 62nd percentile) AND have high background average annual case rates (> 7 cases per 100,000 pop, 50th percentile): Allegheny, Cumberland**, Dauphin, Delaware, Erie, Huntingdon**, Lehigh, Lycoming, Northumberland, Philadelphia, Somerset**, Union**, Wayne**, and York.

- Average annual percent of increase due to IDU cases diagnosed from 1993 through 1997 accounted for at least half of the overall average annual percent of increases observed in ten high outcomes counties: Cumberland**, Delaware, Huntingdon**, Lycoming, Northumberland, Philadelphia, Somerset**, Union**, Wayne**, and York.

**** These five counties with IDU-associated increases had high proportions (≥ 45%) of IDU cases that were diagnosed in state correctional facilities.**

Data supporting these summaries can be found in the 1999 HIV Prevention Plan and the 2000 and 2001 Plan Updates located at the stophiv.com web site.

CROSS PROGRAM ACTIVITIES

In 1998 the Department of Health's HIV, Sexually Transmitted Infections and TB Programs were combined into a single Bureau of Communicable Diseases and Injury Prevention. There are three Divisions within the Bureau: Division of HIV/AIDS, Division of TB/STI, and the Division of Immunization. The realignment has impacted on collaboration in sharing of staff to accomplishing administrative activities (e.g., contract monitoring, budget development, and in improving overall interaction and sharing of information among staff from the programs:

- Individual program grants with county and municipal health departments have been combined to include all funded activities of the Bureau.

- HIV counseling and testing is offered in all Sexually Transmitted Infection and TB clinics statewide. TB testing is offered to all HIV positive clients.

- Training in HIV prevention counseling has been provided to all Sexually Transmitted Infection, TB and HIV staff.

- The Bureau of Drug and Alcohol Programs requires training in HIV prevention, Sexually Transmitted Infection and TB for all drug treatment staff.

- A single contract with AT&T was instituted to provide AT&T Language Line interpreter services to counselors in all HIV, Sexually Transmitted infections and TB clinics.

- The Division of HIV/AIDS works cooperatively with the Bureau of Drug and Alcohol Programs to provide HIV counseling and testing in over 100 drug treatment facilities.

- Relevant satellite broadcasts on HIV prevention are provided to staff from all programs

Cross-program activities also include HIV counseling and testing in county prisons. HIV prevention staff in the Department's six Health Districts and in five County and four Municipal Health Departments work on an ongoing basis with the administration and health care staff in the 66 Pennsylvania county prisons. HIV staff provides HIV education for prison staff and inmates as a way to establish a working relationship with the prisons. HIV education is usually followed by a request for HIV counseling and testing services for inmates.

Some county prisons have been set up to provide HIV counseling and testing to inmates. Health care staff at these prisons attends training in HIV prevention counseling and completing of appropriate paperwork. Currently the collaboration between HIV prevention program field staff and administrators and health care staff at

county prisons has resulted in the routine provision of HIV counseling and testing services to inmates at 59% (39) county prisons statewide.

Staff at the Pennsylvania Department of Health serve on the Pennsylvania Department of Education's program review panel and staff of the Pennsylvania Department of Education sit on the Department of Health's HIV Prevention Community Planning Committee.

In the next two years the Departments of Health and Education will collaborate on a major new initiative to assure effective HIV prevention education in Pennsylvania schools (see HERR Goal I).

All agencies receiving public funding (both federal and state funds) have or will collaborate in initiating a uniform system of data collection and reporting pertaining to HIV prevention and education interventions. These agencies include:

- Agencies receiving funding through the CDC's 99004 funding to the PA Department of Health for HIV prevention-related activities:
    - Four statewide demonstration projects targeting discrete populations at risk of HIV.
    - Nine County and Municipal Health Departments and their subcontractors receiving funds from the PA Department of Health through CDC 99004 funding, as well as other state-generated funds.

- Agencies receiving funding through other state sources:
    - Seven Regional Ryan White Coalitions and over 100 of their subcontractors delivering HIV prevention/education interventions.
    - Council of Spanish-Speaking Organizations of the Lehigh Valley, Inc. and their subcontractors delivering HIV prevention and education interventions.

PA Department of Health staff coordinating Drug and Alcohol programming also participated in meetings regarding uniform data collection and reporting with the intention of eventually creating data collection, analysis, and reporting that would coordinate with the statewide HIV prevention and education data system.

The above agencies met in March 2000 to begin coordinating plans for uniform data collection and reporting. All agencies receiving funds through the CDC's 99004 funding are already required to report data uniformly, following the CDC's guidelines for Intervention Plans and Process Monitoring. All of the above agencies reconvened to decide on a timetable for integrating non-CDC funded agencies into this data system.

Section III
PRIORITY POPULATIONS AND INTERVENTIONS

PENNSYLVANIA PRIORITIZATION MODEL

The content and context of interventions for HIV prevention depend on the intended audience and where that group is located in the AIDS epidemic. Prevention interventions will have their greatest impact, and therefore their greatest relevance, when populations with the highest rates of HIV seroprevalence and the highest rates of risk behaviors are targeted. Designating target populations must therefore reflect the epidemic in terms of populations at greatest risk. Although designating risk groups emphasizes demographic, socioeconomic, and lifestyle characteristics associated with risk, risk groups per se are now only meaningfully defined in terms of behaviors related to HIV transmission in populations of high HIV seroprevalence.

In 1999 the Planning and Evaluation Subcommittee along with the newly formed prioritization work group began to prioritize both target populations and associated HIV prevention interventions. A significant challenge has been continuing this prioritizing process over several years with the membership of both groups regularly changing. In a review of its subcommittees the Committee determined that the Planning and Evaluation Subcommittee should remain focused on evaluation. Therefore, the Prioritization Population and Intervention Subcommittee was formed.

The largest addition to the data this year is information about HIV prevention services provided to transmission groups. Such information consists of service data for local county and municipal health departments. The new data changes the ranking of populations only slightly. Populations that were ranked 5 and 6 last year (Black heterosexual and White injection drug users) were tied at rank 5 this year. Data from Ryan White HIV/AIDS Regional Planning Coalitions and from publicly funded counseling and testing programs were given low weight in the overall ranking but will be given higher weight in subsequent years. Data from the statewide needs assessments for targeted populations (injection drug users, men who have sex with men, and heterosexuals) are still being gathered and analyzed. That information is therefore only partially factored into the overall findings in prioritization.

Ranking of 13 Targeted Populations

1. White men who have sex with men
2. Black injection drug users
3. Black men who have sex with men and are injection dug users
4. White men who have sex with men and are injection drug users
5. Black heterosexuals
5. White injection drug users
7. White heterosexuals
8. Hispanic injection drug users
9. Black men who have sex with men
10. Hispanic heterosexuals
11. Hispanic men who have sex with men and injection drug users
12. Hispanic men who have sex with men
13. Perinatal transmission

Since Hispanics and Latino(a)s may be incorporated into other race categories, the Priority Population and Intervention Subcommittee will explore concerns about better accounting for Hispanic & Latino(a) populations in the next update of the plan.

The prioritization model involves looking at socio-cultural issues that face transmission groups and that may provide barriers to HIV prevention for them. The Pennsylvania Prevention Project has devised a method for using needs assessment data to rank such barriers for each transmission group. Ranking barriers involves agreement by consensus between researchers, consultants involved with the needs assessment, and all members of the priority work group.

The priority work group and Program Evaluation Subcommittee have been working throughout the year in consultation with the state HIV/AIDS Epidemiologist and the Director of Evaluation of the Pennsylvania Prevention Project. The Subcommittee recommends that the following statement regarding prioritization of populations be incorporated into the annual plan: The Pennsylvania HIV Prevention Community Planning Committee recognizes that the above prioritization of HIV risk populations is based on information pertaining to transmission groups. Many other characteristics and life circumstance also define groups of individuals who are at risk of HIV. Some such groups include female sexual partners of injection drug users, female sexual partners of men who have sex with men, female young adults and adolescents, young men who have sex with men, individuals experiencing poverty or homelessness, the incarcerated and those recently released from incarceration, into communities, non-injection drug users, alcohol and drug users who have sex with HIV-infected individuals, individuals who are mentally ill, and transgender individuals. **Whenever service providers and organizations use the above ranking to establish local prioritization of risk populations, the Committee requests that they consider characteristics and life circumstances defining groups such as those listed here.**

Although, the model is still under development, the interim stage that the project has reached illustrates how the model would work under ideal conditions when all or most of the necessary data components that will be identified are entered into the model. The model continues to undergo peer review and development and, as each recommendation emerges, it is submitted to the CPG for review.

<u>Summary of Methods for Application of Proposed Prioritization Model for HIV/AIDS Prevention Planning in Pennsylvania (not including Philadelphia).</u>

1. Transmission categories and factors (predominant mode or risk factor, prevalence of predominant risk behavior during most recent behavioral survey, average annual rate of increase in AIDS incidence in most recent 4-5 year time period, etc.) by which the transmission categories would be ranked were established.
2. Categories (blood to blood, unprotected anal sex, better survival, poor survival, etc.) within each factor were ranked and each factor assigned a relative weight compared to other factors in the model;
3. Then the rank for each factor was multiplied by the weight associated with the factor, resulting in a product score for that factor corresponding with the appropriate transmission category;
4. The product for each factor by transmission category was then entered into the respective cell in the transmission category column;

5. The totals for each transmission category column were calculated; based on the sum of the column scores, the percentage for each transmission category were calculated and entered;
6. Each transmission category was stratified by race/ethnicity to establish population-transmission categories. Each transmission category sum of scores was thus stratified by race/ethnicity according to the relative percentage of incident AIDS cases (diagnosed in more recent years, 1995-1997) in each transmission category by race/ethnicity;
7. A combined composite was established from the population/transmission group cross-tabulation;
8. Each population/transmission group was ranked according to its percentage share of the total score for all population/transmission groups.

Further notes on the specifics of tabulating data appear either as footnotes to the table or in endnotes after Table 1.

TABLE 1. PRIORITY SETTING MODEL FOR PENNSYLVANIA (EXCLUDING PHILADELPHIA) HIV/AIDS PREVENTION PLANNING

RANK OF EACH CATEGORY WITHIN EACH FACTOR BY WEIGHT SCORE OF EACH FACTOR & RESULTING PERCENTAGE SHARE OF EACH TRANSMISSION & POPULATION CATEGORY

FACTOR	RANK OF CATEGORY WITHIN EACH FACTOR	Weight	A. MSM			B. MSM/IDU	C. IDU	D. HETEROSEXUAL				E. Peri-natal	F. Other
			A. Overall	(i) Gay-ID (overall =receptive & insertive)	(ii) Non Gay-ID (overall= receptive & insertive)	B. (iii)	C. (iv)	D. Overall	(v) Female sex partners of male IDU (receptive)	(vi) Male sex partners of female IDU (insertive)	(vii) Het. Sex partner of unknown HIV status (receptive & insertive)	E. (viii)	F. (ix)
HIGHER WEIGHT MORE OBJECTIVE EPI DATA (WEIGHT RANGE: 6 – 10)													
1. Predominant mode/risk behavior	10=Blood-to-blood; 8=Unprotected anal sex; 6=Unprotected vaginal sex; 2=Unprotected oral sex;	10	80	NA*	NA	100	100	60	NA	NA	NA	100	NA
2. Estimated live HIV cases in transmission category as proportion of total living with HIV in Pennsylvania (excl. Philadelphia).	10= Over 40%; 8= >30-35%; 9= >35-40%; 5= >20-25%; 6= >25-30%; 3= >10-15%; 4= >15-20%; 1=0-5%; 2= >5 –10%	8	72 (4,412) 35.7%	NA	NA	16 (784) 6.3%	80 (4,950) 40.0%	24 (1,477) 12.0%	NA	NA	NA	8 (201) 1.6%	NA NA
3. Estimated unadjusted relative risk or likelihood of death; => relative survival time for transmission category; => relative likelihood of increase/decrease in prevalent pool of infected persons, (assuming no decline in other contributing factors	9 =Better survival =lower likelihood of death [RR < 0.5, 1=referent grp. (MSM)]; 7 =RR=(0.5-<1.0); 5= Survival comparable to referent grp. (MSM), [RR=1]; 3=RR=(>1.0-2.0); 1 = Poor survival = higher likelihood of death [RR= >2]	6	30 RR~=1	NA	NA	30 RR~=1	42 RR<1	30 RR~=1	NA	NA	NA	NA NA	NA NA

FACTOR	RANK OF CATEGORY WITHIN EACH FACTOR	Weight	A. MSM			B. MSM/IDU	C. IDU	D. HETEROSEXUAL				E. Peri-natal	F. Other
			A. Overall	(i) Gay-ID (overall =receptive & insertive)	(ii) Non Gay-ID (overall= receptive & insertive)	B. (iii)	C. (iv)	D. Overall	(v) Female sex partners of male IDU (receptive)	(vi) Male sex partners of female IDU (insertive)	(vii) Het. Sex partner of unknown HIV status (receptive & insertive)	E. (viii)	F. (ix)
4. Prevalence of predominant risk behavior during most recent behavioral survey (% of transmission category practicing predominant behavior).	10=Over 50% 7=25-30% 5=10-24% 3=less than 10%	7	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
5. Average annual rate of increase in AIDS incidence in most recent 4-5 year period. [=Rx failure].	10= > 15% increase 7= 11-15% increase 5= 6 - 10% increase 3= ≤ 5% increase	6	30 (8.0 %)	NA	NA	30 (9.0 %)	42 (15.0 %)	60 (20.0%)	NA	NA	NA	NA	NA
6. Rate of change in HIV prevalence and direction;	NA	5	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	TOTAL OF EACH COLUMN	Rank x Weight Sum of Score	212	NA	NA	176	264	174	NA	NA	NA	108	NA
	TRANSMISSION CATEGORY AS PERCENTAGE OF TOTAL		22.7%	NA	NA	18.8%	28.3%	18.6%	NA	NA	NA	11.6%	NA
LESS OBJECTIVE LOW WEIGHT SURROGATE DATA (2 – 4)													
~~7. Fertility rate;~~		~~NA~~	~~NA~~	~~NA~~	~~NA~~	~~NA~~	~~NA~~	~~NA~~	~~NA~~	~~NA~~	~~NA~~	~~NA~~	~~NA~~
8. Gonorrhea/Syph.		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
9. Relative size of transmission category population.		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

FACTOR	RANK OF CATEGORY WITHIN EACH FACTOR	Weight	A. MSM			B. MSM/IDU	C. IDU	D. HETEROSEXUAL				E. Peri-natal	F. Other
			A. Overall	(i) Gay-ID (overall =receptive & insertive)	(ii) Non Gay-ID (overall= receptive & insertive)	B. (iii)	C. (iv)	D. Overall	(v) Female sex partners of male IDU (receptive)	(vi) Male sex partners of female IDU (insertive)	(vii) Het. Sex partner of unknown HIV status (receptive & insertive)	E. (viii)	F. (ix)
LESS OBJECTIVE LOW WEIGHT NEEDS INDICATOR DATA (1-3)													
10. Services Allocated to Transmission Category Relative to Transmission Category as Percentage of Total (sum of factors 1-6).	10=≥5 transmission-category total than services. 5=≥1.5 times and <5 times transmission-category total than services. 3=<1.5 to 1 times transmission-category total than services. 1=more services than transmission-category total.	Local health depart. data= .8	3 (17.2% services/22.7% transmission total) = 2.4	NA	NA	10 (1.5% services/ 18.8% transmission total) = 8	5 (14.8% services/28.3% transmission total) = 4	1 (39.5% services/18.6% transmission total = .8	NA	NA	NA	5 (4.7% services/ 11.6% transmission total) = 4	NA Gen. Pub. 22.3 % serv.
		Couns. & Testing data= .1	5 7.6% C&T/ 22.7% transmission total = .5	NA	NA	10 .5 C&T/18.8% transmission total = 1	5 10.7% C&T/ 28.3% transmission total =.5	1 28.5% C&T/ 18.6% transmission total = .1	NA	NA	NA	10 .06% C&T /11.6% transmission total =1	NA All Other 52.64% C&T
		Coali-Tion data= .1	5 (15% services/ 22.7% trans. total = .5 **SUBTOTAL= 3.4**	NA	NA	10 (1% services/ 18.8% trans. total = 1 **SUBTOTAL= 10**	5 17% services/ 28.5% trans. total = .5 **SUBTOTAL = 5**	1 33% services/ 18.6% trans. total = .1 **SUBTOTAL = 1**	NA	NA	NA	5 6% services/ 11.6% = .5 **SUBTOT-AL = 5.5**	NA Other 28% serv.

