Pennsylvania Community HIV Prevention Plan

DEPARTMENT OF HEALTH

Edward G. Rendell, Governor
Calvin B. Johnson, M.D., M.P.H., Secretary of Health

Developed by the Pennsylvania HIV Prevention Community Planning Committee

The Center for Disease Control and Prevention funded community-planning group (CPG) for the Pennsylvania jurisdiction not including Philadelphia

In partnership with the Pennsylvania Department of Health, Bureau of Communicable Diseases, Division of HIV/AIDS
and the
Pennsylvania Prevention Project
Graduate School of Public Health
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HIV PREVENTION PLAN
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OVERVIEW

Brief Description of Pennsylvania

Between the metropolitan areas in the southeast and southwest lie rural expanses, many of which are extended over and separated by mountainous terrain. Rural regions typically experience unique problems in preventing HIV infection and serving people with HIV/AIDS because of the lack of substantial health and human service infrastructures, as well as cultural denial and resistance to facing the impending transmission of HIV in these areas. It is critical for Pennsylvania to address the distinct problems facing rural regions since the Commonwealth has one of the largest rural populations in the country.

Pennsylvania has 44,820 square miles with a land/population density of 274 persons per square mile (2000 Census—12,281,084) with a range of 11 persons per square mile in Forrest County to 11,088 in Philadelphia (1,517,506). The next highest density not including Philadelphia is Delaware County with 2,876 persons per square mile.

Pennsylvania's population demographics fluctuate greatly from region to region. Where feasible this analysis does not include residents of Philadelphia County as this Plan relates to the remainder of the other 66 counties of the Commonwealth. This is not to ignore the interplay between, in particular the four counties surrounding Philadelphia (Bucks, Chester, Delaware, and Montgomery), and the rest of southeast Pennsylvania. In fact those five counties constitute the Ryan White HIV/AIDS Regional Planning Coalition—The Philadelphia AIDS Consortium (TPAC) who has voting members on the CPG. There are 10,763,504 persons residing in Pennsylvania outside of Philadelphia of which 4,587,556 (48.5%) are male and 5,538,948 (51.5%) are female. The following demographic information is extracted from the 2000 U. S. Census. County-level racial/ethnic tables are included in *Appendix A*.

Table 1
Pennsylvania Residents not including Philadelphia

White	**9,800,936**	**91%**
Black	**568,788**	**5.3%**
Hispanic/Latino	**265,160**	**2.5%**
Asian	**152,159**	**1.4%**
American Indian	**14,275**	**0.13%**
Native Hawaiian and other Pacific Islander	**2,688**	**0.02%**

Table 2
265,160 Hispanic/Latino Pennsylvania Residents
not including Philadelphia

Puerto Rican	**137,030**	**52%**
Mexican	**48,954**	**18%**
Cuban	**7,633**	**3%**
Other	**71,539**	**37%**

Table 3
152,159 Asian Pennsylvania Residents
not including Philadelphia

Asian Indian	**44,422**	**29%**
Chinese	**32,867**	**22%**
Korean	**25,056**	**16%**
Vietnamese	**18,429**	**12%**
Filipino	**10,494**	**7%**
Japanese	**5,768**	**4%**
Other	**15,123**	**10%**
Native Hawaiian and Other Pacific Islanders 2,688 (68%) identify as Guamanian, Charmorro or Samoan, while 32% as other.		

The 508,282 persons of foreign birth are from Asia-36%, Europe-35.9%, Latin America-19.6%, and Africa-5%. English only is spoken by 91.6% of the population, Spanish only by 3.1%, and other Indo-European languages by 3.7%. German ancestry accounts for 25.4%, Irish-16.1%, Italian-11.6%, and English-7.9% of the population outside of Philadelphia.

The Commonwealth population between 0 and 19 years of age is 26.5% (3,270,584), while 53.6% (6,579,649) are between 20 and 59 years, and 19.8% (2,430,821) are 60 years or older of which 237,567 or almost 10% are over 85 years of age. Across the Commonwealth including Philadelphia 81.9% of the population 25 years of age and older are high school graduates or higher while 22.4% have a Bachelor's degree or higher. Widowed persons account for 8.2% of the population of which 81% are women.

Educational, health and social services account for 21.9% of employment, manufacturing-16%, and retail trade-12.1%. Private wage and salary workers account for 82.4% of the work force and 11.3% are government workers. Civilian veterans, 18 years of age or older, account for 13.7% (1,280,788) of the population.

In 1999 7.8% (250,296) of families were in poverty with 188,366 in families with children under 18 years of age and 88,081 with children under 5 years of age. There were 134,560 families with a female householder and no husband present. Median (50% above & below) household income for Pennsylvania is $31,044 with a median range of $21,286 in Forrest County to $47,728 in Chester County. There was a 4.9% overall increase of Pennsylvania's population from 1990 to 2000 with a range of an 11.2% decrease in Philadelphia to a 61.1% increase in Pike County.

Pennsylvania HIV Prevention Community Planning Committee Established in 1994

Changing the Faces and Messages

- When the Committee began in 1994 HIV prevention programs were generally providing information to groups on request. Since then major strides have been made. The providers, the consumers, and the community now understand the need for targeting, culturally appropriate prevention, and science-based interventions. These changes have been nurtured by the Health Department's direction that the Pennsylvania Prevention Plan be used in designing all HIV prevention projects that they fund. This is having a major impact on who is reached and the quality of the programs reaching them.