FACTOR	RANK OF CATEGORY WITHIN EACH FACTOR	Weight	A. MSM					B. MSM/IDU			C. IDU			D. HETEROSEXUAL						E. Peri-natal			F. Other
			A. Overall			(i) Gay-ID (overall =receptive & insertive)	(ii) Non Gay-ID (overall= receptive & insertive)	B. (iii)			C. (iv)			D. Overall			(v) Female sex partners of male IDU (receptive)	(vi) Male sex partners of female IDU (insertive)	(vii) Het. Sex partner of unknown HIV status (receptive & insertive)	E. (viii)			F. (ix)
11. Number of Factors in Transmission Category that are Barriers to Prevention	TO BE COMPELTED 12/01	TO BE COMPLETED 12/01	TO BE COMPLETED 12/01			NA	NA	TO BE COMPLETED 12/01			TO BE COMPLETED 12/01			TO BE COMPLETED 12/01			NA	NA	NA	NA			NA
	TOTAL OF EACH COLUMN	Rank x Weight Sum of Score	215.4			NA	NA	186			269			175			NA	NA	NA	113.5			NA
Race/Ethnicity as Proportion of AIDS incidence 1995-1997.	W=White B=Black H=Hispanic	Percent within Transm. Category	W 73	B 23	H 4			W 40.5	B 46.0	H 13.5	W 26	B 50	H 24	W 39	B 40	H 21				W 4	B 48	H 48	NA
	% x Column Total		157	49	9			75	86	25	70	134	65	68	70	37				5	54	54	NA
	Relative Row %		18.6	5.8	1.1			8.9	10.2	2.9	8.3	15.8	7.7	8.0	8.3	4.4				NA			NA
Rank of Population/ Transmission Category	**Rank of Population/Transmission Category**		**1**	**9**	**12**			**4**	**3**	**11**	**5 tie**	**2**	**8**	**7**	**5 tie**	**10**				**Proposed for set-aside funds, see Table 2**			

NA* = DATA NOT YET AVAILABLE TO ENTER INTO MODEL;

Notes to Table 1:

1. The Prioritization Group agreed by consensus that factor 7, fertility rate data, should be removed from consideration in the prioritization process given that these data do not pertain to all transmission groups (i.e., they pertain only to women who may be part of heterosexual and IDU groups). This factor in line 7 appears with a "strikethrough" this year, and will be completely removed from the table next year.

2. Factor 10 (services allocated to transmission category relative to transmission category as percentage of total—sum of factors 1-6) is a newly derived factor in this year's process. Data was calculated in the following manner.

    - Nine county and municipal health departments receive CDC 99004 funds through the Pennsylvania Department of Health to provide HIV prevention interventions. These health departments provide direct prevention services as well as subcontract with local agencies to provide such services. The local health departments have fully implemented the CDC-guided uniform data collection system that is part of the CDC Evaluation Guidance. They provided Intervention Plans in 2000 for the year 2001. Data from these prospective plans were used to derive the percentages of services by each of the transmission groups appearing in the table. These percentages of services by transmission groups were then compared with the percentage total of factors 1 through 6 for respective transmission groups. That is, for each transmission group, the percentage of HIV prevention services provided by the local health departments was compared with the percentage that is the sum of factors 1 through 6 for the respective transmission group. Each transmission group was then assigned a rank score using the ranking criteria appearing under "rank of each category within each factor" in Table 1. Local health department data was given a weight of .8, since, compared with the following two categories of data explained below, these were the most robust data. In the future, weight of these local health department data will be increased as data will be based on actual services rendered (taken from Process Monitoring reports) rather than predicted services (taken from Intervention Plans).
    - HIV Counseling and Testing data for all publicly funded agencies was also used to derive factor 10. The ranking system for these data was similar to the ranking of local health department data, described above. The weight assigned to these data was only .1, given that a large percentage of other transmission categories besides MSM, MSM/IDU, IDU, Heterosexual, and Perinatal (Mothers at risk) are reported in the Counseling and Testing reporting system. Other groups include: sex partners at risk, Sexually Transmitted Infection diagnosis, sex for drugs/money, sex while using non-injection drugs, hemophilia, victims of sexual assault, health care exposure, no acknowledged risk, risk not specified, and other. Since a large percentage (52.64%) of all Counseling and Testing clients were reported as being represented in these categories rather than the standard transmission groups used in prioritization, a lower weight was given to C&T data relative to the local health department data. Next year, the PA Department of

Health and Prioritization Group will collaborate to define ways of including the other transmission groups listed above in appropriate transmission-group data for prioritization purposes. When these decisions are made, data will be given increased weight in the prioritization process.

- Seven Regional Ryan White AIDS Coalitions exist in the state and receive state (non-CDC) funding to conduct HIV prevention interventions through local subcontractors. These Coalitions will be adopting the uniform data collection system for HIV prevention interventions in Fall 2001. In the meantime, the way in which data is collected and reported by these Coalitions regarding risk categories for HIV is not consistent with the CDC's risk categories and, therefore, the transmission groups used in the prioritization process. This year, each Coalition was approached to estimate the number of clients reached with HIV prevention interventions so that these estimates could be included in deriving factor 10 data. Estimates were derived by "crosswalking" each Coalition's risk categories with the categories of transmission groups used in the prioritization process. Then, using actual prevention intervention data from 2000, each Coalition was able to derive estimates for each transmission group used for prioritization. Because of these data are only estimates, they were given a weight of .1. Next year, these data will be given greater weight because the data will be derived from the Coalitions' Intervention Plans for 2002, which, of course, report data by consistent transmission groups as those used in the prioritization process. The ranking of transmission groups using Coalition estimates in Table 1 was similar to the ranking system used with local health department and Counseling and Testing data, as explained above.

  At this writing, only four of the seven Coalitions have reported estimates that are included in Table 1. It is expected that the remaining 3 will also report data. When these reports are received, data will be updated in line 10 of the table. However, since such low weight is given to these data this year, the updated information will not change the ranking of the population/transmission groups in Table 2. Therefore, the ranking in Table 2 is final and is to be used in 2002.

TABLE 2: SUMMARY RESULTS OF PROPOSED PRIORITIZATION MODEL FOR HIV/AIDS PREVENTION PLANNING IN PENNSYLVANIA (EXCL. PHILADELPHIA).
– RANKED POPULATION/TRANSMISSION GROUPS: 2002

BY SEX BY AGE GROUP

V.10.00

Rank	Relative % (Overall Score)	Population/ Transmission Group	Sex M=Male/F=Female Distribution	Age Group/ Miscellaneous	Geographic Distribution
1	18.6(157)	White - MSM	M	*20-39; 13-19, 40-49;	NA*
2	15.8(134)	Black - IDU	M & F, Mostly Male	*20-39; 13-19	NA
3	10.2%(86)	Black – MSM/IDU	M	*20-39	NA
4	8.9% (75)	White – MSM/IDU	M	*20-39	NA
5 (tie)	8.3% (70)	Black - Hetero	F & M, Mostly Female sex partners of IDU	-history of STD, 13-19; -partners of IDU, 13-39;	NA
5 (tie)	8.3% (70)	White - IDU	M & F, Mostly Male	*20-39	NA
7	8.0% (68)	White - Hetero	F & M, Mostly Female sex partners of IDU	-history of STD, 13-19; -partners of IDU, 13-39; -(?white F<13?)	NA
8	7.7% (65)	Hispanic - IDU	M & F, Mostly Male	++13-19; *20-39	NA
9	5.8% (49)	Black - MSM	M	13-(*20-29)-39	NA
10	4.4% (37)	Hispanic – Hetero	F & M, Mostly Female sex partners of IDU	-history of STD, 13-19; -partners of IDU, 13-39;	NA
11	2.9% (25)	Hispanic – MSM/IDU	M	*20-29	NA
12	1.1% (9)	Hispanic MSM	M	*20-29	NA
TOTAL ADULTS	100% - ?5%?				
13	1 %	Perinatal Transmission	Blacks & Hispanics Comparable, Whites 2%; See Table 1.	Hetero Females who are IDU and/or partners of IDU	NA
	?4 %?	Emerging Risk Group Needs Assessments	To be determined by CPG informants;		NA
TOTAL ALL GROUPS	100%	ALL RISK GROUPS	ALL RISK GROUPS	ALL RISK GROUPS	ALL RISK AREAS

NA*=Variable not applied in model. >>*^Please note that perinatal transmission has been removed from the final distribution model for adults ranked 1-12;

>>Prioritization for this mode of transmission may need to take into account the relative percent share of this mode of transmission in Table 1 as a set-aside & also consider the large amount of resources currently spent in the public (through a Ryan White initiative to eliminate perinatal transmission) and private sector.

CURRENT INTERVENTIONS FOR HIV PREVENTION

Throughout PA, demonstration projects conceived as interventions for HIV prevention are funded by the Pennsylvania Prevention Project (PPP) using CDC resources allocated by Department of Health. In March 1998 the Committee adopted the following basic criteria and stages for demonstration projects:

Basic Criteria for Demonstration Projects

- The project should address a priority population identified by the Committee.
- The project should be based on proven interventions for HIV prevention and grounded on behavioral science theory.
- The project should be capable of assuming its own fiscal and administrative responsibilities.

Stages of Demonstration Projects

1) Year One
-establish a work agreement and contract
-staff hiring, orientation, and training
-develop data collection and reporting
-implement the project
-in-service training
-periodic site visits; program and budget monitoring
2) Year Two
-revised work plan and contract
-continue implementation and data collection
-program modifications as necessary
-two site visits; program and budget monitoring
3) Year Three
-revised work plan and contract
-continue implementation and data collection
-continue monitoring and assessing projects ability to be self-sustaining (fiscally, organizationally, and programmatically)
-final assessment of project

The Committee further determined that any agency interested in offering a demonstration project should: (1) be able to serve the target population and in particular should have a staff that reflects it; (2) have a good reputation among the target population and among the broader human services community; and (3) have both the capacity to staff and fund a demonstration project and the capacity to collect data, perform basic research, and conduct evaluations.

Demonstration projects are developed to show usefulness of certain interventions for HIV prevention and are not in themselves interventions. Once they have proven their

effectiveness, demonstration projects might be replicated in other communities. At the very least, the theoretical underpinnings of a successful demonstration project can be shared with other communities for possible implementation.

The Committee identified the target group and the concerns to be addressed by a demonstration project. Staff from the University of Pittsburgh staff issues a request for proposals based upon the Committee's specific guidance for a project and the overall direction provided in the Committee's Prevention Plan. Demonstration projects subcontract with the University of Pittsburgh and are subject to its fiscal and contractual guidelines. The University's staff provides technical assistance, evaluation, and monitoring for demonstration projects.

Youth Theatre Demonstration Projects: The Youth Theatre Demonstration Project will be entering its third year in 2002. The project was proposed in 1998 by Roundtable members and endorsed by the Pennsylvania Department of Health and the Pennsylvania HIV Prevention Community Planning Committee due to the lack of HIV prevention programs targeting young adults and because of the alarming rate of HIV infection among young adults. The project was initially implemented in 1999 in three cities: Erie, Pittsburgh and Wilkes-Barre/Scranton area. The project was terminated in Erie in 2000 due to capacity limitations of the Erie agency, as identified through site visits and feedback from Roundtable members. Pittsburgh and Wilkes-Barre project have continued to develop of the last two years and plan to continue into year 2002. This targeted demonstration project employs HIV risk-reduction principles and endeavors to meet the primary and secondary HIV prevention needs of gay, bisexual, African American and Latino/a youth between the ages of 13 and 24, through a *theater-based, peer-based, outreach* intervention.

This project is an adaptation of the Nite-Star Theater Program in New York City. It has been tailored to the needs and capacities of the Pittsburgh and the Wilkes-Barre/ Scranton area, and shaped by the vision and creativity of each subcontractor. High-risk youth are targeted in small groups through theatrical presentations by peers and through facilitated follow-up discussions led by an HIV prevention specialist and including the young acting company. Theatrical presentations and follow-up discussions include topics in risk reduction and strategies aimed at clarifying risky behavior by improving self-efficacy and self-management skills.

The demonstration project completed its "pilot phase" at the conclusion of year 2000. Year 2001 began the implementation phase of the project, which is being implemented on several levels: The first two levels are small and large group HIV prevention **outreach education**. Pre-post test surveys will measure HIV prevention information learned by audience members after the production. The second two levels are individual and small group HIV prevention (behavior change) **outreach intervention**. The latter levels require a series of interventions over time with the same individuals (actors) and targeted (gay, African American and Latino/a) youth (ages 13-24) community groups. Pre-post test instruments will measure intended behavior change over time.

Sub-contractors for this demonstration project were required (by the RFP) to ground it on behavioral science theory. Thus the project's proposed goals, objectives, and activities emanate from two conceptions. **Social Learning Theory;** which assumes reciprocal interaction between an individual, his or her behavior and the environment, posits that behavioral change is achieved through modeling, a basic acting technique that is the foundation of this demonstration project. Young actors perform as characters confronting specific issues in HIV prevention that are later discussed by the audience. During such discussions members of the audience interact with the characters, who are asked about alternative solutions to the issues they face. One subcontractor also engages audience members in improvised role-playing, another technique based on Social Learning Theory.

The format is repeated during four or five subsequent visits with the same audience. As their understanding of personal risk increases and as alternative solutions to risky behaviors are explored, members of the audience are helped to develop intentions to change risky behaviors. This cognitive change underlies the **Theory of Reasoned Action**, the project's other theoretical pillar.

The theory posits that members of the audience will change their risky behaviors over time through heightened expectancy and efficacy expectations **(SLT)** and through perceived hazards and benefits **(TRA)** of reducing risky behaviors.

The two subcontractors are seeking funding resources for this project beyond the three-year demonstration phase. In addition, they had requested the postponement of the small group intervention component until year 2002. They reasoned that year 2001 would allow them to finalize the scripts, improve the production, and master recruitment and targeting of desired target population. Each subcontractor is required to have a community advisory board. Members of the Community Advisory Board represent members of the project's target populations (race, age, sexual orientation, etc.), provide ongoing input on the development of the project, comprise local experts and leaders in the areas of HIV prevention, youth, public schools, program evaluation, funding, etc. Local Roundtable members, as well as, the Young Adult Roundtables Executive Co-chairs also serve to provide feedback into the development and progress of the project. The subcontractors have also identified the following goals and objectives for year 2001:

<u>Pittsburgh Playback Theatre</u>
Track 1: Actors/youth participants

- Document changes in behavior for the actors
- HIV Prevention Training performed by Matt Moyer 2 times in 2001 to the youth participants.
- At the beginning of the rehearsal process survey the youth participants about their practices of HIV and Sexually Transmitted Infection Prevention.
- Up to two times throughout the year again survey the youth participants about their practices of HIV and Sexually Transmitted Infection prevention and note any behavioral modification or risk reduction that the youth participants have utilized

- Perform 9 Rehearsals throughout 2001, and additional rehearsals will occur I or 2 hours before performances

Track II: Small Groups
- Perform for 12 small groups throughout 2001.
- At each performance survey the audience before and then after the performance to document knowledge gained through the performance and any intention of utilizing behavioral changes or risk reduction.

Track III: Large Group
- Perform for 4 large groups throughout 2001.
- At each performance survey the audience before and then after the performance to document knowledge gained through the performance and any intention of utilizing behavioral changes or risk reduction.

Wilkes University
1. Maintain a company of actors that represents the target population.
2. Actors will provide performances and discussions for 3000 youth between 13-24 in Columbia, Lackawanna, Luzerne, Pike, Wyoming counties between January and December 2001.
3. All actors involved with the project in the first and/or second year will fill out Risk Assessment forms that measure knowledge, skills, and behavior as it pertains to HIV. These results of these forms will be used to inform the project of the relationship between knowledge of HIV risks and the ramifications, if any, that it has on skills and behavior.
4. At least 40% of all small group and large group audience members will state in a written post-performance test that they learned new information about:
    - The risks of unprotected sex.
    - Risk reduction with a variety of condoms.
    - HIV testing methods and resources.
    - Self-efficacy or assertiveness in condom negotiation skills.
    - The relationship of drugs and alcohol in HIV infection.

5. At least 60% of small and large group audience members will state in a written post-performance test that they:
    - Are satisfied with the length of the performance.
    - Have experienced similar events or situations as the actors.
    - Thought the situations and scenes seemed real.
    - Thought that the post-performance discussion was helpful.
    - Felt free to suggest other topics or subjects that were not covered in the discussion that should be.

6. In the first period of the project (January to June) “gatekeepers” for the Latino/a and African American audiences will be identified. In the second period (July to December) pilot performances will be arranged for those target groups.

New Directions Treatment Services

The Demonstration Project in the Lehigh Valley is *The Living Project*, an HIV prevention outreach program to prevent perinatal transmission among Latinas and African American women. The project was established in July 1999 through the New Directions Treatment Services, a narcotic addiction treatment program in the Lehigh Valley since its founding in 1980 as a nonprofit, independent agency. New Directions serves clients in the Lehigh Valley with offices in Allentown and Reading.

The agency continues to collaborate with the HIV/AIDS case manager and the clinics and social service departments at Lehigh Valley and St. Luke's Hospitals, Allentown and Bethlehem Health Bureaus, the AIDS Service Center, Latino AIDS Outreach, and Lehigh Valley Community Mental Health Center, and other private medical practitioners. In addition, the agency continues to utilize physicians, nurse practitioners, and RNs on their staff for staff and clients of The Living Project.