- A second major change occurred in 1997 when the HIV Prevention Community Planning Committee was invited by the state's Ryan White Coalitions to design their prevention standards to which all Ryan White funded agencies are required to adhere.

- In addition, the state and the Planning Committee have focused considerable attention to the most used HIV prevention intervention, namely, HIV antibody testing and counseling. The Committee recommended that every county in the state have sites for anonymous testing. The state has followed through on that recommendation. Further, the Committee and the state have helped design the most comprehensive evaluations of HIV testing and counseling in the country. The state has used those data to make necessary changes in publicly funded sites.

The Planning Process

- From its very first meeting, the Committee has committed itself to including members who reflect the epidemic in terms of gender, race, age, place of residence and mode of transmission. The Committee has also been sure to include among its members, HIV infected people, their family members, at-risk populations, state officials, and experts in the field.

- The Planning Committee, using outside consultants and academicians, has worked closely with the state to design inclusive needs assessments, state of the art intervention demonstration projects, gap analyses, and evaluations.

Prevention Programming

The Planning Committee thoroughly examined the Center for Disease Control and Prevention's "Compendium of Interventions with Evidence of Effectiveness" and developed ten HIV prevention interventions targeting high-risk populations. Some of these were:

- Outreach to Minority Women: This project provided street outreach and prevention interventions to economically disadvantaged women of color and their infants. This program was established in Chester and Allentown, two urban areas. Outreach workers were trained in prevention interventions and in Allentown a rigorous outcome evaluation is being carried out.

- Outreach to MSM: A project aimed at reaching young MSM and MSM of color has been organized and is currently funded in Erie. This project works in conjunction with local gay community leaders and groups.

- NiteStar: NiteStar is a program that uses young people to create and write HIV relevant scripts and perform them for targeted young adult audiences. The scripts portray the lives of young people growing up in a world with HIV/AIDS. A project in Pittsburgh targeted young people, who are sexually active, in particular, those who are MSM and racial and ethnic minorities.

- Outreach to IDUs: A number of programs were developed to reach active and recently recovered injection drug users in Erie, Allentown, and York . These programs used peer outreach workers who worked evenings and weekends to reach those at highest risk.

- Committee members have long discussed the need for effective HIV prevention interventions targeting HIV positive people. These needs were most recently described in the 2001 HIV prevention plan. Funding from the Centers for Disease Control and Prevention has allowed the state to begin the process of data collection so that interventions can be designed and carried out in 2004.

- Pennsylvania was one of seven states selected to participate in a federally sponsored Action Learning Lab to explore methods for combating perinatal transmission utilizing a variety of government and private sector partners.

Including Young Adults in HIV Planning

- The incorporation and inclusion of high-risk for HIV infection young adults in the planning process has been a major goal of the state and the Committee. At the suggestion and direction of the Department of Health, staff working with Committee members in 1996 began organizing Young Adult Roundtables in various cities in the Commonwealth. There are currently Roundtables in ten cities

involving 159 participants. They include groups of teen mothers, LGBT youth and rural youth. Committee members continue to provide support to the Roundtables, identifying local recruiters, mentoring groups and identifying the need to get youth to participate directly in the process.

- The Young Adult Roundtables is the first successful effort in the country to significantly and effectively provide for youth's participation in the HIV prevention planning process. It's nationally recognized staff and youth have assisted planning committees in other states to set up similar programs.

- The Young Adult Roundtables with the support of the Planning Committee created the Young Adult Advisory Team which includes 18 young adults, ages 16-24, to develop an HIV prevention intervention for sexually active youth. To our knowledge, this is the first intervention aimed at youth that has been developed by youth. This intervention will be piloted in 2004.

- To address HIV Prevention through Public Schools, young adults from the Roundtables encouraged the Committee to add objectives in the 2001 Plan to focus more attention and resources to educating young people in Pennsylvania's public schools. As a result, a new program was developed to work closely with Department of Education personnel to gather information, organize resources, and disseminate information through a number of methods including a web site link on stophiv.com that will be online in 2004.

Evaluation and Needs Assessment

From its beginning this Committee has valued and supported monitoring and evaluation. Evaluations were required of all programs supported by CDC and other funding sources since 1994. Receiving input and guidance from the Committee with the strong support of the Pennsylvania Health Department, the Pennsylvania Prevention Project embarked on a major evaluation of the state's entire HIV testing program. Client satisfaction surveys for users of HIV testing sites, site visits, interviews, and participant observation by actors were all used in the state and have resulted in many changes in HIV testing and counseling services.

In 1998, in conjunction with the CDC evaluation and monitoring guidance, this jurisdiction developed a five-year plan to conduct an outcome-based evaluation. New Directions, a drug and alcohol treatment facility in Allentown/Bethlehem, was selected as a provider of outreach to Latina women who were IDUs, needle-sharing or sexual partners of IDUs, or otherwise at risk for HIV infection. Results of that evaluation will be available at the end of 2003.