Program Goals and Objectives

New Directions Treatment Services developed program goals and objectives that were designed primarily to establish a presence in the community, develop relationships with women who may be pregnant or plan to become pregnant, and establish linkages with other human service organizations in the community to provide comprehensive HIV prevention services. The following are among the goals and objectives that were defined for the first six months of 2001:

Street Outreach

- Providing ongoing staff development;
- Conducting comprehensive street outreach activities reaching 1200 new clients:
- Distributing 1600 male and female condoms;
- Conducting HIV counseling and testing for 110 individuals;
- Distributing 1100 pieces of educational materials, such as brochures and posters, for use by project staff for outreach and peer education.

Peer Education

- Recruiting and training for 15 peer educators;
- Conducting graduation exercises for 13 peer educators;
- Conducting 23 peer home parties and baby showers.

Prevention Case Management (PCM)

- Referring 12 women for PCM services;
- Providing 24 hours of PCM;

- Completing outcome evaluation of 15 women for behavioral change and maintenance.

Street Outreach

Agency continues to provide staff development activities;

- Staff reaching 1652 new clients; Distributing 1600 male and female condoms;
- Sixty-nine individuals received HIV counseling and testing;
- Staff distributed 1659 pieces of educational materials, such as brochures and posters, for use by project staff for outreach and peer education.

Peer Education

- Forty-seven women have been recruited and trained as peer educators;
- Twenty-three peer educators completed training and graduated;
- Staff held 33 peer home parties and 1 baby shower.

Prevention Case Management

- Staff referred 11 women for PCM;
- The plan for this facet of the evaluation is being refined.
- Sixty-nine women were referred for training;
- A reunion for two peer educators was held in late June as a way of acknowledging the work of those who have participated, as well as to encourage others to become peer educators and to conduct Home Parties.

In summary, this project continues to provide comprehensive services to meet the needs of women in the community around HIV prevention. Those needs include prenatal, perinatal, and postnatal care and support. The staff has established and continues to work with a complex network of care, services, and referral that offers women a continuum of care. That continuum extends from street outreach to transportation and childcare, from HIV counseling and testing to HIV prevention and prevention case management, and from health and prenatal care to drug and alcohol treatment. The staff has utilized a variety of approaches to recruit and service the community that were unique, especially to women. The women whom the project is reaching responded favorably through their enthusiastic participation in the program, particularly the Peer Education and Training component. The women continue to see this program as both education and empowerment. They have been pleased to see themselves “accomplishing something” in their lives. Completing the program and receiving their certificates has been a source of pride and oftentimes a “first.” They now incorporate these new experiences into their home and family life with a better understanding of the challenges they face on a daily basis. They not only are applying what they have learned in their own lives but they continue to takethose lessons to others in their community, thereby affecting new community norms and values.

Erie MSM Demonstration Outreach Project

SHOUT is an HIV prevention street outreach program in the Erie community for Men Who Have Sex with Men (MSM). This project was established in July of 1999 with Serenity Hall, Inc, an agency that provides comprehensive services including detoxification, inpatient rehabilitation, outpatient treatment, partial programs, halfway services, and community outreach. This agency has built a strong outreach component reaching the injection drug using community and has been active in the Erie community promoting for more than twenty-five years. In 1999, Serenity Hall developed this outreach project targeting MSM of color, utilizing the Shout Outreach Model.

Program Goals and Objectives

The goals and objectives of this project for 2001 are listed below:

- To establish a working relationship within the MSM community and the larger community in which the targeted population resides or interacts;
- To increase exposure and access to HIV/AIDS information among 200 MSM who are African American or Latino;
- To provide HIV/AIDS testing and counseling, education and prevention to 10 MSM within the African American and Latino communities;
- To refer 20 MSM for clinical or social support;
- To provide an assessment of the project;
- To develop and implement a plan to provide intensive education and prevention appropriate for the MSM population.

For 2001, the staff continued their efforts to develop a working relationship with MSMs of color. The addition of staff with relationships in the MSM community has enhanced SHOUT staff's ability to reach their population. The new staff person also brings to the project a link to the faith community. The faith community has historically been a community of which the MSM of color in Erie have been a part. In addition, the staff continues their collaboration with organizations such as the Erie Pride group and Parents and Friends of Lesbians and Gays (PFLAG). Again, while those organizations have connections with the MSM communities of color, the connection is limited at best because MSM of color have tended not to identify as "gay" and, therefore, have not had membership in those organizations.

The staff reported the following accomplishments for the period January – June 2001:

- Two staff members were hired specifically to concentrate their efforts and expand the capacity of project staff to reach MSM of color.
- Staff have developed a collaboration with local ministers with plans to implement a faith-based prevention program in one African American church and later to extend the program to other African American and Latino churches.
- Staff set up booths at three local colleges and universities:

- Staff conducted two risk-reduction programs for college students;
- Staff were invited to conduct a risk-reduction program at a local high school for all 8th – 12th graders in their health classes;
- Counseling and testing have been conducted but not by category as such (those data are incomplete);
- Referrals have been made for drug and alcohol treatment for 13 individuals;
    - The educational curriculum has been delivered in several venues such as a local gay bar and two local agencies.

In summary, this project continues to build on its reputation for effective HIV prevention street outreach. Reaching the MSM communities of color has been and continues to be a challenge to the staff. While they have met with some measure of success in establishing connections with their population, they are continuing to identify and develop new and more effective strategies.

SECTION IV
GOALS, OBJECTIVES, AND ACTIONS

FIVE-YEAR PROGRAMMATIC GOALS

In 1998 the Pennsylvania HIV Prevention Community Planning Committee developed four overarching programmatic goals for the five years of the present Centers for Disease Control and Prevention planning cycle (1999-2003). These goals are to be used as beacons to guide Pennsylvania's overall HIV prevention community planning process.

I. Reduce the incidence of HIV transmission in the state of Pennsylvania

II. Reduce the progression of HIV disease and prolong life in persons living with HIV in the state of Pennsylvania

III. Reduce HIV-related stigma in the state of Pennsylvania

IV. Increase the involvement of priority populations in developing and implementing effective HIV education and prevention in the state of Pennsylvania

PRIORITY POPULATIONS AND INTERVENTIONS (PPI)

The Priority Population and Interventions Subcommittee worked upon prioritizing targeted populations based upon the October 2000 Priority Setting for Pennsylvania HIV/AIDS Prevention Planning model. This document is the recommendations of the then existing Priority Sub-Group of the Committee. By following the model for prioritization, the following goals, objectives and activities are recommended by the Priority Populations and Interventions Subcommittee for priority populations:

PPI Goal I
By September 2001 identify populations at risk and to assign weights for ranking them.

Objective-1 Formally adopt the Priority Setting for Pennsylvania HIV/AIDS Prevention Planning model and its interim results by September 2001.

Activity Recommend the Committees for counseling, testing, referral and partner counseling and referral services, health education and risk reduction activities, public information, and capacity building all use the model in setting priorities.

Objective-2 Recognize HIV positive people as a priority or targeted population for secondary prevention and determine the most appropriate mechanism(s) for meeting secondary prevention needs.

Activity Priority Populations and Interventions Subcommittee to determine most appropriate mechanism(s) for meeting their secondary prevention needs.

Objective-3 Give prioritization a regional focus with respect to targeted populations.

Activity Begin using data from the seven regional coalitions and counseling and testing data, with more extensive use of such information and higher weighting of it next year.

PPI Goal II
Identify priority interventions that concur with the rank of each population.

Objective-1 Identify possible interventions for targeted populations by September 2001.

Activity Begin using anecdotal and statistical data for interventions practiced within the state.

Activity Identify a mechanism within community planning for assessing priority interventions.

Objective-2 Resource allocation should follow identified priority populations by January 2003.

Activity The linkage work group will review gaps in services delivered and the ratio of targeted populations.

Activity The Counseling and Testing Subcommittee will review gaps in services delivered and the ratio of targeted populations.

PPI Goal III
Make recommendations for considering populations that may not be among the CDC's defined targeted populations or in the model for Priority Setting for Pennsylvania HIV/AIDS Prevention.

Objective-1 Assess emerging populations and populations at risk by January 2002.

Activity Recommend allocating 4% of all HIV prevention resources received from the CDC for data collection concerning HIV prevention needs, resources, and barriers to services for these populations.

Activity Recommend that 1% of all HIV prevention resources received in from the CDC be set aside for hard to reach women likely to transmit HIV perinatally.

Activity Recommend that various circumstances of individuals at risk be considered in local (i.e., in regional and community) prioritization.

Activity Recommend that the Department of Health require reporting of services delivered to subgroups of the larger transmission groups (e.g. to female partners of male injection users and so forth) by the nine County and Municipal Health Departments, the seven Ryan White HIV/AIDS Regional Planning Coalitions and publicly funded contractors.

COUNSELING, TESTING, REFERRAL, AND PARTNER COUNSELING AND REFERRAL (CTR/PCR) SERVICES

Development of an HIV antibody test resulted in federal assistance to state and local health departments and to other public health services for establishing a network of publicly funded HIV-testing programs. Counseling was formally incorporated into HIV-testing in 1987. Consequently emphasizing behavior change as an expected outcome from HIV counseling and testing the centerpiece of comprehensive HIV prevention programs.

The Counseling and Testing Subcommittee has worked throughout the year in consultation with both the Chief of the Counseling and Testing Section of the Division of HIV/AIDS and the Pennsylvania Prevention Project's Director of Evaluation. The Subcommittee's work has led it to issue the following recommendations:

- Prevention counseling curricula should address issues in cultural diversity as they affect HIV counseling and testing.
- Employees of all publicly funded HIV counseling and testing sites and of contract Participating Provider Agreements (PPA) sties should complete the CDC's three-day *Fundamentals of HIV Prevention Counseling Training* offered by the PA Department of Health or by subcontracted trainers.
- PA Department of Health personnel should be involved in providing some components of the training.
- Program reviews with the Division of Maternal and Child Health should include verification that counselors have been trained as recommended in skills building.
- All sites conducting HIV counseling, testing, and referral that receive Department of Health funding should adhere to the Department's standards and guidance.
- Program site reviews should include assessment of adherence to standards of the CDC and the PA Department of Health by means of client audits, site visits, and monitoring of HIV counseling and testing.
- HIV reporting is anticipated to begin in 2002 for the whole state. A primary barrier of current counseling and testing is hours of services at sites affecting rural populations.

C&T Goal I

By 31 December 2003 assure the availability of anonymous HIV testing, counseling, referral, and partner counseling and referral services within all 67 counties of Pennsylvania.

Objective-1 Increase to 100% the proportion of counties (67) that offer anonymous counseling and testing for persons at risk of acquiring or transmitting HIV.

Activity Identify counties that do not offer anonymous counseling, testing, and referral.

Activity Assess barriers related to providing such services in those counties and address the barriers. Implement anonymous testing where needed.

Activity Mandate that the Department of Health's current anonymous clinic sites offer services at least two full days per month, in order to assure accessibility to emerging populations at risk and to rural residents. Use acceptable media outlets to create awareness that counseling and testing hours have been extended.

C&T Goal II

By 31 December 2003 increase HIV Prevention Services for incarcerated populations and increase their access to HIV prevention counseling and testing.

Objective-1 Increase by 10% the number of correctional facilities and agencies participating in HIV counseling, testing and referral and partner counseling and referral services.

Activity Identify correctional facilities, youth detention centers, probation and parole agencies not currently providing HV counseling, testing and referral and partner counseling and referral services. Assess barriers related to counseling and testing services within those facilities and agencies.

Activity Provide HIV educational events at the State Warden's Conference highlighting: basic HIV prevention education for incarcerated populations, tenets of HIV counseling, testing, referral and partner counseling services, oral HIV testing procedures, and skills building programs in pre-release, probation, and parole programs. Emphasis should be placed on risk reduction and knowledge of resources as vital issues for both HIV positive and negative persons.

Activity Establish and initiate HIV counseling, testing and referral and partner counseling and referral services for those newly identified facilities and agencies.

Activity Provide individualized HIV technical assistance to promote and sustain HIV counseling, testing and referral and partner counseling and referral services within correctional facilities.

C&T Goal III

By 31 December 2003 increase the number of HIV counseling, testing, referral and partner counseling sites working with priority and emerging populations at risk.

Objective-1 Increase by at least five the number of publicly funded HIV counseling, testing, referral and partner counseling sites for emerging populations at risk.

Activity Identify provider agencies already working with priority and emerging populations.

Activity Educate HIV provider agencies on the HIV prevention needs for priority and emerging populations in their areas.

Activity Establish HIV counseling, testing, referral and partner counseling services at agencies through Participating Provider Agreements and instruct them in the use of oral testing.

Activity Provide individualized technical assistance to these agencies where needed.

C&T Goal IV
By 31 December 2003 increase by 20% the number of private health care facilities providing legally mandated counseling with HIV antibody testing.

Objective-1 Offer a minimum of three educational events to inform private health care providers of their legal responsibility to provide prevention counseling with HIV testing.

Activity Partner with private and public educational entities and the HIV Integrated Planning Council to develop strategies aimed toward reaching private health care providers.

Activity Design within the partnership educational events to include grand rounds at teaching hospitals.

Activity Develop fact sheets reflecting Pennsylvania law on clinical and legal responsibilities for distribution to private providers.

C&T Goal V
By 31 December 2003 create a list of what constitutes quality HIV Counseling and Testing, which informs consumers of best practices that defines what should occur during the provision of HIV Counseling, Testing, and Referral services.

Objective-1 Convene the HIV Counseling and Testing Subcommittee for the purposes of developing the list of what constitutes quality HIV Counseling and Testing and the associated consumer survey.

Activity Produce a draft for approval of the Pennsylvania HIV Prevention Community Planning Committee.

Activity Distribution of the standard will occur at all public counseling and testing sites and made available at not cost to private providers. Mandate the posting of the standard at all publicly funded sites.

Activity The Quality of HIV Counseling and Testing standard will be posted on the stophiv.com web site as well as the Pennsylvania Department of Health web site.

Activity Survey consumers of counseling, testing, referral, and partner counseling and referral services to evaluate the provisions of the standard and to document its implementation.

C&T Goal VI
By 31 December 2003 all publicly funded counseling and testing sites will be competent in issues related to mandatory HIV reporting.

Objective-1 The Counseling and Testing Subcommittee will develop competencies to reflect concerns related to HIV reporting.

Activity Design an HIV reporting training and educational document to instruct HIV counselors in Pennsylvania.

Activity Implement Committees recommendations at all publicly funded counseling and testing sites.

Activity Chart and site audits as well as counselor monitoring sessions will include evaluation of competencies.

HEALTH EDUCATION AND RISK REDUCTION (HERR) ACTIVITIES (INDIVIDUAL LEVEL, GROUP LEVEL, COMMUNITY LEVEL, AND STREET OR COMMUNITY OUTREACH)

HIV prevention at the individual level embodies both health education and strategies for changing health behavior through client-centered counseling. Most HIV risk reduction counseling takes place in conjunction with HIV antibody testing, in both pretest and post-test sessions. Models for risk reduction counseling have also emerged outside of HIV testing and include innovations brought about through case management, substance abuse treatment, and HIV-AIDS hotlines.

Interventions for HIV prevention delivered at the group level bring individuals together to learn about AIDS, discuss safer sex practices, and participate in educational activities. Group interventions are typically delivered in community settings, such as clinics, schools, recreation centers, and community-based organizations. Group interventions tend to be intensive, involving several hours of face-to-face contact, and to facilitate interaction among participants. In particular, such interventions emphasize collective experiences, encouraging members to learn from each other.

Community-level Intervention for HIV risk reduction interventions occur within defined geographic areas and entire populations. Changes in behavior are typically of a small magnitude, since an intervention's effects are distributed across a population. However, in areas with a high incidence of HIV, small reductions in a population's risk behaviors can result in significant reductions in HIV transmission.

The Health Education Risk Reduction Work Group believes that risk-reduction education offered in Pennsylvania should be of the highest quality, fact-based, sensitive to cultural diversity, and delivered without bias to all risk populations. The group is aware that risk reduction education in many areas of the state is exceptional. It recognizes that educating youth about HIV and decision-making skills may be the best

way to eradicate this virus. The Work Group believes now that it is necessary to refine the process of accessing resources relevant to these issues and to increase the knowledge of service providers, so that the state will be unsurpassed in the quality of service offered to all communities and populations. To this end, the Work Group makes the following recommendations:

HERR Goal I
For the next two years promote effective education and prevention strategies for all populations at risk in the state.

Objective-1 For the next two years collaborate with the Pennsylvania Department of Health and the Pennsylvania Department of Education to identify and disseminate a complete list of effective educational tools and related resources to all school districts.

Activity The Department of Health will use existing review committees to compile a list of relevant educational materials and successful interventions which will be available on Pennsylvania's stophiv.com web site by December 2002

Activity The Department of Health will promote this list among all school districts in the state and will make it available to local Department of Health offices by December 2003.

Activity The Departments of Health and Education will cooperate to offer a list of effective HIV prevention curricula for each school level.

Activity The Department of Health will provide curricular resources to school administrators. Suggested for distribution among other titles: The HIV and sexually transmitted infections Prevention Intervention recently developed by the Young Adult Advisory Team, and the CDC Compendium of Programs That Work.

Activity Provide parent education and resources regarding HIV, sexually transmitted infections, human sexuality, and communication skills.

Objective-2 For the next two years the Departments of Health and Education will improve their available resources for providing education to health educators about HIV, sexually transmitted infections, and Hepatitis C.

Activity Develop a list of accessible HIV training professionals from the seven regional HIV Prevention Planning Coalitions by December 2002

Activity The Department of Health will distribute the list of professional trainers to all school districts and make it available on Pennsylvania's stophiv.com web site by December 2003.

Objective-3 Using proven interventions increase peer education for students at all schools and educational levels.

Activity Promote the development of a curriculum for training peer educators at all appropriate ages.

Activity Add HIV/AIDS education to after school programs.

Objective-4 Reduce fear arising from the new HIV reporting plan and maintain the current volume of testing continues and more people get tested each year.

Activity Expand education for all populations at risk to include the following topics: treatment options for HIV/AIDS, the special pharmaceuticals benefit program, case management services, new statewide HIV reporting requirements, and testing options.

Objective-5 The Department of Health will assist regional coalitions to develop continuing education workshops for health care personnel.

Activity Assist coalitions in stimulating interest among local health care professionals for educational workshops on HIV and related topics such as, the effects of stigma on diagnosis and quality of care.

Activity Provide guidelines for continuing education for health care providers on issues pertaining to HIV/AIDS and to the effects of drug and alcohol use on transmission.

Objective-6 Since local churches and faith-based agencies sometimes are the most effective means of reaching individuals at risk, increase the capacity for faith-based initiatives to reach their communities.

Activity In year one the Department of Health will survey the Regional Coalitions on faith-based prevention initiatives.

Activity The Department of Health will develop or purchase appropriate materials for identified statewide faith-based initiatives by June 2002.

Activity The Division of HIV/AIDS will provide or distribute faith-based education materials by June 2003.

Activity A similar list appropriate for the needs of rural populations should be developed and distributed.

Objective-7 Over the next two years the Department of Health will assist the Regional HIV Prevention Planning Coalitions in finding and distributing literature that addresses HIV-related issues unique to MSMs and especially to MSMs who are racial and ethnic minorities.

Activity The Department will contact the regional coalitions to offer assistance in this regard and to discuss local needs for such literature by December 2002.

Activity By December 2003 the Department will distribute a list of available literature to the regional coalitions; this list will also include contact information for vendors or providers of the materials.

Activity The Department of Health will survey the Regional HIV Prevention Planning Coalitions in order to assemble a database of creative interventions for reaching MSMs and especially MSMs from racial and ethnic minorities by December 2003.

Objective-8 Provide periodic up-to-date education on HIV, Sexually Transmitted Infections, Hepatitis C, and the effects of drug and alcohol use on HIV transmission to all inmates of state and county correctional facilities, and to those recently released from incarceration.

Activity The Department of Health will assist regional coalitions in contacting state and county correctional facilities in their regions in order to offer them educational resources and a list of professional educators.

Objective-9 Continue demonstration projects using the Adept/Adapt format to showcase successful interventions for interested organizations.

Activity Continue funding existing demonstration projects for MSMs, IDUs, Youth, and the Perinatal project until the end of each project's three-year lifespan

Activity Determine the Committees preference on new demonstration projects for priority populations and identify intervention models to implement in Pennsylvania.

HERR GOAL II

Increase use of the risk reduction and harm reduction approaches for all populations at risk in the state.

Objective1 In the next two years continue counseling HIV positive persons about risk-reduction and harm-reduction in order to help them in prevent transmission and maintain health as long as possible.

Activity Conduct a needs assessment of the regional coalitions to determine gaps in service and which case management efforts at prevention are successful by 2002.

Activity The Division of HIV/AIDS will implement effective prevention case management programs throughout the state by December 2003.

Objective-2 Increase contact between public health professionals and high-risk substance users.

Activity Regional Coalitions will conduct a survey of drug and alcohol providers and substance abusers to assess barriers to drug and alcohol treatment.

Activity The Department of Health will implement prevention case management programs for high-risk substance users not in treatment by December 2003.

Activity For the next two years the state's HIV Prevention Planning Committee will continue advocating for legal syringe exchange programs (SEPs) in Pennsylvania.

Activity For the next two years encourage regional coalitions and local health departments to collaborate with syringe exchange Programs on offering services to high-risk substance users not in treatment.

Activity For the next two years encourage local health departments to work with the Bureau of Drug and Alcohol Programs; and also encourage community health providers to offer comprehensive on-site services to substance users in treatment.

Objective-3 Increase access and admission to treatment for substance abuse.

Activity Regional coalitions will coordinate outreach activities to determine needs in access to treatment for substance users.

Activity Regional coalitions will replicate model programs in implementing targeted outreach activities.

Activity Regional coalitions will improve communication and sharing of services with the drug and alcohol Single County Authorities for reaching high-risk substance users.

Activity The Department of Health will work with the Bureau of Drug and Alcohol Programs (BDAP) to implement low-threshold, easily accessible, non-threatening drop-in centers for high-risk substance users in order to help them access services.

Activity The Department of Health will collaborate with the BDAP and consumer advocacy groups to develop and implement social marketing campaigns that address the concerns of high-risk substance users (e.g., privacy, labeling, and stigma related to addiction).

Objective- 4 Provide a continuum of care approach in counseling inmates to be released from state and county correctional facilities, so that they can be tested for HIV and can readily access services if they are HIV positive.

Activity The Division of HIV/AIDS, working with the State Department of Corrections and corresponding county officials, will promote the inclusion of partners in pre-release counseling.

Activity The Division of HIV/AIDS, working with the regional coalitions, will identify local agencies for referral and develop a resource list to be provided to the State Department of Corrections and corresponding county officials by December 2002.

Activity The Department of Health will contact the Governor's Office by June 2002 to determine what currently is done by the state in referring of inmates for HIV-related outreach programs, prevention, and care.

Activity By December 2002 the Department of Health working with the regional coalitions will identify from a list of referral agencies, one in each county to serve as the primary referral source for inmates released there.

Activity The State Department of Health collaborating with the regional HIV Planning Coalitions, will provide a list of HIV-specific resources to all individuals who come in contact with the corrections system, including parole and probation.

Activity The Department of Health working with the State Department of Corrections will distribute to each regional coalition a list of agencies and contact persons identified for delivering services to persons being released from correctional facilities.

Objective 5 The Division of HIV/AIDS collaborating with the regional coalitions will provide more prevention activities throughout the state specific to women.

Activity The Division of HIV/AIDS will survey the regional coalitions to identify existing effective, prevention programs specific to women by December 2002.

Activity Over the next two years the Division of HIV/AIDS will replicate successful prevention programs for women throughout the state.

Objective-6 For the general population, the Department of Health will continue to encourage sharing successful outreach and prevention programs regarding heterosexual transmission.

Activity In collaboration with the regional HIV Prevention Planning Coalitions, the Division of HIV/AIDS will conduct at least one cross-coalition training workshop per year to improve communication and sharing effective programs for reaching individuals at risk.

Activity The Division of HIV/AIDS will continue to publicize available resources for prevention training and outreach over the next two years through the stophiv.com. web site and other appropriate means.

HERR Goal III

Purchase or produce culturally appropriate Hispanic and Latino(a) HIV prevention literature, which is culturally competent and not simply translations of literature for other populations.

Objecctive-1 Gather information on state of the art, effective HIV prevention programs for Latino(a) populations.

Activity Have funded Latino(a) HIV prevention programs present information about their work to the Committee.

Activity Assess what the Department of Health is doing in respect to Hispanic and Latino(a) population health disparities as it relates to HIV prevention.

Activity Invite a panel to address the Committee on HIV and drug and alcohol problems in the Hispanic and Latino(a) Communities.

PUBLIC INFORMATION

Media-based interventions rely on mass communication to channel information to entire populations. The power of media interventions lies in their breadth of exposure and potent audio and visual imagery. Widely diffuse media messages are limited in their ability to individualize and tailor messages to specific cultural and social contexts. Nevertheless, information delivered through mass media has played a critical role in national AIDS prevention strategies. The Media and Capacity-Building work group therefore recommends:

PI Goal I
Develop a media campaign and other outreach endeavors informing populations at risk about the availability of anonymous HIV testing and counseling services by 31 December 2003.

Objective-1 Undertake a minimum of three media initiatives to inform high-risk populations that anonymous counseling and testing remain available.

Activity Identify three media outlets among targeted and emerging populations.

Activity Encourage community involvement in order to customize media initiatives appropriate to these populations. Television channels, radio stations, magazines, and newsletters that are culturally specific could carry announcements soliciting such involvement.

Activity Sponsor advertisements on movie screens and distribute stophiv.com business cards in public places such as the lobbies of movie theaters, schools, skating rinks, and fast food restaurants. Create and distribute stophiv.com bumper stickers. Update the stophiv.com web site to reflect current information about counseling testing, referral, and partner counseling and referral services.

Activity The Department of Health will initiate a media campaign to address the risk of heterosexual transmission by December 2002.

Stophiv.com Web Site
Since the launch of the *stophiv.com* web site in July 1997, the Internet site has undergone numerous changes and advancements with the latest improvements

occurring in September 2001. The redesigned site features improved navigation, enhanced user interactivity, and a whole new look and feel. In July 1997, the Pennsylvania Prevention Project Internet site became publicly accessible at *http://www.stophiv.com.*

In October 1999, an official web access counter was added to site. This counter tracks the number of "hits" or how many times a page is accessed by an Internet user. This year the *stophiv.com* web site has been accessed **226,522** times (1 January to 14 August 2001). On average the site is accessed 900 times each day, allowing individuals to retrieve information and resources related to HIV/AIDS. The top five accessed resource pages (1 January to 14 August 2001) are as follows:

- Facts and Myths about HIV/AIDS
- Stories
- Online Resource Directory
- AIDS Statistical Summary and Epidemiology
- Articles/Online News

Since October 1999, the site has been access **537,839** times.

- Year 1999 hits (10 October to 31 December 1999): 40,796
- Year 2000 TOTAL hits (1 January to 31 December 2000): 270,521
- Year 2001 TOTAL hits (1 January to 14 August 2001): 226,522

Awards/Accomplishments

- *Editor's Choice Award – HealingWell.com*

On **29 September 1999**, the *stophiv.com* Internet site was awarded the Editor's Choice Award by HealingWell.com. HealingWell.com, a Boston based organization, is a thriving community and information resource site to medical news, feature articles and health information, patient stories, message boards and chat rooms, free email, newsletters, books and directories of disease-related web sites for patients, caregivers, and family coping with diseases, disorders, or chronic illness.

- *Pennsylvania Site of the Day Destination*

On **19 April 1999**, the *stophiv.com* Internet site was awarded the Pennsylvania Site of the Day Destination. The site was profiled on the Pennsylvania Destination of the Day web site at http://www.aboutpennsylvania.com.

- *American Public Health Association*

In **November 1997**, the *stophiv. com* Internet site was entered in the "Seventh Annual Health Education Materials Contest" held at the American Public Health Association's national conference in Indianapolis, Indiana. The American Public Health Association's Public Health Education and Promotion (PHEHP) section sponsored the contest. The PHEHP section provides a forum for public health educators and those involved in health promotion activities to discuss ideas, research, and training; promotes activities related to training public health professionals; and promotes the advancement of the health promotion and education profession. The *stophiv.com* Internet site was voted by the section members as the winning web page submission that best depicts health education and health promotion in action.

Site Development

1. **Online Service Provider Resource Directory.** The Directory of Pennsylvania HIV/AIDS Service Providers assists clients, providers, family, and friends in locating services. The directory contains over 1,200 HIV/AIDS service providers from across the Commonwealth and covers a wide range of services. Clients are able to locate services and/or providers by clicking on a county of reference. After selecting a county, the database displays all of the services available in the county. The services are separated into the following categories: education and prevention, health care, support groups, screening and testing, case management, financial assistance, transportation, and additional services. In addition, an interactive query function allows individual to query the resource directory for a specific service within a radius mile of their geographic location or zip code.

   Unlike paper directories that are usually out of date when printed, the online directory can be updated on a regular basis. The resource directory is continually being updated both on an informal basis and annually on a formal basis. On an annual basis (formally), all the providers listed in the directory are mailed a provider profile and asked to update their agency profile with us. Also, the *stophiv.com* web site has developed an online update section. This section allows individuals to update their records on-line at any time throughout the year. Once an online update is received, a staff member of the *stophiv.com* web site will contact the agency to verify the data submitted and then post the update in the directory. Follow-up postcards were sent to agencies that had neglected to reply to the request for updates urging them to respond to the survey. New agencies are continually being added to the directory. Additionally, the Planning Committee members and the seven Ryan White Planning Coalitions are asked to review the directory for accuracy and to assist with updates.

2. **Epidemiological Data.** This section of the site contains, in a Web format, the Pennsylvania Department of Health, Bureau of Epidemiology's AIDS Quarterly Statistical Summary. The on-line availability of the publication allows community organizations and program developers to have instant access to the latest AIDS statistics. New additions to this page include a listing of federal and state links to epidemiological data. The 2002 epidemiological section of the plan is also available on-line. This page also has links to other epidemiological sections of previous plans and other resources.

3. **Personal Stories Page**. Research indicates that personal stories or perspectives are one of the most effective methods of prevention. The Pennsylvania Prevention Project is continuing to gather personal perspectives or stories related to HIV/AIDS. The stories are categorized and compiled anonymously on the Prevention Project's Internet site to a personal perspective to HIV infection and prevention.

4. **The Facts.** A "Facts and Myths" section has been developed to assure that individuals have access to general information about HIV infection. The section was created with information from the Centers for Disease Control and Prevention. The

section contains information about frequently asked questions about AIDS, how individuals can and cannot become infected with HIV, a section for adults on how to talk to young adults about AIDS, and a list of national and state hotlines to acquire additional information.

5. **Treatment Page**. The site contains the current treatment guidelines and recommendations as published in the Center for Disease Control and Prevention's Morbidity and Mortality Weekly Report (Center for Disease Control and Prevention. MMWR.).

7. **Web Page for Young Adult Roundtable.** The staff of the PA Prevention Project continues to work with members of the PA Young Adult Roundtable Project to develop and maintain a web page that will function both as an educational piece for other young adults and as a communication link for members of the Roundtables. The young adults wanted to develop a web site to improve the lines of communication between the Roundtables and to increase access to HIV prevention information to other young adults at risk of HIV infection. The web site was developed solely by young adults. The Internet staff has only added technical support in the design of the site. The young adults have developed the content and all the graphics for the site. The Young Adult Roundtable Executive Committee is currently working on updating the entire Young Adult site in year 2002

8. **Community Planning Update Newsletter.** Issues of the Community Planning Update Newsletter have been placed on-line. This keeps the community informed about the community planning process and projects being implemented across the state.

9. **Pennsylvania Comprehensive HIV Prevention Plan.** The 1999, 2000, 2001, and 2002 Pennsylvania Comprehensive HIV Prevention Plans are available online. Each plan is downloadable in Adobe Acrobat format. Individuals accessing this page can view and print sections of a plan or the entire document.

10. **Links Page**. The page provides links to other online resources, all of which have been reviewed and evaluated by an HIV prevention specialist for content, graphics, language, and costs. Individuals accessing this page can view all the links at once or select links dealing with specific subjects.

11. **Funding/Announcement List-Server**. The PA Prevention Project has developed a funding/announcement list server. Individuals with access to email can add their addresses to the server's distribution list. When the University of Pittsburgh receives relevant funding announcements or other pertinent HIV/AIDS information, that information is quickly and inexpensively distributed to the entire list. There has been an overwhelmingly positive response to this service. Currently over 350 individuals are signed up to receive these announcements though this system.

12. **Spanish Version.** Selected pages on the *stophiv.com* web site will be translated into Spanish. The launch of a Spanish version of the site is projected for year 2002.

13. **Community Calendar.** With the redesign of our site, the web development team will be adding a community calendar to the site. This feature will allow users to post HIV related activities on the site for public view. Over the past year, user feedback has indicated the need and desire for this new feature.

14. **Interactive Components.** In an effort to improve user return rates, an interactive education poll will be added to the site in late 2001. This poll will allow users to answer questions related to HIV transmission and prevention. Once the user answers the poll, he/she will automatically be transported to a primary prevention page that gives them the correct answer to the poll question.