- Confidentiality concerns, stigma, the invisibility of many at-risk, and distrust of those at-risk are some of the major barriers in needs assessment. Focus groups surveys and interviews were used to gather the data. These methods allowed us to work with participant recruiters, facilitators, and interviewers known and trusted

by those at risk. In 1995-96 and 1999-02 the Committee designed large needs assessments. These assessments, some still being completed in 2003, involved over 160 groups and dozens of interviews of those at risk of infection, including MSM, IDU, and heterosexual partners of those people. The groups were chosen to reflect the epidemic and reflected the racial, ethnic, age, sex, sexual orientation, and place of residence of people with AIDS in the state. Groups that appeared to be on the growing edge of the epidemic were over sampled and special efforts were made to include sub-populations in special need such as the physically and mentally challenged, transgender people, sex workers, recently incarcerated and others.

- Needs Assessment and Evaluation data provided ideas from a broad cross section of people and it was this input that enriched the data. The needs assessment process made use of qualitative data, and various process evaluations identified ways to improve the process. Valuable information has been collected over the years describing priority populations. A detailed and systematic method has been developed to prioritize populations.

- The Participant Observation Study was a unique process that involved sending paid 'actors' into counseling and testing sites to monitor and assess counseling and testing services. The study was accepted for publication in the American Journal of Public Health, Volume 90, No. 7.

- To meet the needs of the Committee and the CDC, the Department has implemented statewide a Uniform Data Collection System. When fully functional, the system will collect data from all local county and municipal health departments and Health Department funded HIV intervention programs that will allow planners to identify gaps in services as well as provide the ability for HIV prevention program monitoring.

HIV Counseling and Testing

HIV prevention counseling and testing, is the most common intervention for primary and secondary prevention in Pennsylvania. Publicly funded counseling and testing is currently offered at more than 500 sites in Pennsylvania. The Department has steadily increased testing programs in community-based settings that are often more successful in reaching high-risk clients.

- One of the earliest Committee projects was the institution of a statewide, internet-based resource directory in response to data showing that some HIV testing personnel were not aware of all the services available to their clients. The committee recommended establishing a web page, www.stophiv.com, which facilitates the dissemination of accurate, prevention and education information and provides capacity building assistance to people at risk of HIV infection and agency personnel. This resource maintains an on-line statewide HIV/AIDS

service provider resource directory, treatment and prevention information, and downloadable forms from the PA Departments of Health and Public Welfare.

- Free, anonymous or confidential HIV antibody testing and counseling is now offered through a network of providers. Providers include HIV clinics, STD clinics, TB clinics, drug treatment facilities, county prisons, five county and four municipal health departments, colleges/universities, and numerous other community based agencies contracted to provide HIV prevention services for at-risk populations.

- CD4+ T-Cell and viral load testing is provided on a confidential basis for uninsured HIV-infected persons by HIV Prevention staff located in the Department of Health's district health offices and local county and municipal health departments.

- HIV counseling and testing targeted to substance abusers is provided at more than 200 drug and alcohol treatment facilities through a cooperative effort with the Bureau of Drug and Alcohol Programs.

- The Department of Health began promoting the OraSure method of specimen collection as an alternative to blood testing in 1998. This non-invasive process of specimen collection has been widely accepted and is being used increasingly by drug and alcohol providers, prisons, community based organizations and other providers involved in the Department's publicly-funded HIV Counseling and Testing Program.

- A long-term objective of this Committee has been to see that anonymous testing sites exist in each of Pennsylvania's 67 counties. As of this year anonymous counseling and testing is currently available in all counties.

- Partner counseling and referral services are offered on a voluntary basis to HIV-positive persons. Three options for notifying sex and needle-sharing partners of possible exposure to HIV are available: the infected person may choose to notify partners; Department HIV prevention staff will inform partners confidentially without identifying the infected person; or Department staff will work with the infected person to jointly inform partners.

- Since 1994, 122,166 substance abusers in treatment received one-on-one HIV prevention counseling. 84,134 substance abusers in treatment were tested for HIV antibodies; and 1,700 substance abusers in treatment were identified as HIV-positive and linked to health and social services.

- The Committee's recommendation to target HIV counseling and testing services to priority populations has prompted the Department of Health to implement Participation Provider Agreements (PPAs) with over 28 community based agencies. The PPAs establish these agencies as publicly funded sites that offer

counseling, and testing services to the public. All providers are listed in the Resources Directory, *Appendix P*.

The Committee

The Calendar Year 2003 Pennsylvania HIV Prevention Community Planning Committee, the CDC funded community planning group (CPG) is composed of 39 members. Since its inception in 1994 the CPG has appointed some voting members because of their unique job responsibilities such as the staff person responsible for HIV education in the public schools, or responsible for HIV services in the state correctional system and so forth. However, this appointment process skews the composition of the CPG in terms of gender, race/ethnicity, and geographic distribution. Members from the Pennsylvania Departments of Education and Corrections are appointed to the CPG. Two members from the Ryan White HIV/AIDS Regional Planning Coalitions are appointed. Four young adults are appointed by the Young Adult Roundtable Executive Committee. One young adult resigned in July to return to graduate school and has not yet been replaced. Appointed members represent the local county and municipal health departments and the state health district field offices. Five of the six women and three of the four men appointed are Caucasian. In addition, members of the Pennsylvania Bureaus of Drug & Alcohol Programs and Epidemiology, and Division of HIV/AIDS regularly attend and participate at CPG meetings. Staff of the Division of Tuberculosis and Sexually Transmitted Diseases is available upon request.