15. **Primary Prevention Pages**. In late 2001, the Internet team will be adding primary prevention pages to the site. These pages will include information related to: how to use a condom (both male and female), how to clean needles/works, dental dam usage, safer sex information, as well as, links to other online primary prevention resources.

16. **Counseling and Testing**. Information pages related to counseling, testing, referral, and partner, counseling and referral services will also be implemented. These pages focus on the types of tests available, accuracy of tests, procedures, and a list of publicly funded counseling and testing sites in Pennsylvania (separate from the online resource directory).

17. **Community Planning Pages**. In an effort to keep the community up-to-date related to the Community Planning process, a planning committee web site is currently under development. This page will provide the background information related to the community planning process, information related to membership and composition of the community planning committee, meeting dates and activities, and reference materials associated with the community planning process (glossary of terms, meeting minutes, principles of HIV Prevention Community Planning, and state HIV prevention plans).

18. **Online Question and Answer Service**. The Internet staff is currently exploring the possibility of implementing an online question and answer service. This would allow users of the site to ask specific questions related to HIV transmission and infection by an HIV prevention specialist. Selected questions would be posted anonymously on the *stophiv.com* web site.

Access Reports

The information presented is accurate to the potential of the data gathering software utilized and may be an under-representation of the actual number of hits to the site.

Total Number of Hits to the Site (10/99 to 8/01)	537,839
Average Hits per day (10/99 to 7/00)	900 hits
Most Active Day of the Week	Thursday
Time of Day When Most Active	10:00AM to 10:59AM

CAPACITY-BUILDING ACTIVITIES

Unlike other health behavior problems where science had led the way through research and development to provide prevention technologies for application, AIDS first mobilized communities to address needs before prevention researchers arrived on the scene. There is considerable disparity between resources required to implement research-based prevention interventions in community settings and resources available to service providers. Capacity building must therefore precede efforts to transfer prevention technology to communities. Community-based agencies often lack sufficient staff to meet their daily programmatic needs. In addition, staff turnover is notoriously high among AIDS service organizations. It is also likely that community-based interventions will not be experienced or trained for delivering behavioral interventions. Cultivating talents and training in techniques for effective HIV-risk reduction interventions must be a priority. The Public Information and Capacity Building Work Group recommends:

CB Goal I
To increase supportive services within Pennsylvania's targeted case management model

Objective-1 Initiate meetings between the Department of Health and the Department of Public Welfare to discuss billable services within this system.

Activity Survey targeted case managers about emerging client issues not addressed by the current model.

Activity Based on the survey's findings the Department of Health will promote necessary changes to increase billable services.

CB Goal II
Increase the availability of HIV primary and secondary prevention services to those at risk of or with HIV infection.

Objective-1 Determine gaps in HIV prevention services in rural areas of Pennsylvania.

Activity Compile and analyze existing data from rural area focus groups in order to determine gaps in and barriers to services.

Activity Analyze the regional coalitions to determine barriers to HIV primary and secondary prevention services in rural areas.

Objective-2 Based on the results of the analysis of focus groups and regional coalitions, identify the methods and resources necessary to increase services to rural populations.

Activity Conduct a literature search to compile the most effective methods to deliver the prevention services identified by analysis of focus group and regional coalition data.

Activity Consult with CDC to determine what resources are available from the Department of Health and Human Services to serve the HIV prevention needs of rural communities in Pennsylvania and, if necessary, request technical assistance in accessing those resources.

LINKAGES BETWEEN PRIMARY AND SECONDARY HIV PREVENTION ACTIVITIES

Guidance from the Centers for Disease Control and Prevention defines primary prevention as halting the transmission or acquisition of HIV. Secondary prevention is defined as halting or delaying the onset of illness in an infected person. It is, therefore critical that HIV prevention efforts focus on the current pool of infected individuals in order to keep them from progressing to an AIDS diagnosis and since they are the sole source of new infections.

The Department of Health has developed directories of regional resources. Because field staff are responsible for conducting the results counseling of all HIV-positive clients identified by publicly funded sites within their jurisdictions, these directories are critical in assuring that such clients are referred to appropriate medical and social services.

Field staff is responsible for documenting whether HIV-positive clients act on referrals. The Division of HIV/AIDS has developed a form used by HIV counselors for this purpose. The first page of the form documents the client's risk reduction plan. The second page documents service referrals. Because field staff provides the majority of HIV-positive clients with referrals to viral load and CD4+ T-Cell testing identified at publicly supported sites, monitoring follow-through by clients to referral services becomes an ongoing process.

Linkages Goal I

Link all HIV positive persons identified at publicly funded counseling and testing case management, medical care, and support services.

Objective-1 Update and maintain regional resource directories.

Activity Offer TB testing, and initial CD4 T-Cells and viral load testing to all HIV positive persons

Activity Serve as a provider of last resort, for ongoing CD4 T-Cell, and viral load testing to all HIV positive persons.

Activity Refer HIV positive persons to needed services to include case management, prevention case management, medical care and support services.

Linkages Goal II
Create a seamless system to facilitate the transition of HIV positive clients identified in public funded testing sites into secondary prevention services.

Objective 1 Establish a formal tie between the HIV Prevention Planning Committee and the Ryan White Integrated Planning Council.

Activity Select a fulltime Secondary Prevention Specialist who will act as liaison between the Committee and the Council.

Activity Coordinate, convene, and staff a work group consisting of members of the Committee and the Council.

Activity Provide technical assistance to the Committee, the Council, and the Department funded organizations that deliver primary and secondary prevention services for the purpose of identifying and eliminating barriers to clients transition from primary to secondary services.

TRAINING AND QUALITY ASSURANCE (T&QA)

T&QA Goal I
Increase the ability of pertinent stakeholders in the community planning process to conduct and utilize gap analysis in statewide HIV prevention planning.

Objective-1 Train pertinent stakeholders in the theory, rationale, methods, analysis, and application of gap analysis for statewide prevention planning.

Activity Consult with the Project Officer to identify organizations or individuals capable of conducting gap analysis training.

Activity Select the organization or individual deemed most qualified to conduct gap analysis training and deliver the training to the stakeholders.

T&QA Goal II
Increase the capacity of all Department funded agencies that deliver HIV prevention interventions to better plan and monitor their interventions.

Objective-1 Train all Department funded agencies to implement the statewide HIV uniform data collection system (based on CDC's Evaluation Guidance) by Spring 2002.

Activity Train the seven Ryan White AIDS Coalitions and their subcontractors to use Intervention Plans by January 31, 2002, and have them complete these Plans in their subsequent contract year.

Activity Train the seven Ryan White AIDS Coalitions and their subcontractors to use Process Monitoring Forms by January 31, 2002, and have them begin collecting data using these forms in their subsequent contract year.

Activity Train the four Council of Spanish Speaking Organizations that provide Department funded HIV prevention interventions to use Intervention Plans in Spring 2002, and have them implement these Plans in their subsequent contract year.

Activity Train the four Council of Spanish Speaking Organizations that provide HIV prevention interventions to use Process Monitoring Forms in Spring 2002, and have them begin collecting data using these forms in their subsequent contract year.

Objective-2 Ensure continual improvement of quality and timeliness of uniform data collection.

Activity Within two months after each of the above agencies provides annual Intervention Plans and Process Monitoring Forms, provide written feedback to these agencies about the quality of completion of these forms for future quality improvement of data collection.

Activity By December 2003 have Intervention Plans and Process Monitoring Forms available online at the PA Department of Health's web site www.health.state.pa.us.

COORDINATION OF HIV PREVENTION SERVICES AND PROGRAMS

For the next two years the Pennsylvania Department of Health will collaborate with the Pennsylvania Department of Education to identify and disseminate a complete list of effective educational tools and related resources to all school districts. In addition, the Departments of Health and Education will improve their available resources for providing education to health educators about HIV, sexually transmitted infections, and Hepatitis C. Further by using proven interventions this collaboration will seek to increase peer education for all schools and educational levels.

Coordination of HIV prevention services and programs is accomplished in part through improving communication and planning between regions, agencies, and individuals engaged in prevention efforts. Pennsylvania covers a large geographic area. Its rural and urban communities have different needs and resources, and its population represents diverse cultures. Coordination is intended to maximize the use of local and state resources in order to strengthen HIV prevention efforts.

The Pennsylvania Prevention Project at the Graduate School of Public Health, University of Pittsburgh (PPP) provides a liaison with the nine county and municipal health departments (CMHD). This collaboration further insures that HIV prevention community planning is interpreted and implemented within those jurisdictions in accordance with the comprehensive HIV prevention plan. This process creates a practical feedback loop of information and concerns between these jurisdictions and the HIV Prevention Community Planning Committee.

In addition, the Pennsylvania Prevention Project works with the State Health Improvement Plan (SHIP) to exchange information about community-based HIV prevention programs in order to create linkages and promote communication and collaboration. This is in part accomplished by creating communication between Committee members, other local HIV prevention leaders, and the local partnership members of the SHIP.

One source of information is the quarterly Community Update newsletter of the Division of HIV/AIDS, Pennsylvania Department of Health (DOH). This newsletter keeps the regional state health district offices, county and municipal health departments, Ryan White HIV/AIDS Regional Planning Coalitions, local partnership members, and others informed of HIV prevention efforts of the Committee, Pennsylvania Prevention Project, and the Division of HIV/AIDS.

SECTION V
FIVE-YEAR STRATEGIC EVALUATION PLAN 1999-2003

Introduction

Developing a five-year, strategic evaluation plan was initiated by the PA Department of Health in December 1998. Since then, a comprehensive evaluation plan was included as a draft in the 2000 Comprehensive Prevention Plan submitted to the CDC in September 1999. Subsequently, a final evaluation plan was included in last year's Comprehensive Prevention Plan. The following is a reiteration of this evaluation plan. Changes that have been made since last year's submission or updated information are indicated in bold within the text.

FIVE-YEAR PROGRAM EVALUATION TIMELINE

1998	**1999**	**2000**	**2001**	**2002**	**2003**
-Initiation of planning for evaluation of HIV prevention	-Evaluation of community planning process -Evaluation of prevention plan -initial meetings of constituents regarding use of intervention plan & process monitoring	-Pilot intervention plans with county & municipal health departments Evaluation of community planning process including CDC Co-Chair survey -Assessment of linkages exercises -Meeting with non-CDC funded providers regarding use of CDC Evaluation Guidance -Client satisfaction surveys of CRT/PCR First CDC report of intervention plans	**April:** First CDC report of process monitoring **July:** Implementation of process monitoring among C&MHD **Fall:** Implementation of process evaluation and outcome monitoring of the Living Project (perinatal HIV prevention) **Fall:** Taining of non-CDC funded providers in use of intervention plans and process monitoring **Fall:** Pilot client satisfaction of CRT/PCR HIV+ clients **Fall:** Assessment linkages **Nov: E**valuation of community planning process [outcome evaluation on hold]	**April:** CDC report of process monitoring **Spring:** Implementation of client satisfaction of CTR/PCR of HIV+ clients **Spring:** Implementation of intervention plans & process monitoring of non-CDC funded providers and continuing training -Linkages exercises and possible linkages T.A. -continuation of intervention plan reporting & process monitoring of CDC funded providers -Continuation of all other annual evaluation activities	Full implementation of all required evaluation activities as well as outcome evaluation report pending CDC permission to begin such evaluation in 2001 or 2002.

The following plan is divided into two parts:

I. An overview of the evaluation plan includes:
   - An explanation of the stakeholders involved in *developing* and *implementing* the evaluation plan.
   - An outline of the components of the evaluation plan and a general timeline for initiating and implementing each component or type of evaluation.
   - The philosophy, purposes, and potential barriers to overcome regarding evaluation of HIV prevention or education interventions in Pennsylvania.

II. A detailed outline of the specific objectives to be achieved by particular types of evaluation over a five-year period, with timetables for each type of evaluation.

Part I. Overview of Evaluation Plan

A. Stakeholders: (Changes in bold italics):

Many stakeholders have been involved in compiling this evaluation plan, they inlcude:

- The PA Department of Health's Division of HIV/AIDS (Division) is ultimately responsible for establishing a comprehensive HIV Prevention Evaluation Plan. Staff involved are those who oversee HIV prevention and education programming, including one staff member responsible for prevention and educational activities funded with state dollars but implemented through the Ryan White Regional Coalition structure and another staff member responsible for the state's Council of Spanish Speaking Organizations, which also receive funds for HIV prevention and education from state funding streams). The Division is ultimately responsible for evaluation planning and implementation and has contracted with the University of Pittsburgh to facilitate these activities in the initial years. After several years of implementing the evaluation plan and when program evaluation has been further institutionalized in prevention planning, the Division will both oversee *and* facilitate evaluating HIV prevention activities and interventions. A that point it will likely draw on experts as needed for conducting discrete evaluations.
- The HIV Prevention Planning Committee has participated in devising the evaluation plan. The Committee has reached consensus on methods for evaluating its own prevention planning. It has also reviewed the CDC's recommendations for assessing linkages between the Comprehensive HIV Prevention Plan and resource allocations for prevention interventions. The Committee adopted the process for assessing linkages that appeared in the 2001 Prevention Plan, ***and built on this process in the 2001 planning year***. The Committee has also reviewed and commented on the Department of Health's incremental drafts of the Intervention Plan, which is being used to collect prospective data on HIV prevention and education interventions. The Committee will continue to contribute updates to the evaluation plan as needed. One important role played by the Committee is representing consumers' perspectives on issues pertaining to evaluation and decision making.
- Other community groups have taken part in constructing of a draft evaluation plan.

- Staff members from demonstration projects, who represent community agencies implementing prevention interventions, have participated in planning meetings. Demonstration projects have piloted the intervention plans and are now implementing it. ***They are also collecting process monitoring data***. Their staff members have attended evaluation training meetings not only to address data collection issues involved in the intervention plan and process monitoring but also to discuss process and outcome monitoring of their respective projects. These projects receive funding through 99004 funds.
- Nine county and municipal health departments and their subcontractors piloted the intervention plan ***in 2000 and continued implementing it in 2001. These health departments also began*** process monitoring based on these prospective data in **July** 2001. These nine health departments receive both 99004 funds and state funds to implement various HIV prevention and education initiatives.
- Seven Ryan White Coalitions and their subcontractors also implement HIV prevention and education interventions through state funding. Staff members from Coalitions and representatives of their various subcontracting agencies have participated in meetings and other activities focused on tailoring the intervention plan to the state's needs. These agencies will use the intervention plan ***beginning in Fall 2001*** and corresponding process monitoring forms beginning in ***Spring 2002***. The Coalition's staff members have also participated in evaluation training for HIV prevention provided by the Division. Such training is meant to increase coordination of approaches to evaluating HIV-prevention and collaboration between agencies supported through various funding streams.
- The Council of Spanish Speaking Organizations and their subcontractors specifically serve Latino(a) communities in various regions of the state where this subpopulation is concentrated. The Council and their subcontractors receive state funding to provide HIV prevention and education to those at risk of acquiring HIV in the communities they serve. The Council and various agencies have been involved tailoring and implementing the intervention plan, and will use it and the corresponding process monitoring Forms in ***2002***.
- In addition, other agencies have been part of evaluation planning in order to foster integrating evaluation approaches and systems in the future. For instance, a representative of the Bureau of Drug and Alcohol Programs has attended and contributed to planning meetings, and the prevention planning and programming participants from Philadelphia have been invited to collaborate on statewide integration of approaches to evaluation.

- As stated above, the University of Pittsburgh has facilitated devising the evaluation plan. The Director of Evaluative Research of the Pennsylvania Prevention Project (PPP) is also a faculty member at the University's Graduate School of Public Health. For now he will continue to facilitate planning and implementation, but staff from the Division will eventually facilitate all aspects of program evaluation, including planning and designing assessments; collecting, managing, and analyzing data; making program decisions based on these data; and making decisions about the use of consultants for carrying out aspects of evaluations that need particular expertise.

Although the Department of Health is ultimately responsible for developing and implementing an evaluation plan, it understands that individuals will most likely see the value of evaluating prevention programs and activities if they are involved in making decisions about how to evaluate the ones in which they have a stake. Therefore, decisions about evaluation are made by consensus among stakeholders of the activity or program being evaluated.

The following table summarizes the various stakeholders and their participation by the types of evaluations that are part of the evaluation plan:

(Changes in bold Italics):

Type of Evaluation	**Stakeholders and Roles**
Evaluation of community planning process and prevention plan development.	Community Planning Committee members will continue to participate in the evaluation of the planning process; and co-chairs will complete a co-chair survey concerning the process. [Note: In addition to the Committee process evaluation, all Committee members will participate in any future assessments of the Comprehensive HIV Prevention Plan, as well as assessment of Committee/Planning outcomes. These outcomes are given evidence in linkages between the Plan and allocations (see below) and gap analysis, which shows evidence that Committee recommendations were or were not incorporated in actual interventions.]
Intervention Plans.	Community prevention/education providers (both CDC-funded and other providers who have agreed to use the Intervention Plan) and the Community Planning Committee has had input in designing the Intervention Plan; the University of Pittsburgh has been facilitating the design and implementation; the Division of HIV/AIDS is ultimately responsible for implementing and evaluating Intervention Plans.
Evaluation of linkages between comprehensive HIV prevention plan and application for funds, and between Comprehensive HIV Prevention Plan and resource allocation.	The Funding Guidelines Subcommittee commenced this process in 2000; however, due to lack of sufficient data from all sources (that should in part be resolved with uniform data collection) this process is ongoing and should vastly improve in subsequent years.
Process monitoring	Community prevention/education providers; consumer groups; the Community Planning Committee; and other stakeholders in prevention/education interventions provide feedback about data needs that may be fulfilled by process monitoring, as well as monitoring approaches. Provider agencies implement monitoring; the University of Pittsburgh continues to help facilitate decision making on data needs and monitoring designs; the Division is responsible for oversight and facilitation of the entire process monitoring method.
*Outcome monitoring and process evaluation. *Note: Outcome monitoring, which is	**Community prevention/education providers who participate in process monitoring are also encouraged to develop plans for outcome monitoring and process evaluation if these activities**

a periodic or ongoing check on whether providers are likely to meet outcome objectives, including tracking whether clients are progressing toward meeting client outcome objectives, is not required by the CDC. Also, process evaluation, or a descriptive assessment of the implementation of program activities, is not required by the CDC. However, these types of evaluation are included in the Pennsylvania Evaluation Plan since they occur among some discrete HIV-related projects.	**seem to be appropriate given agencies' resources and planning needs. To this end, an optional section has been included in Pennsylvania's version of the Intervention Plan (attached) that provides a section for program goals and objectives, and proposed plans for monitoring and evaluating the project based on these objectives. The Division coordinates technical assistance for agencies desiring to implement outcome monitoring and process evaluation.** *One of the state HIV prevention demonstration projects, The Living Project, is beginning an extensive process evaluation in September 2001. This is a multi-component project targeted to reduce perinatal transmission of HIV. This process evaluation will be implemented by the contracting agency with the assistance of an outside (objective) contractor/evaluator. The project staff and evaluators have cooperated on the evaluation design with the guidance of University of Pittsburgh staff. The Division is ultimately responsible for oversight and facilitation of this evaluation.* **Additionally, The HIV Counseling, Testing, Referral, and Partner Notification Program, also coordinated by the Division, has embarked on a large-scale, nationally recognized, multi-method process evaluation. Methods and instruments used for this evaluation—for example, a Client Satisfaction Survey that is implemented periodically statewide—are added to a compendium of examples of process evaluations. These models are made available to other agencies that wish to implement process evaluations of their particular HIV prevention/education interventions.**
Outcome evaluation.** ****Currently on hold.	**The Living Project (perinatal HIV prevention project) is positioned, with the assistance of an outside evaluator, to design and conduct an outcome evaluation, as well as the process evaluation described above. However, the outcome portion of this evaluation design has been put on hold until further notice from the CDC regarding the protocol for conducting outcome assessments using federal funding.**

B. General Timeline: (Changes in bold italics):

The following is a timeline for the implementation of the various types of evaluations, as well as dates that data is due to the CDC relative to each evaluation type. More specific timetables for implementation and reporting are included in Part II of the Evaluation Plan.

Type of Evaluation	**Implementation**	**Date Data is Due to the CDC**
Evaluation of community planning process and prevention plan development.	Community process evaluation was implemented prior to 1999, but a co-chair survey was added in November 1999. ***The entire above evaluation process was again implemented in November 2000, and will occur again in November 2001.*** Evaluation will occur annually	Data was provided in September 1999; data including co-chair survey information were included in September 2000. Data from the 2000 planning year will be provided in September 2001.
Intervention Plans.	Piloted among Demonstration Projects in December 1999 and draft Intervention Plan implemented as part of agency grant renewal in July 2000. Intervention Plan piloted among County and Municipal Health Departments in July/August 2000, ***and fully implemented in July/August 2001.*** Intervention Plan will be piloted among Ryan White Coalition subcontractors and Council of Spanish Speaking Organization agencies in 2001/02. Interventions will be updated annually.	First report was due September 2000. ***Intervention Plan data is included with the state's application to the CDC in September 2001.*** Ongoing annual reporting thereafter.
Evaluation of linkages between the Comprehensive HIV Prevention Plan and application for funds, and between the Comprehensive HIV Prevention Plan and resource allocation.	Linkage between Prevention Plan recommendations and Application for Funds accomplished August 2000. Linkages between Prevention Plan and resource allocation ***reported in April 2000***.	Report on Plan/Application linkages was due September 2000. Report on Plan/Resource Allocation Linkages was due April 2001.

		Ongoing annual reporting in September and April thereafter.
Process monitoring.	Currently, all funded providers conduct process monitoring, though not all report data in a uniform fashion. Some conduct outcome monitoring and process evaluation. Uniform Process Monitoring, using the Process Monitoring Form, was implemented among County/Municipal Health Departments in ***July 2001.*** Other (non-CDC) funded agencies will incrementally begin using the Process Monitoring Form.	First report due April 2002. Ongoing annual reporting thereafter.
Outcome monitoring and process evaluation.	Demonstration Projects implemented outcome monitoring in 2001. ***Process evaluation will be implemented as appropriate to each project in Fall 2001 through 2002. (The Living Project, described above, is included in the process evaluation implementation.*** Counseling and Testing Client Satisfaction Survey, which is part of a larger process evaluation, is implemented on a periodic basis statewide.	Reporting is not required by CDC, but will be included in regular annual updates of activities.
Outcome evaluation.	***On hold until further notice from CDC.***	***On hold until further notice from CDC.***

C. Philosophy, Purpose, and Potential Barriers: (No changes):

An important early step in developing an evaluation infrastructure and comprehensive Evaluation Plan is to determine the uses of evaluation. Key questions to answer include, "Will assessment be used primarily to inform funders of contract compliance and success of programs? Will assessment be used as part of a learning process? Will it be used by prevention providers to improve programs? Will evaluation feed into future prevention planning?"

Pennsylvania stakeholders or partners have adopted a "Utilization-Focused" Evaluation approach, which is the systematic collection of data about activities, characteristics,

and/or outcomes of programs done *for* and *with* specific, intended primary users for specific intended purposes. An underlying principle is, "If the evaluation is not useful to anyone, then why implement it?"

Partners have agreed that the primary purpose of evaluation should be to provide information about program activities, barriers, attainment of objectives, and intended and unintended outcomes that would aid in continually improving programs. Related is the use of evaluation findings as information for further planning of HIV prevention interventions and activities. It was agreed that evaluation should yield such information for multiple constituents, such as program staff, program planners, HIV prevention/education advocates, potential funders, consumers/clients, policymakers, and others.

In the midst of gathering data to improve programs and plan, accountability may be assured. That is, subcontractors can account for its work to the PA Department of Health. The Department of Health can provide an aggregate accounting of statewide activities and outcomes to the CDC. Ultimately, this statewide data will be useful to the CDC as it provides information to the Office of Management and Budget and Congress regarding the uses of federal funds designated for HIV prevention.

Further, providers, who themselves are funded by various funding streams, suggested that uniform and complementary evaluation approaches could be a vehicle for providing coordination between and among a number agencies concerned about HIV prevention/education, and could raise the level of professionalism, creditability, and accountability among these agencies and in the eyes of their clients.
Of course, implementation of a statewide Evaluation Plan has potential barriers that could impede the success of the plan. In regular meetings leading to the five-year Evaluation Plan, stakeholders shared these concerns as possible barriers that an effective evaluation system must address:

- Uneven resources and capabilities among a large number of agencies to collect, manage, and report data.
- The possibility of creating irrelevant and non-user-friendly data collection forms and approaches.
- The possibility that agency staff may hold fears and biases about evaluation, data collection, and ways that data may be used for decision making.
- Possible difficulty in obtaining/maintaining a high quality of data.
- Possible "midstream" changes in data collection requirements.
- The possibility that evaluation and data collection will "drive" the program, rather than programs "driving" data needs and appropriate evaluation approaches.

Most if not all of these barriers may be avoided or eliminated earlier rather than later with careful planning and adequate resources for carrying out an Evaluation Plan. To this end, the Division has embarked on a strategic and comprehensive five-year plan that will serve to meet the goals and purposes set forth by partners, while identifying and eliminating barriers when they arise.

Part II. Detailed Outline of Evaluation Plan

The following provides a detailed outline for each type of evaluation activity. For each activity, the purposes of the evaluation, assessment methods, scope of evaluation, staffing and resources, and a timeline are provided. A narrative discussion of ways that implementation and data will be managed relative to each evaluation activity appears after the respective table.

Evaluation of community planning process and prevention plan development: (Changes in bold Italics):

Note: At the suggestion of the CDC Project Officer in the CDC review of the 5-Year Comprehensive Evaluation Plan, possibilities for technical assistance are included below, as well as a graphic timeline of planned evaluation activities.

Purposes	**Methods**	**Scope**	**Staffing and Resources**	**Timeline**
1. Assess the process of the HIV Prevention Planning Committee (the CDC-guided Community Planning Core Objectives provide the basis of variables to be assessed).	1. Committee Member Anonymous Survey; Facilitated Committee Member Discussion Groups; Co-Chair Survey	1. The survey is administered among all Committee members, and all members are given the opportunity to participate in the discussion groups; both co-chairs complete the respective survey.	1. PPP staff administer the member survey, analyze data, and issue a written and oral report to the Committee; outside consultants, typically former Committee members skilled in group facilitation, administer two separate discussion groups; each co-chair completes and submits the Co-Chair Survey.	1. All evaluation methods are administered in November of each planning year; discussion groups are part of the regular November Committee meeting.
2. Assess the composition of the Community Planning Committee (with reference to geographic distribution, agency/other representation, expertise, sex/gender, age, race/ethnicity, and HIV exposure)	2. Anonymous survey that includes questions about characteristics of Committee members.	2. The survey is administered among all Committee members.	2. PPP staff administer the member survey, analyze data, and issue a written and oral report to the Committee; data is translated to CDC's "Profile of Community Planning Group Members" report form.	2. Survey administered with other process evaluation methods in November of each planning year.

Evaluation of community planning process and prevention plan development, continued:

Purposes	Methods	Scope	Staffing and Resources	Timeline
3. Assessment of the ***HIV Prevention Plan*** and its use in planning actual HIV prevention/education interventions	3. In the past, Committee members conducted an assessment of ***the HIV Prevention Plan*** once this plan was issued. Specifically, a content analysis of the plan was conducted, and a tally was made regarding the goals, objectives, and activities that were actually addressed in implemented activities after the Plan was issued. As data collection improves and becomes more uniform across CDC-funded and non-CDC-funded interventions, the gap analysis that results from these data provide a way of showing whether Plan recommendations are addressed or not. Further, the Linkages exercise, described below, provides further evidence of implementation of Plan	3. All Committee members participate in a final assessment of gaps between actual interventions rendered and recommendations in the Prevention Plan; a task group of the Committee, in cooperation with the Division, assess the linkages as described below to assess the correspondence between Plan recommendations and HIV prevention/education interventions rendered.	3. ***The beginnings of a gap analysis between actual HIV prevention services rendered by target populations and need in target populations was begun this year, using the service data provided by County and Municipal Health Departments (see line 10 of Table 1 that is part of the Prioritization Process). PPP staff and the Department of Health have coordinated these data and have presented it to the Prioritization Task Group. As the data improve and becomes more comprehensive, they will be able to be used more fully in the analysis of gaps of services by target population across the state. In particular, the Funding Guidelines Subcommittee will be***	3. Uniform data collection regarding CDC and non-CDC funded interventions was initiated, but not complete for 2001 planning. Assessment was made of correspondence between Plan recommendations and actual interventions rendered with respect to, at least, CDC-funded interventions in August 2001. Full gap analysis data will be available to use for this purpose in August 2002. Linkages data began to be assessed in August 2000, and is assessed each year thereafter.

	recommendations.		***able to increasingly use these data to compare against recommendations made in the Plan regarding the quantity and nature of prevention/education interventions actually funded and implemented.*** A task group of the full Committee, in coordination with the Division, will continue to assess linkages, as described below.	

Implementation and data management*:* As suggested in the table above, data from the written Committee Member Surveys are anonymous. Members are provided with the survey and a return mailing envelope at the annual November meeting and instructed to return it to the University of Pittsburgh by mail, with no identifiers attached. Members who may be absent from that meeting are mailed a survey, a return envelope, and instructions for returning the survey anonymously. Data from the survey are entered into a statistical software program for processing and analysis. Qualitative data are coded and likewise entered into a computer software program. Co-Chair surveys are not anonymous since only two Co-Chairs exist and demographic information identifies the Co-Chair. Data from this survey is processed in the same way as the member survey.

Discussion groups are recorded and transcribed word-for-word. One University transcriber solely transcribes the tape and does not reveal the identity of Committee Member participants or other information deemed by Committee Members to be confident in the printed transcript. (At the beginning of discussion groups, participants are told that they can request that the tape be shut off for a short time period for "off-the-record" comments, and that they can request that particular contents of the tape be kept "off-the-record" after group has been conducted.) A University researcher skilled in qualitative methods analyzes transcripts and results are written in summary form. These data are compared, contrasted,

and integrated with survey data, and presented in a final written report, which the full Committee and Co-Chairs review for accuracy. If parts of the report are found to be inaccurate, Committee members may request that data be revisited and the report be revised appropriately. Committee members give final approval of the parts of the report involving member responses; and Co-Chairs give final approval of the accuracy of related data.

Gap analysis data will be garnered from the upcoming Process Monitoring Forms that were implemented in January 2001. ***A partial gap analysis occurred based on Intervention Plan data provided by the nine County and Municipal Health Departments.*** A full gap analysis will not be able to be conducted until the majority of agencies conducting HIV prevention/education interventions through funding other than the federal 99004 funding begin reporting data uniformly through Process Monitoring. Therefore, assessment of the implementation of Plan recommendations in actual interventions across the state will be limited until 2002 when these other agencies begin reporting HIV prevention intervention data uniformly.

The linkages assessment is described below.

The Planning and Evaluation Sub-Committee annually reviews the appropriateness and adequacy of the assessment of the HIV Prevention Community Planning Process before implementation the following year.

Intervention plans:

Purposes	Methods	Scope	Staffing and Resources	Timeline
Determine agency plans to provide HIV prevention/education in their communities and use these prospective determinations to help assess adequacy and appropriateness of proposed interventions with respect to target populations, scientific/best-practice basis of interventions, and overall soundness of proposed approaches.	Implementation of Pennsylvania's version of the Intervention Plan.	In stage 1, all CDC-funded used Intervention Plans to report on the subsequent year's prospective activities. In stage 2, non-CDC-funded Ryan White Coalitions and subcontractors, and the Council of Spanish Speaking Organizations and subcontractors, will use Intervention Plans.	The Division is ultimately responsible for preparing agencies to implement and use Intervention Plans in HIV prevention planning. The Division has contracted with PPP to facilitate the process working with agencies in designing the Intervention Plan and preparing agencies to use the Intervention Plan. PPP is initially undertaking data collection, aggregating, and reporting tasks; but these tasks will likely be assumed by the Division over time. Planning/provider agencies assign at least one staff person to coordinate Intervention Plan activity as a regular task in the administration of HIV prevention/education programs. Joint meetings are held in Harrisburg, which, to a large extent, is centrally	August 2000: Demonstration Projects and County/Municipal Health Departments submitted Intervention Plans as a pilot stage in implementing this process. October 2000: Those who piloted Intervention Plans were provided feedback on the process of using these Plans; feedback is provided for the purpose of improving the process as well as to prepare other agencies to begin using Intervention Plans. December 2000: Non-CDC-funded agencies were provided an initial estimate of a timetable for instituting the Intervention Plan among their subcontracting agencies. March 2001: Non-CDC-funded agencies developed timetables

			located to all state agencies.	and plans (including training plans) for implementing the Intervention Plan among their subcontractors. ***According to this schedule, the 7 Ryan White Coalitions will be trained in the use of Intervention Plans in October 2001. These Intervention Plans will be completed by Coalitions, and will include information from each of their subcontractors, in the following contract year. The Council of Spanish Speaking Organizations will be trained similarly in Spring 2002.***

Implementation and data management: Demonstration Projects and County/Municipal Health Departments have piloted Intervention Plans. Each pilot involved a different draft of the Intervention Plan, with incremental improvements to the Plan based on pilot experience. Intervention Plans have been completed and returned on either hardcopy or in a word-processed file, which was transmitted electronically through e-mail. Demonstration projects represent single agencies, therefore, submit cohesive Intervention Plans for their respective agencies' prevention projects. County/Municipal Health Departments submit plans for their own HIV prevention/intervention activities funded through the PA Health Department with either state legislator or CDC funding. Some County/Municipal Health Departments also have subcontractors that implement HIV prevention/education programming. Each health department aggregates their and their subcontractors' information before submitting these data.