Since 1994, members selected by the CPG can serve two consecutive three-year terms as dictated through bylaws. It is a continual balancing act to maintain members who have the experience and history of the process as well as add new members. Eight new members have been appointed to the CPG in 2003. As of this writing five members are on extended leave of absence for three months due to financial or health challenges. By October 2003 members in a leave of absence status will be evaluated by the Co-Chairs to determine if they can continue to serve or need to resign. If they desire, they can reapply for membership. In 2003, three members have resigned as a result of job change, work commitment and movement out of state.

The following list provides the name and city of residence for the current Committee. An asterisk indicates an appointed member with the area of expertise noted. CPG member bibliographies are available in *Appendix B.*

2003 Pennsylvania HIV Prevention Community Planning Committee

Shaista Ajaz *
King of Prussia
Young Adult

Gloria P. Banks
Williamsport

Ruth Banks Bell
Bethlehem

Marilyn Bergt
Pittsburgh

Shirley Black *
Harrisburg
PA Dept. of Education

Rodney Brooks
Harrisburg

Richard Buzard
Oil City

Sheila Church
Chester

Anna M. Claudio
Bethlehem
Ronnie Colcher
Norristown

Larry Cole
Williamsport

Sonny Concepcion
Erie

Janeen Davis *
Elizabethtown
Dept. of Corrections

Maria Deffley
York

Rod Gereda
Kingston

Steve Godin
East Stroudsburg

Henry Green
Aliquippa

Dennis Hakanen
Nanty Glo

Reneé Hartford
Harrisburg

Keith Hill
Braddock

Donna Johnson *
Philadelphia
Ryan White Coalitions

Denise Knorr *
Camp Hill
Ryan White Coalitions

Robert Lee
Lehighton

Dianna Pagan
Hamburg

Floyd Patterson
Pittsburgh

<u>Community Co-Chair</u>
Angi PeaceTree
Altoona

<u>Health Co-Chair *</u>
Joe Pease
Harrisburg

Judith Peters
Philadelphia

Deborah Bray-Preston
University Park

Deborah Rock
McKeesport

Steven Simmelkjaer
Erie

Columbus Speller *
Crafton
Young Adult
Roundtable

James Taylor
Mt. Union

Tracey Thomas
Erie

Travis Varner *
Shippensburg
Young Adult
Roundtable

Elsa Vazquez
Allentown

Christopher Whitney *
Doylestown
Local County Health Department

Helen Wooten
Sinking Spring

Carol Yozviak *
Wilkes-Barre
State District Health Department

Structure

In January 2002 the CPG eliminated existing subcommittees and created four new subcommittees: (1) Evaluation, (2) Epidemiology, (3) Interventions and (4) Needs Assessment. Each subcommittee selects a Chairperson and Alternate who are responsible for facilitating meetings and maintaining minutes. Subcommittees may recruit volunteers (including former members) to provide expertise. The work of subcommittees is communicated to the Steering Committee at the end of each Committee meeting. The Steering Committee is composed of each of the Subcommittee Chairs and Alternates along with the Committee Co-Chairs. The Steering Committee meets to insure that the individual work of subcommittees is progressing and specific needs are being met. Health Department staff supports each subcommittee. In addition, the Steering Committee sets the agenda for the next CPG meeting.

Epidemiology	**Evaluation**	**Interventions**	**Needs Assessment**
Ruth Banks Bell, Chair	Steve Godin, Chair	Dennie Hakanen, Chair	Tracey Thomas, Chair
Columbus Speller, Alternate	Marilyn Bergt, Alternate	Gloria Banks Alternate	Sonny Concepcion, Alternate

Agenda Items from Committee Meetings

In order to provide an overall description of the CPG activities as they relate to planning, we present the following. A description for the agenda items from CPG meetings since the issuance of the 2003 plan. It does not describe conference calls and smaller meetings that occurred during that time. Minutes from November 2002 through September 2003 are in *Appendix C.*

September 18, 2002

a. Discussion of 2003 process for writing that plan and how the CPG would complete the 2004 five year plan occurred.
b. The CPG discussed the votes for concurrence on the 2003 plan (29 votes for concurrence, 5 for concurrence with reservations, and one vote for non-concurrence).
c. Subcommittee responsibilities related to the 2004 plan.
d. The Young Adult Roundtable Report.
e. Discussion about the role and functions of the Ad-hoc Committee for nominating new members.
f. Discussion of the duties of the Community Co-chair occurred to prepare for next month's election.
g. The Epidemiology, Evaluation, Interventions and Needs Assessment Subcommittees met to discuss the 2004 Planning Cycle.
h. The Steering Committee met to develop a timetable for writing the 2004 Plan.

November 2002

a. Election of a new Community Co-Chair.
b. Discussion of recruitment of new members and a discussion of the qualities needed in the incoming class in terms of representing the epidemic and skills for serving on the CPG effectively.
c. University staff presented data on the previous year's needs assessments that were collected from racially, ethnically, and geographically diverse groups of MSM, IDUs, and their sexual partners.
d. Distribution and collection of the process self-evaluation of the CPG.
e. Small group discussion and collection of group interview data on CPG functioning by outside interviewers.
f. Discussion of a timeline for the CPG for the upcoming meetings in order to produce the 2004 plan in a timely manner.
g. Discussion of the Reception to be held for new members in January.
h. Discussion of the timeline for writing the 2004 Plan.
i. The Subcommittees and Steering Committee met to discuss the timeline for the coming year.

January 14, 2003

Full day orientation for 7 new CPG members. One new Committee membere was unable to attend Orientation. Mentors, interested CPG members, Department of Health staff and University facilitators participated. A binder with pertinent information about HIV Prevention Community Planning in Pennsylvania was distributed to new members.

January 15, 2003

a. Discussion and revision of the planning timeline for the coming year.
b. Presentation by University staff of a web and literature search on HIV prevention in public schools around the country. Specific jurisdictions highlighted were Idaho, Maine, Massachusetts, Michigan, Montana, Tennessee, Wisconsin and Philadelphia. Common elements of their programs were described and compared to the situation in Pennsylvania, see Minutes of March in *Appendix C*
c. The Epidemiology, Needs Assessment, Intervention, and Evaluation Subcommittees met to begin identifying the materials they needed in preparing the 2004 plan.
d. The Rural Work Group presented its planned activities for 2003.
e. The CPG Steering Committee met to review and integrate the subcommittees' plans for writing their sections of the plan.

March 19, 2003

a. Self-introductions by members describing characteristics, skills, experience, and commitments relevant to the planning process.
b. Young Adult Roundtable Report: A report of meetings and activities of high-risk and diverse young adults (13 to 24 years of age) in 10 locations around the state that the Committee has assembled to do HIV prevention planning was delivered by a University staff person.
c. A Research Staff member for the Republican members of the Pennsylvania House of Representatives addressed the Committee. A discussion of HIV prevention, namely, syringe exchange, funding, rural concerns, drug and alcohol treatment funding, and prevention in public schools was discussed.
d. Prevention Summit Update: The two CPG Co-Chairs and the CPG Facilitator as well as one CPG member, who presented two posters, reported on the summit held in New York. They described the draft 'Guidance' that was presented and outlined what the CPG would need to do to meet it.
e. Subcommittees met to discuss and begin organizing their sections of the Plan as affected by the new draft 'Guidance.'

March 20, 2003

a. Needs Assessment Update: University staff presented the Needs Assessment's research plans for the carrying out needs assessments of the 'special populations' identified by the CPG. These populations are transgendered people, homeless people, Asian and Pacific Islanders, and high-risk minority and rural adolescents.
b. HIV Prevention in Pennsylvania Schools: The representative from the Department of Education presented on the state of HIV prevention education in the Pennsylvania public school system. The CPG discussed the adequacy of the programs being carried out as well as the need to collect data on the HIV education given in the schools by Department of Health staff and ASO staffs.
c. Epidemiology Update: The state epidemiologist responsible for HIV/AIDS data presented the current epidemiological profile of HIV/AIDS in Pennsylvania. He also discussed the new regulation for HIV reporting and described other data needed by the CPG for identifying 'Priority Populations.'

d. Subcommittees met to integrate new information from the Epidemiological profiles into their sections of the plans and to continue working on the plans.
e. The Steering Committee met to review the plans of the four subcommittees to assure that their work would be completed in a timely fashion for this year's planning cycle.

May 21, 2003

a. The Executive Committee (2-3 representatives of the 10 Roundtables) of the Young Adult Roundtables attended this meeting and participated in the Committee and Subcommittee meetings.
b. The CDC Project Officer presented information about the 'Guidance' and her expectations of the Pennsylvania Plan.
c. University staff presented plans for the needs assessment of HIV positive people. This assessment using focus groups, interviews, and surveys is directed by the 2003 plan and the data and analysis will be completed by the winter of 2004.
d. The Young Adult Roundtable report for 2003 describing the demographic and risk behaviors of the 142 participants on the Roundtables was distributed.
e. The Rural Work Group presented an update on their work and a discussion ensued.
f. The Bylaws Work Group presented an update of their work for discussion by the CPG *(Appendix D).*
g. Discussions about the timeliness of the current year's work towards production of the Plan and leave of absences by some CPG members occurred.
h. Subcommittees met to continue their work and to identify data or technical assistance needed.
i. The Steering Committee met to review the Subcommittees' reports.

May 22, 2003

a. The CPG discussed the previous day's presentation by the CDC Project Officer.
b. Subcommittees met for the rest of the day to write their sections of the report. The Interventions Subcommittee met in turn with the other Subcommittees to coordinate their work.
c. The Steering Committee met to review the Subcommittees' progress and to review the production and distribution of a draft of the Plan.

July 16, 2003

a. The CPG briefly reviewed the draft of the Plan and received a draft of the state's Application.
b. A presentation on Priority Populations, Community Services Assessment, (Needs Assessment, Resource Inventory and Gap Analysis).
c. Discussions of the term of the planning cycle for the 2004 plan occurred.
d. A discussion of the monitoring and evaluation tools (surveys and worksheets).

e. The Subcommittees met for the rest of the day to continue their work. This included work by the Intervention and Needs Assessment subcommittees on the Gap Analysis.

July 17, 2003

a. The Community Planning Membership Survey was distributed.
b. The Needs Assessment and the Interventions Subcommittees worked on and presented information about the 2004 Priority Populations.
c. The Subcommittees continued their work for the rest of the day.
d. The Steering Committee met to review their progress and to arrange for revising the drafts of the Plan and the Application.