Because there have been relatively few agencies submitting Intervention Plans to date, data are aggregated manually by PPP staff. The plan, however, is to computerize the Intervention Plan, using a software package that will aggregate data automatically as it is submitted electronically to a central source. Of course, narrative data will and should accompany the Intervention Plan. Qualitative data from these narrative descriptions will be used to provide context for proposed interventions and, in turn, will be incorporated in narrative reporting to the CDC from the PA Department of Health. As mentioned above, PPP staff is facilitating the adoption and implementation of the Intervention Plan to date. This facilitation has been closely monitored and supported by Division personnel directly responsible for the corresponding agencies using the Intervention Plan.

Agencies who have adopted or will be adopting the Intervention Plan have collaborated in a series of meetings, telephone conferencing, and email and fax correspondence as a way of constructing the actual Intervention Plan and coordinating its implementation. These forms of communication will continue to occur until all agencies are using the Intervention Plan effectively. Agencies that began using the Plan earlier will assist agencies that will subsequently use the Plan.

Evaluation of linkages between comprehensive HIV prevention plan, application for funds, and resource allocation:

Purposes	**Methods**	**Scope**	**Staffing and Resources**	**Timeline**
1. Assess the linkages between the Comprehensive HIV Prevention Plan and the Department of Health's CDC funding	1. Compare the recommendations in the Plan by target populations to the interventions proposed in the CDC funding	**The Funding Guidelines Subcommittee has completed the CDC recommended forms**	PPP staff will work closely with the subcommittee as well as the Division staff to assist in creating the most comprehensive	1. Plan/Application linkages (for proposed activities in 2001) reported in September 2000; ***and again in September 2001 for***

application. 2. Assess the linkages between the Comprehensive HIV Prevention Plan and resource allocation for interventions.	application, using the CDC-provided forms. 2. Compare linkages between the Prevention Plan recommendations/goals/ objectives/strategies and resource allocation for interventions.	**for the current Plan recommendations and CDC funding guidelines.** That process will be expanded to a wider scope of reviewing HIV prevention interventions funded by other resources to gain the most comprehensive perspective of HIV prevention.	view of HIV prevention efforts in the Commonwealth.	***2002 activities.*** 2. Plan/resource allocation linkages (for 2000 interventions) reported in April 2001; ***and planned to be reported in April 2002.***

Implementation and data management*:* As implied, the Funding Guidelines Subcommittee will continue to compare Plan recommendations with interventions proposed in the funding application.

To gather and compare data for assessing linkages between Plan recommendations and actual resource allocation for interventions, resource allocation from Process Monitoring Forms will be used to derive percentages of allocations by target populations. Until all agencies (CDC- and non-CDC-funded) delivering HIV prevention interventions implement the Process Monitoring system, however, estimates of resource allocation by target population are gathered from agencies.

Technical assistance needs: Since evaluating linkages remains a fairly new and evolving process for Pennsylvania planning, assistance may be needed particularly from other jurisdictions with experience in assessing linkages or consultants who have worked with such jurisdictions.

Process monitoring:

Purposes	**Methods**	**Scope**	**Staffing and Resources**	**Timeline**
Document and report intervention characteristics describing: • The target populations served. • The services that were provided. • The resources used to deliver these services.	Implementation of Pennsylvania's version of the Process Monitoring Form.	In stage 1, all CDC-funded agencies participate in process monitoring and use the Process Monitoring Form to aggregate and report data for the respective year's actual HIV prevention/education intervention activities. In stage 2, non-CDC-funded Ryan White Coalitions and subcontractors, and the Council of Spanish Speaking Organizations and subcontractors, will be integrated into this process monitoring system and begin using the Process Monitoring Form. These agencies will be trained in use of Process Monitoring Forms in conjunction with Intervention Plan training explained above.	Same as indicated above under "Intervention Plan."	**July 1, 2001. County and Municipal Health Departments initiated process monitoring using Process Monitoring Forms. Data will be reported to CDC in April 2002 report.** ***October 2001. Coalitions (non-CDC-funded) will be trained in process monitoring using Process Monitoring Forms, and will implement process monitoring in the next contract year.*** ***Spring 2001. Spanish Speaking Organizations (non-CDC-funded) will be trained in process monitoring and will subsequently implement such monitoring.***

Implementation and data management*:* Implementation and data management will occur in a very similar way to that described for the Intervention Plan. A difference is that agency-level data collection forms are likely to be computerized and available online, and eventually will be linked to an electronic version of the Process Monitoring Form. In essence, agencies should be able to enter discrete client- and group-level data, which will easily be aggregated in electronic Process Monitoring Forms. This process, however, will not likely be available until the later part of 2001 and, therefore, will not be used for the first round of process monitoring conducted by the Demonstration Projects and County/Municipal Health Departments. Plans for such electronic coordination will be forthcoming in the update to this Evaluation Plan in 2001.

Outcome monitoring and process evaluation:

Goals	Methods	Scope	Staffing and Resources	Timeline
Note: Outcome monitoring and process evaluation are not required by the CDC, however, agencies implementing HIV prevention/education interventions are encouraged to conduct such activities. Technical support for these evaluative activities is coordinated through the PA Department of Health. Since this in not a requirement, goals and activities specific to agencies that do incorporate outcome monitoring and process evaluation are not included in this overall Evaluation Plan, **aside from the important evaluation of The Living (perinatal HIV prevention) Project**. Additionally, since process evaluation of the HIV Counseling, Testing, Referral, and Partner Notification System has been ongoing and extensive, information about plans for continuation of this evaluation is included below.				
1. Assess the process of implementing the perinatal HIV prevention project—The Living Project.	1. **Interviews with women who are clients of the project; pre- and post-test regarding HIV prevention knowledge at baby showers and home parties, which are intervention components of the project; risk assessment questionnaires for participants of showers/home parties (data used as baseline for outcome monitoring); questionnaire for peer educators and prevention case management participants.**	1**. The first stage of the process evaluation will occur September through December 2001, with ongoing assessment to be determined based on this stage of the assessment.**	**1**. The Living Project Staff, PA Department of Health, PPP staff, and an already-identified outside evaluator have cooperated in the evaluation design. The evaluator will work closely with the Living Project staff in implementing the interviews, pre- and post-tests, and other questionnaires. PPP staff will offer general guidance over methodological and implementation issues. The Department of Health will monitor the entire evaluation process in context of monitoring the Project. An evaluation line has been established in the project budget.	**1. Implementation of first-stage process evaluation in September 2001 through December 2001, with ongoing plans to be decided based on this stage's results.**

2. Assess satisfaction of clients of CTRPN services statewide.	**2. A Client Satisfaction Survey has been administered periodically since 1996 at select CTRPN sites.**	2. Implementation of surveys occurred over a six-week period at 65 selected CTRPN sites across the state. Clients of results counseling were provided with surveys. (Prevention counseling clients have been surveyed extensively in previous assessments; and results counseling clients were surveyed at 50 sites in 1999.) Only clients who test HIV-negative were given surveys (HIV-positive clients will be surveyed in a carefully implemented manner in a separate process).	**2. PPP has historically facilitated the client satisfaction assessment process with oversight from the Division's staff responsible for the CTRPN program.**	**2. Survey implemented in Fall/Winter 2000 and final report issued in June 2001**
3. Pilot and Implement a results-counseling client satisfaction survey for clients who test HIV-positive. (This survey will not be implemented immediately after test results for obvious reasons of sensitivity to clients. Through follow-up contact with Department of Health	3. Client satisfaction survey.	3. Scope to be determined after pilot testing.	3. An outside consultant who assisted in the development and piloting of both the previous prevention- and results-counseling surveys will develop and pilot the survey for HIV-positive clients. She will also assist PPP staff in training field staff to carefully implement the	3. **Pilot test to be completed by December 2001, with implementation at select sites (or among a sample of field worker/counselors) thereafter.**

field staff, clients who test positive will carefully be asked if they would like to participate in the satisfaction assessment. Field staff will be trained to implement this survey.)			survey among HIV-positive CTRPN clients. Division staff will oversee the entire process.	
4. Conduct a meta-analysis of all past CTRPN process evaluation findings to recommend quality improvement to the CTRPN system and future evaluation needs. (Past methods have included, in addition to the ongoing client satisfaction survey, a CTRPN staff mail survey and randomly selected site visits and a participant observation component in which paid and trained actors participated in the counseling and testing process to assess the quality of services.)	4. Synthesize all past process evaluation findings, comparing findings across methodologies.	4 N/A	4. PPP's Director of Evaluative Services will conduct the meta-analysis with oversight and assistance from the Divisions CTRPN staff and the Counseling and feedback from the Testing Sub-Committee of the Prevention Planning Committee.	**4. On hold until client satisfaction survey of HIV-positive clients is complete.**

Implementation and data management: To implement the process evaluation of the Living Project, the outside evaluator will work closely with project staff in designing, piloting, and implementing each of the instruments. This implementation will be conducted in a way that is not intrusive or compromising of the project activities. PPP and Division staff will be available for general guidance and oversight. The evaluator will collect, computerize, and analyze data using standard procedures for the respective methods. The evaluator will report data to the Project staff and PPP staff simultaneously for feedback. A final report will be issued to the Division through PPP.

The final Counseling and Testing Client Satisfaction Survey for HIV-negative clients has been completed, and results were reported through to the Department of Health. An outside evaluator, already identified, works closely with PPP and Department of Health staff responsible for HIV counseling and testing to develop the pilot survey. Department staff will choose a pilot site (or individual field staff) and will provide the consultant entrée for piloting the survey. Implementation will be decided based on pilot results. (That is, changes will be made to the survey as necessary, and the actual mode of implementation, e.g., reading questions to clients, relating questions conversationally, a combination of written and oral questions will be determined after the pilot. The Division will have final approval of methods and timing of implementation.

As with the former client satisfaction surveys of HIV-negative clients, PPP generates a report about four months after the survey period ends. Reports are distributed in draft form to the Division and the Counseling and Testing Subcommittee of the Planning Committee. Client anonymity and counselor confidentiality are guaranteed in reporting. After feedback and necessary changes, reports are finalized and made available through the Division. Findings are considered in review of Counseling and Testing Recommendations in the Annual Plan Update.

Outcome evaluation:

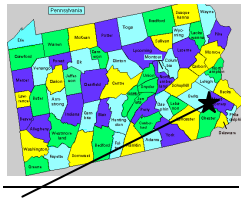
Goals	Methods	Scope	Staffing and Resources	Timeline
Evaluate the achievement of desired client outcomes related to The Living Project (perinatal HIV prevention project).	**On hold until further notice on status of outcome evaluations from CDC.**	**On hold until further notice from CDC.**	**On hold until further notice from CDC.**	**On hold until further notice from CDC.**

Implementation and data management: **To be determined after notice from CDC.**

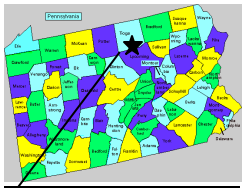
APPENDIX

Pennsylvania HIV Prevention Community Planning Committee
Member Biographies

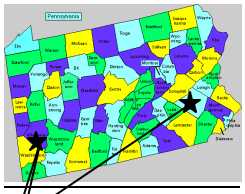
Pennsylvania Department of Health
Pennsylvania HIV Prevention
Community Planning Committee
2001



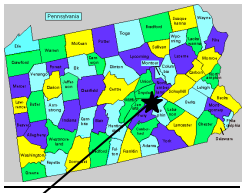
Shaista Ajaz – has been a member of the PA Young Adult Roundtables since January of 1996, is also a member of the Roundtable executive committee and of the Youth Advisory team in Pittsburgh which is a group of young people currently working to create their own HIV prevention intervention. She has an associate's degree in Sociology from Montgomery County Community College and is now working toward her bachelor's in Social Work at West Chester University.



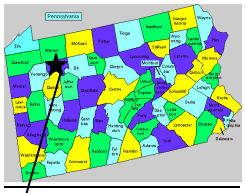
Gloria P. Banks – Originally from Newark, NJ where she did her first HIV/AIDS outreach training in 1988. She attended Newark schools and spent the greater part of her adult life being "Mom" to 3 children, all of whom are now in their adult years. She is currently working as an HIV/AIDS outreach worker with AIDS Resource Alliance in Williamsport. I am also a certified African American HIV/AIDS prevention trainer through the American Red Cross, a hospice care volunteer, and a facilitator for Grace Unlimited, which is a prison ministry through the United Methodist Church. I am caring, fun loving, happy, and enjoy listening to music, dancing, walking and entertaining friends. I like most things most days and only really hate one thing—laundry.



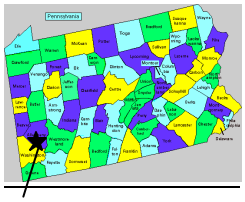
Ruth Banks Bell –maintains a home in Pittsburgh as well as working in the Reading area as a nurse.



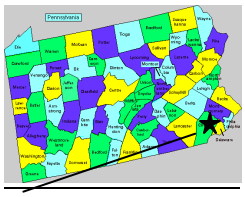
Shirley Black - has worked in the field of education since 1974 as a Health and Physical Education teacher/coach, Health and Physical Education Advisor for the Pennsylvania Department of Education and Pennsylvania HIV Project Director for CDC/DASH. Shirley has been involved with implementing HIV prevention education in schools since 1974 as a teacher and continues this effort as well as providing HIV prevention education training for Pennsylvania teachers in her current role. During her 22-1/2 years working in the public school system, she kept busy by coaching volleyball, basketball, track and field, softball, co-directing musicals, and working with the band and continues to be an avid sports fan.



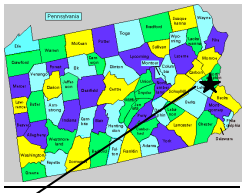
Richard Buzard – Has worked in the drug and alcohol field for 25 years and has been dealing with HIV issues since 1986. Currently, a Drug and Alcohol Services Coordinator and Trainer at Cornell Abraxas I. Enjoys raising and training German Shorthaired Pointers, upland bird hunting, and fly-fishing.



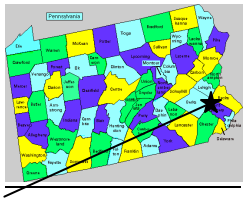
Darnell Christian - a 22 year-old Pittsburgh resident, working in retail. I have been involved in HIV prevention since 1995, since the roundtables began. I love to help people, and be a part of their lives. I believe nothing can be a barrier in accomplishing what is right.



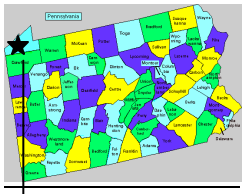
Sheila Church – has worked in the field of HIV/AIDS for the past ten years. Currently, she holds the title of Outreach Program Director at ChesPenn Health Services in Chester, Delaware County. She has experience in both street outreach and HIV/AIDS case management. She is also a Certified Addictions counselor in Pennsylvania with twenty-six years in the field. She enjoys going to the movies and watching TV especially the world news with Dan Rather and the Sunday Morning Show on CBS.



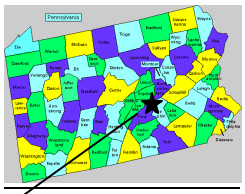
Anna M. Claudio – Experienced in social services, HIV/AIDS Case Management, and drug and alcohol counseling. Employed at New Directions Treatment Services in Allentown, PA. Is a leader in the Latino(a) Community and serves as a board member in various human services organizations. She is interested in traveling and service in faith community.



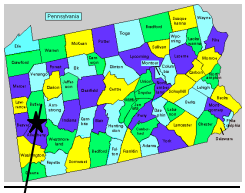
Ronnie Colcher – Is the Director of Drug, Alcohol and AIDS at Valley Forge Medical Center and Hospital, Montgomery County. Likes cooking, basket weaving and giving parties.



Sonny Concepcion – Working in the field of HIV/AIDS mainly with youth and incarcerated adults. Is originally from Puerto Rico and was an IV drug user. Lives in Erie, PA and is the father of three children. Hobbies include computer, food, and music.

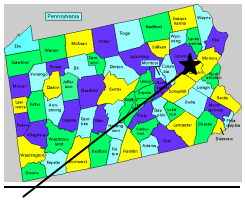


Janeen M. Davis – Employed as an HIV Education Coordinator with the Pennsylvania Department of Corrections at Elizabethtown, PA. Her duties are developing, coordinating and ensuring that HIV/AIDS education is provided appropriately and accurately to all Department employees and inmate population.

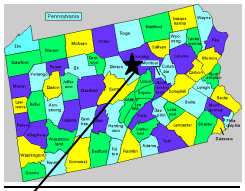


Linda Frank – Director of the Pennsylvania/MidAtlantic AIDS Education Training Center, headquarter at the University of Pittsburgh, Graduate School of Public Health. The program is one of a network of 14 training centers funded by the Ryan White CARE Act. The AETCs are the training arm of the CARE with the aim of training clinical care providers to increase the quality and access to HIV clinical treatment. She is actively involved in HIV advocacy at a national level, serving on the Board of Directors of AIDS Action Council and a member of the CAFAR

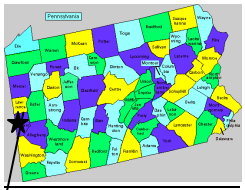
Coalition representing the National AETC Program. She is a founding member of the HIV Integrated Planning Council.