August 20, 2003

a. Part II of the Community Membership Survey was distributed.
b. Interventions Subcommittee reported on its work.
c. Discussion of currently funded prevention interventions and priority prevention needs.
d. An update on the Epidemiological Profile update was delivered.
e. CPG discussed current versions of the Plan and Application
f. A vote on Concurrence was delayed until the 17 September CPG meeting.
g. The Steering Committee met to discuss the final printing of the Plan.

September 17, 2003

a. Final review of the HIV prevention Plan and CDC grant application.
b. Completion of concurrence statement.
c. Development of the 2004 planning year timeline.
d. Establish 2004 new membership nomination work group.
e. Discussion on 2003 process evaluation procedures.

INTRODUCTION

The *Guidance for HIV Prevention Community Planning* defines the Centers for Disease Control and Prevention's (CDC) expectations of health departments and HIV prevention community planning groups (CPG(s) in implementing HIV prevention community planning. The *HIV Prevention Community Planning Guidance* provides a blue-print for HIV prevention planning and provides flexible direction to CDC grantees receiving federal HIV prevention funds to design and implement a participatory HV prevention community planning process.

I. THE IMPORTANCE OF HIV PREVENTION COMMUNITY PLANNING

A. CDC HIV Prevention Strategic Plan

HIV Prevention Community Planning plays an important role in achieving the goals of the CDC's "HIV Prevention Strategic Plan Through 2005" (and subsequent strategic plans.). CDC's *Overarching National Goal for HIV* prevention in the United States is to:

- **Reduce the number of new HIV infections in the United States from an estimated 40,000 to 20,000 per year by 2005, focusing particularly on eliminating racial and ethnic disparities in new HIV infections.** To accomplish this goal, CDC expects:

1. By 2005, to decrease by at least 50% the number of persons in the Untied States at high risk for acquiring or transmitting HIV infection by delivering targeted, sustained and evidence-based HIV prevention activities.
2. By 2005, through voluntary counseling and testing, increase from the current estimated 70% to 95% the proportion of HIV-infected people in the United States who know they are infected.
3. By 2005, increase from the current estimated 50% to 80% the proportion of HIV-infected people in the United States who are linked to appropriate prevention, care, and treatment services.
4. By 2005, strengthen the capacity nationwide to monitor the epidemic, develop and implement effective HIV prevention interventions, and evaluate prevention programs.

CPGs should be familiar with the CDC Strategic Plan and should work to address the national goal within their jurisdiction's community planning process. However, the local epidemic and needs of the jurisdiction must be a priority for each CPG. Two major components from the strategic plan must be considered by CPGs: (1) targeting populations for which HIV prevention activities will have the greatest impact, and (2) reducing HIV transmission in populations with highest incidence. CPGs must consider the unique issues related to providing HIV prevention for persons living with HIV/AIDS (PLWHA).

B. Advancing HIV Prevention Initiative

CPGs should also be familiar with CDCs *Advancing HIV prevention (AHP) Initiative.* Through *Advancing HIV Prevention*, CDC is putting more emphasis on counseling, testing, and referral for the estimated 180,000 to 280,000 persons who are unaware of their HIV infection; partner notification, including partner counseling and referral services; and prevention services for persons living with HIV to help prevent further transmission once they are diagnosed with HIV. In addition, since perinatal HIV transmission can be prevented, CDC is strengthening efforts to promote routine, universal HIV screening as a part of prenatal care. All of this will be accomplished through four strategies: (1) making HIV screening a routine part of medical care; (2) creating new models for diagnosing HIV infection, including the use of rapid testing; (3) improving and expanding prevention services for PLWHA; and (4) further decreasing perinatal HIV transmission.

***Advancing HIV Prevention* will impact the HIV Prevention Community Planning priority setting process.** Because of its potential to

substantially reduce HIV incidence, HIV Prevention Community Planning Groups will be required to prioritize HIV-infected persons as the highest priority population for appropriate services. Uninfected, high-risk populations such as sex or needle sharing partners of PLWHA should be prioritized based on local epidemiology and community needs.

C. Goals of HIV Prevention Community Planning

GOAL One—Community Planning supports broad-based community participation in HIV prevention planning

GOAL Two—Community Planning identifies priority HV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

GOAL Three—Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

D. Guiding Principles for HIV Prevention Community Planning

Guiding Principles for HIV Prevention Community Planning – To ensure that the HIV prevention community planning process is carried out in a participatory manner, the CDC expects all CPGs to address the following *Guiding Principles of HIV Prevention Community Planning* as they carry out HIV prevention community planning:

1. **The health department and community-planning group must work collaboratively to develop a comprehensive HIV prevention plan for the jurisdiction.**

2. **The community planning process must reflect an open, candid, and participatory process, in which differences in cultural and ethnic background, perspective, and experience are essential and valid.**

3. **The community planning process must involve representatives of populations at greatest risk for HIV infection and PLWHA.** Persons at risk for HIV infection and PLWHA play a key role in identifying prevention needs not adequately met by existing programs and in planning for needed services that are culturally appropriate.

4. **The fundamental tenets of community planning are: parity, inclusion and representation (often referred to as PIR).** Although these tenets are not accomplished or achieved in a linear fashion, there is a strong relationship between each – with one building on another.

- ***Representation*** *is defined as the act of serving as an official member reflecting the perspective of a specific community.* A representative should truly reflect that community's values, norms, and behaviors (members should have expertise in understanding and addressing the specific HIV prevention needs of the populations they represent). Representatives must be able to participate as group members in objectively weighing the overall priority prevention needs of the jurisdiction.

- ***Inclusion*** *is defined as meaningful involvement of members in the process with an active voice in decision making.* An inclusive process assures that the views, perspectives, and needs of all affected communities are actively included.

- ***Parity*** *is defined as the ability of members to equally participate and carry out planning tasks/duties.* To achieve parity, representatives should be provided with opportunities for orientation and skills building to participate in the planning process and to have equal voice in voting and other decision-making activities.

5. An inclusive community planning process includes representatives of varying races and ethnicities, genders, sexual orientations, ages and other characteristics such as varying educational backgrounds, professions, and expertise. CPGs should have access to:

- Persons who reflect the characteristics of the current and projected epidemic in that jurisdiction (as documented by the epidemiological profile) in terms of age, gender/gender identity, race/ethnicity, sexual orientation, socioeconomic status, geographic and metropolitan statistical area (MSA)-size distribution (urban and rural residence), serostatus, and risk for HIV infection.
- State and local health department HIV prevention and sexually transmitted disease (STD) treatment staff; staff of state and local education agencies; and staff of other relevant governmental agencies (e.g., substance abuse, mental health, corrections).
- Experts in epidemiology, behavioral and social sciences, program evaluation, and health planning.
- Representatives of key non-governmental and governmental organizations providing HIV prevention and related services (e.g., STD, TB, substance abuse prevention and treatment, mental health services, homeless shelters, prisons/corrections, HIV care and social services, education agencies) to persons with or at risk for HIV infection.
- Representatives of key non-governmental organizations relevant to, but who may not necessarily provide, HIV prevention services (e.g., representatives of business, labor, and faith communities).

6. The community planning process must actively encourage and seek out community participation. **The community planning process should attempt to accommodate a reasonable number of representatives without becoming so large that it cannot effectively function. Additional avenues for obtaining input on community HIV prevention needs and priorities – especially for input relevant to marginalized populations or to scientific or agency representation that may be difficult to recruit and retain include:**

   - **Holding well publicized public meetings,**
   - **Conducting focus groups, and**
   - **Convening ad hoc panels.**

7. Nominations for membership should be solicited through an open process and candidate selection should be based on criteria established by the health department and the community-planning group.

8. An evidence based process for setting priorities among target populations should be based on the epidemiological profile and the community services assessment.

9. Priority setting for target populations must address populations for which HIV prevention will have the greatest impact. Target populations should include populations in which the most HIV infections are occurring or populations with the highest HIV incidence. Moreover, CPGs should discuss the risk behaviors and prevention needs of PLWHA (as PLWHA are included across target populations, their unique needs may not be readily evident) and determine how PLWHA will be included in the priority setting process for target populations.

10. **The set of prevention interventions/activities for prioritized target populations should have the potential to prevent the greatest number of new infections.** CPGs should conceptualize interventions/activities as a set of mix of interventions/activities versus one specific intervention/activity for each target population.

II. HIV PREVENTION COMMUNITY PLANNING PROCESS

A. The Comprehensive HIV Prevention Plan and Key Products

The primary task of the CPG is to develop a comprehensive HIV prevention plan that includes prioritized target populations and a set of prevention activities/interventions for each target population. The CPG's comprehensive HIV prevention plan should include details of these key products:

- Epidemiological Profile: **describes the impact of the HIV epidemic in the jurisdiction, provides the foundation for prioritizing target populations** *(Page 232);*

- Community Services Assessment: **describes the prevention needs of the populations at risk for HIV infection, the prevention activities/interventions implemented to address these needs and service gaps** *(Pages 239);*

- Prioritized Target Populations: **focuses on a set of target populations (identified through the epidemiological profile and community services assessment) that require prevention efforts due to high rates of HIV infection and high incidence of risky behaviors** *(Page 235);*

- Appropriate Science-based Prevention Activities/Interventions: **a set of prevention activities/interventions (based on intervention effectiveness and cultural/ethnic appropriateness) necessary to reduce transmission in prioritized target populations** *(Appendix Q);* **and**

- Letter of Concurrence/Concurrence with Reservations/Non-concurrence: **describes via a written response from the CPG whether the health department application does or does not, and to what degree, agree with the priorities set forth in the Comprehensive HIV Prevention Plan** *(page 364).*

The Comprehensive HIV Prevention Plan – The CPG is required to develop at **least one Comprehensive HIV Prevention Plan every five years.** This jurisdiction-wide plan should address all HIV prevention activities and inform decisions about how all HIV prevention funds are to be used, including federal, state, local, and when possible, private resources. If a jurisdiction implements more than one CPG, the comprehensive plan should summarize any multiple or regional plan into one document. The plan, whether designed to be one- or multi-year document, must be updated annually. As the health department's federal funding for HIV prevention is on a five-year cycle, the CPG's final plan for the 2004-2008 project period should guide the development of the next five-year funding cycle (January 2009-December 2013).

B. Planning Cycle

The community planning process should be flexible. CPGs should be routinely informed by the health department of other relevant planning efforts. The health department and CPG are jointly responsible for determining the planning process and cycle and determining progress made in accomplishing the Goals and Objectives of HIV prevention community planning.