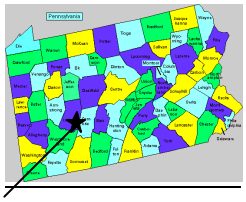
Rod Gereda – Provides corporate and personal coaching services in Transformational Leadership – Conflict Resolution Skills and Service Leadership Initiatives. Holds a Bachelor of Architecture from the University of Houston degree and practices along side his wife Kathy. His proudest achievement: three daughters – Arisa, Katarina, and Maria Lucia.



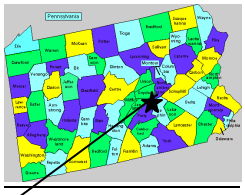
Ralph E. Godbolt – serves as Executive Director of the Campbell Street Family, Youth and Community Association Inc., located in Williamsport, PA. The association operates a local community center and provides programming geared towards minority and low-income youth and families. Originally from Pittsburgh, PA, Godbolt holds two Bachelors of Arts Degree in history and political science from Clarion University of PA. He is presently completing a book of poetry, titled "Reflections of a Black Man." In his free time, Godbolt likes to read, listen to music, and write. He is the proud father of five-year-old twins, Kenny and Khyana.



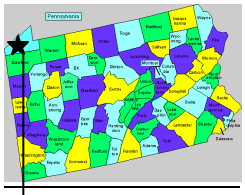
Henry P. Green – Worked for the Beaver County AIDS Service Organization for 3 years as Supervisor/Coordinator for Project Hope. Graduated from Aliquippa High School. Attended Bidwell Cultural and Training Center. Enjoys collecting ashtrays (the older the better). Also enjoys eating and tasting all sorts of food and doing presentations to area middle and high schools.



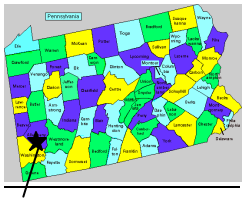
Dennie Hakanen - is an HIV+ volunteer, HIV/AIDS educator, and activist from rural Cambria County in western, south-central Pennsylvania and serves as the Rural Issues Advisory Board volunteer co-chair of the Southwestern Pennsylvania AIDS Planning Coalition. As a gay Finn person, Dennie has a genetic predisposition to being stubbornly and openly active, in both church and community, and is used, albeit reluctantly at times, as a resource and presenter by various groups in his area dealing with HIV/AIDS or sexuality issues.



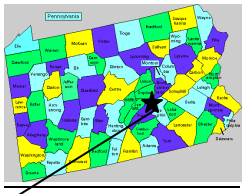
Reneé Hartford - is Prevention Project Coordinator with AIDS Community Alliance of Harrisburg. Reneé received a certificate in Substance Abuse Counseling at the University of California State Northridge in 1976. Over the years she has continued to up-date her education in the fields of drug and alcohol, human services, and HIV/AIDS. After working in the field of human services for over 20 years in Los Angeles and Harrisburg, Reneé became aware of the rapid growth of HIV/AIDS among her clients and their feelings of fear, helplessness, and hopelessness. Since returning to Harrisburg, Ms. Hartford has dedicated her career to the education, prevention, and risk reduction of HIV/AIDS in women and the African American community.



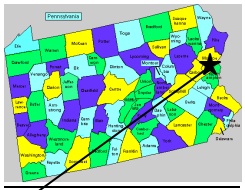
Lester Howard – is a resident of Erie, PA.



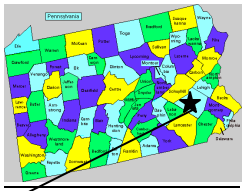
Grace Kizzie – is the founder and CEO of Grace Kizzie & Associates: Counseling and Employee Assistance Program Support Services Center. Her agency provides mental health counseling and EAP support services in the community, specializing in counseling of mood disorders and assisting clients who are HIV+, as well as, their significant others. She has served as an EAP counselor, psychiatric and medical social worker in several healthcare organizations. Grace is a native of Pittsburgh and received both here graduate and undergraduate degrees at the University of Pittsburgh. Grace is married and has two sons and nine grandchildren. She (and her family) became involved in the struggle to reduce HIV infection rates in 1991, after learning that her brother (James Dixon) had AIDS. Since that time, her surviving brothers and their closest friends founded the nonprofit organization, The Seven Project, Inc. Grace was appointed as that organizations first Executive Director in 1988. She continues to act as a valuable member of the Seven Project, Inc.



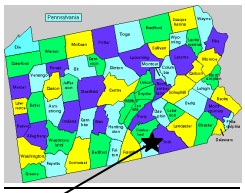
Jennifer L. Kunkel - is Research Coordinator for the South Central AIDS Planning Coalition. She has 12+ years in the substance abuse field as clinician and supervisor for multiple treatment modalities. In addition, Jen has 2+ years as an Adolescent substance abuse consultant for the inpatient adolescent psychiatric unit, criminal justice experience working with Maryland State Parole/Probation for the Drug Court Program, 3+ years as a HIV Case Management/supervisor, Targeted Case Manager, and 4+ years co-leading a research project on perinatal substance abuse for what was then York Health System. She likes horse back riding, going to Harley events, reading something interesting in bed with a warm cup of tea and chocolate chip cookies, and being around the people (personally) that I am friends with. She dislikes all other football teams other than the Steelers.



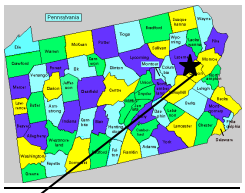
Robert Lee – is the Prevention Specialist with Carbon-Monroe-Pike Drug & Alcohol Commission, Lehighton, since September 1999. In addition, he is a substitute middle school teacher one-day per week at the Panther Valley School District. He retired in August 1999 from the Social Security Administration after 26 fun filled years. He graduated from Fordham University College at Lincoln Center, NYC with a B.A. in Sociology. He is married, has two children, and enjoys communing with nature and is a Seinfeld fan. He recently turned fifty and is enjoying and making the best of mid-life crisis.



Orlando Lozada – is a resident of Reading, PA.

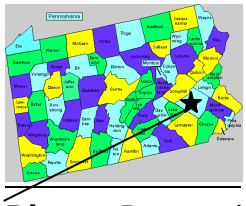


Jeannette Montgomery – Obtained her Bachelor's Degree in Human Services and has worked with migrant and seasonal farm workers for the past five years. Serves as a Board Member for Big Brothers, Big Sisters program for Adams and York Countries. Enjoys dancing and reading.

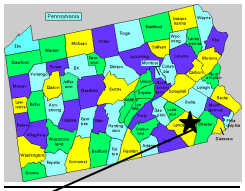


Jody Morris – hails from Philadelphia, P.A. where he attended the church of our Lord Jesus Christ Bible Institute for the ministry. Philadelphia was the right-field in which to begin his outreach ministry to the homeless, sick, and the community at large. As the ministry progressed, he furthered his education in medicine first obtaining an EMT certification, then Paramedics license at Star Technical

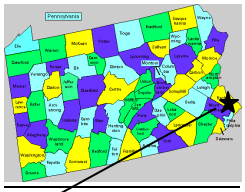
Institute. He began his career in car medicine with the Philadelphia fire and rescue Medic unit, lovingly known as Medic 7. "I won't bore you with my war stories in Philadelphia but I will tell you that my hair wasn't gray when I started, but I wouldn't change that experience for anything. It was dealing with and treating the cities terminally ill that prepared me for this position at Northeastern Network Inc. through almost daily interaction I began to understand the mind set of the HIV AIDS population. Some of my interests are flying(not the big planes to small ones), and race car driving (you need that type of experience in this area!!)."



Dianna Pagan - has worked in the HIV field since 1989, is currently the Executive Director of Reading Risk Reduction, a harm reduction agency based in Reading, PA. Dianna's area of expertise is injection drug use and how it relates to HIV infection in Pennsylvania. In addition, Dianna is an avid football fan who thinks her Dallas Cowboys will play in every Super Bowl.

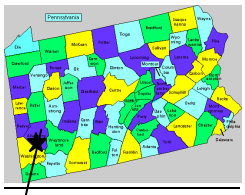


Rechinda Palmer – is a resident of Lancaster, PA.

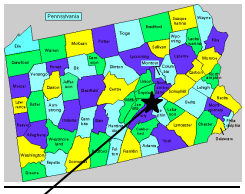


Elaine Pasqua - is an ex-dental hygienist whose passion is AIDS prevention education. After losing her mother and stepfather to AIDS she decided to speak out to teach others that AIDS is everyone's disease. Since 1995 she has worked with thousands of students. As president of Project Prevent, a not for profit organization, she presents programs to elementary through high school students, as well as parent groups. Teacher training programs are also available. Since 1997, Elaine has presented a program called "Living and Loving In a World With AIDS" at over 60 colleges and universities across the country. She loves working with students of all ages! As a faculty member of the New Jersey AIDS Education and

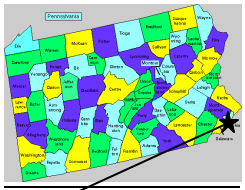
Training Center, she also presents programs to social workers, and health professionals. She loves to sing, hike, travel, garden, photography, and to play tennis. Elaine lives in Doylestown, with her husband Jeff, and her 11 and 9-year-old sons.



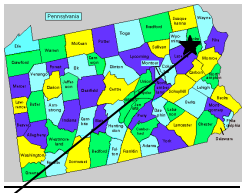
Floyd Patterson – is Community Relations Coordinator with the Pittsburgh AIDS Task Force since June 2000. "Prior to that, I was employed as the Social Services Coordinator for the Myasthenia Gravis Association of Western PA since 1992. Previously, I had volunteered for the Task Force in a variety of ways, and at different events. I served on the Southwestern PA Health and Welfare Committees, as well as serving as a board member and committee chair of the Shepherd Wellness Community, Inc. I was also an active member and participant on the AIDS Interfaith Care Teams; A founding member of the African-American focus group which originally sprung from the AIDS Interfaith Care Team, but has become officially The RAPHA Program (**R**each **A**ct **P**rovide **H**ealth **A**wareness), and is affiliated with the Rodman Street Missionary Baptist Church's HIV/AIDS Initiative. I enjoy my church, which is the Fourth Presbyterian Church located in the Bloomfield/Friendship area of Pittsburgh. I enjoy gospel singing (I like almost anything that has to do with music). And I really enjoy opportunities that allow me to get on a dance floor and "work out" to nice rhythmic sounds. My biological family is mostly in the Washington DC area, but I have been blessed to become a part of the Pittsburgh "family" of friends."



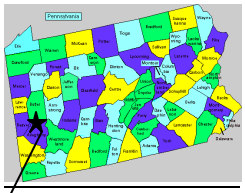
Joe Pease - Worked with the HIV/AIDS program in the Dept. of Health since 1987 currently as Director of the Division of HIV/AIDS. Graduated from the U. of Pittsburgh Graduate School of Public Health with a M.P.H. in Health Services Administration. Also received a Masters in Clinical Psychology "when I thought that was the road I was taking. I enjoy collecting wine, cooking Italian food and coaching my daughter's Soccer team."



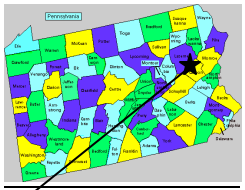
Judith Peters – is the Community Co-Chair Community Planning Group for HIV prevention in Philadelphia.



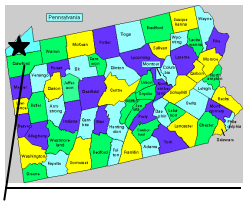
Maggi E. Rambus – Started to do HIV outreach with IDUs, homeless and at risk youth on 1-10-2000. She has been training for this position since 1985 when she was sent to New York by the Job Corps program to learn about this new virus and how it would affect their students. Worked with the Job Corps program as a counselor and was trained each year on HIV, as she was the counselor assigned to special needs students (those diagnosed HIV+). Continued to fulfill this role casually as the Alcohol and Other Drugs of abuse specialist until she left the program. Graduated from College Misericordia in 1985 with a BSW, "and now have earned my CAC. I am married with four grown children, and two grandchildren. In my spare time, what little there is, I like to read, do needlework, and play on my computer. "



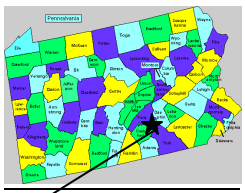
Deborah Rock – is the current Director for Mon Yough Community Services, Inc. Drug & Alcohol Support Services component. She attended Waynesburg college for Business Administration. She has successfully secured funding for 19 grants over a four-year period. She very much enjoys her daughter and dog BB. She confesses to being a workaholic.



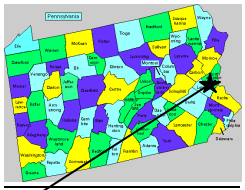
Ann Stuart Thacker - has worked in the field of HIV since 1985, notifying blood donors of their seropositive status, and working for the next ten years at Columbia University, School of Public Health in psycho-social research projects aimed toward helping people cope with HIV while looking at ways to change risk behaviors. Currently she is the program manager of the AIDSNET coalition and her focus remains reducing primary and secondary HIV infection. A bit of a control freak at heart, God has given her the task of raising her granddaughter who currently is 15, which not only gives her gray hair, but teaches her daily, depending on what the day brings, lessons in humility, frustration, wonder and homicidal ideation.



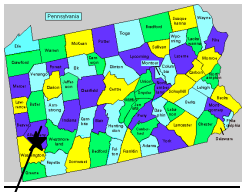
Tracey Thomas – wife and mother of three teenage children. She entered the field of substance abuse in 1981 specializing in work with "Adult Children of Alcoholics" like herself. She has continued in working with the full spectrum of treatment to include prevention, treatment, and dual diagnosis. She served as a Supervisor for an inpatient residential treatment program and currently is the Project Director of the SHOUT Outreach Program of Erie. She has extensive experience in prevention, education, outreach, and counseling in the area of HIV/AIDS, particularly as it relates to minorities and the substance abuse client.



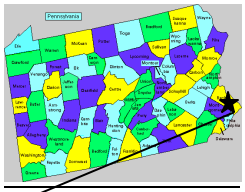
Travis Varner – is a member of the Roundtable executive committee and of the Youth Advisory team in Pittsburgh, which is a group of young people currently, working to create their own HIV prevention intervention. He is a resident of Walnut Bottom, PA.



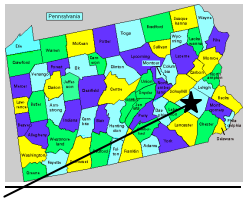
Elsa Vazquez – works as a Social Worker for HIV positive patients at Saint Luke's Hospital in Bethlehem for the past ten years. Previously, provided drug and alcohol treatment to Latino(a) clientele. She's an advocate for better human services for the Latino(a) population. A single mother of three who likes dancing, cooking, reading, and traveling.



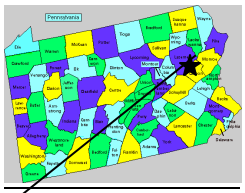
Jesse Alpha Virago – is interested in issues pertaining to gender, race, class and sexual orientation, especially as they affect health, particularly HIV. Her other interests include wellness, spirituality and living well with chronic illness. For fun she bikes, hikes, travels, tends her herb garden, feeds her friends and listens to jazz.



Cristopher Whitney - is a 5-year member of the committee and serves as Director, AIDS Education with one of the county and municipal (Bucks Co.) health departments in the state. A former high school English teacher, he has been working in HIV since the epidemic began; originally with the National Hemophilia Foundation and involved with getting Ryan White admitted to school when his Indiana community blocked his entrance. He has served on numerous Boards at the local, regional and national level. A classical pianist and church organist, Chris is often accused of being an unpaid ambassador to historic, hysteric and scenic Bucks County; his beloved home. His political affiliation is puzzlement to many, but he is a culturally sensitive W.A.S.P. - only his wit bites.



Helen Wooten – Committee member for three years, working as Assistant Director of Prevention for three years in a local HIV/AIDS organization in Reading. Has, also, worked in the drug and alcohol field with incarcerated populations. Speaks Spanish and enjoys reading,



Carol Ann Yozviak - has worked exclusively in the area of HIV/AIDS since 1988. Was a Charter Member of the Wyoming Valley AIDS Council, a community-based organization in Northeastern Pennsylvania that provides or arranges for service provision for persons in Luzerne and Wyoming Counties who are infected with or affected by HIV. "I have worked at the Pennsylvania Department of Health Northeastern District Office as the HIV Prevention Program Nurse Consultant since October 1988.Became a nurse as a second career later in life. Love my five children dearly, and my husband as well. I enjoy and collect baskets, watches, and most of all nurses, of which I have hundreds."