At the 16 July 2003 Committee meeting the CPG and health department discussed the Planning Cycle and agreed upon submitting a one-year Plan for 2004 and then two subsequent Plans for years 2005 and 2006 as well as 2007 and 2008. The primary rationale for this adoption was to align the HIV Prevention Plan with the local county and municipal health departments contracting process. Hence, Plan recommendations will be incorporated into the county and municipal contracts in their next three-year contract period commencing on 1 July 2006 through 30 June 2009.

III. MONITORING AND EVALUATION OF HIV PREVENTION COMMUNITY PLANNING

The monitoring and evaluation of HIV prevention community planning is based on the three goals and eight objectives of HIV Prevention Planning. Each goal provides an overall direction for community planning. The goals are broad, however, the objectives delineate specific processes and products expected for each goal. In addition, fifty-two critical attributes have been designated to monitor implementation of each objective. For example, if the designated attributes of an objective for a given jurisdiction are present in a community planning process, then there is an indication that the objective is being met. Monitoring and evaluation of HIV Prevention Community Planning is a shared responsibility between the health department and the CPG.

Goals of HIV Prevention Community Planning

GOAL 1: Community Planning supports broad-based community participation in HIV prevention planning

Recruitment Process

Committee members volunteer at the September meeting for an ad hoc nominations committee to nominate new members to the Committee. In late September or early October the department of health, following input from the Committee, widely distributes nominating forms to the seven Ryan White HIV/AIDS Regional Planning Coalitions for distribution to their subcontractors and community representatives, the ten local county and municipal health departments, Committee members, posts at the stophiv.com web site in a downloadable fashion, and special mailings to other pertinent groups particularly

those representing target and sub-populations. The Pennsylvania Prevention Project analyzes the current composition of the Committee to determine representation within several categories. These include racial/ethnic categories in relation to both the epidemic and Epidemiological profile in Pennsylvania not including Philadelphia, gender, geographic representation, and HIV-infected persons by transmission categories in accordance with the most recent surveillance data. Committee member attendance for the current year is reviewed to determine any vacancies. Nominations are reviewed and scored by the Nominations Committee. Nomination Committee members contact potential new Committee members for a brief interview emphasizing the commitment of time necessary for the community planning process. Once the potential members have completed the interview process the Nominations Committee has a final vote. New Members are notified in writing that they have been selected and are invited to attend a one-day orientation and reception the day preceding their first meeting in January. In addition, they are assigned a Committee member who will mentor them through the community planning process.

2003 Committee

The current Calendar Year 2003 Pennsylvania HIV Prevention Community Planning Committee (Committee) is composed of 39 members. The Committee appoints some voting members based on their unique expertise in prevention planning, policy experience, or familiarity with systems. Every effort is made to ensure the appointment process does not skew the categories of gender, race/ethnicity, and geographic distribution. Members from the Pennsylvania Department of Education and the Department of Corrections are appointed to the Committee. Two members from the Ryan White HIV/AIDS Regional Planning Coalitions have been appointed. The Young Adult Roundtable Executive Committee elects four young adults. Consultants from the Pennsylvania Department of Health Bureau of Drug & Alcohol Programs, the Bureau of Epidemiology, and the Bureau of Communicable Diseases Division of HIV/AIDS regularly attend and participate at Committee meetings.

The CY 2004 Committee is expected to remain in the 40-member range. Attrition will require new members to ensure maintenance of the identified categories. Following the September 2003 meeting Co-Chairs and the Nominations Committee will review attendance and participation records of Committee members. Those no longer capable of participation will be removed. The Committee decided in 1999 that members could have excused absences. If excused members are not present for an identified amount of time for planning, their ability to commit and participate should be examined. Members not in attendance are sent all materials distributed at each meeting. Reminders are sent to communicate to Co-Chairs if CPG members are experiencing problems with participation. CPG members can serve two consecutive three-year terms as dictated through the bylaws

	Total Members	Minus appointments	
Ryan White Coalition Area/AIDS cases *	**Females—2 7% ** 55% (16)**	**Males—7 3% ** 45% (13)**	**Totals 29**
Northeast—5%		3	10% (3)
North Central—5%	2	1	10% (3)
Northwest—5%	1	3	14% (4)
Southwest—23%	2	3	17% (5)
South Central—22%	2	2	14% (4)
AIDSNET—16%	5		17% (5)
TPAC—25%	4	1	17% (5)

*Diagnosed cases of AIDS as of September 2001, TPAC not including Philadelphia
** Distribution of new cases of AIDS reported in 2001

2003 Committee

Race/Ethnicity—AIDS *	Female (16)	Male (13)	Total (29)
Caucasian—32%	44% (7)	54% (7)	48% (14)
African American—54%	31% (5)	31% (4)	31% (9)
Latino(a)/Hispanic—13%	19% (3)	15% (2)	17% (5)
American Indian	6% (1)		3% (1)

* Based upon new AIDS cases reported to CDC July 2001-June 2002

The CPG meets 7 times each year and the Steering Committee meets following each of these times. The 2004 CPG Orientation will take place on Tuesday 20 January and the full CPG will meet on Wednesday 21 January. CPG meetings for the remainder of 2004: 17 & 18 March, 19 & 20 May, 21 & 22 July, 18 August, 15 September and 17 November. The Committee meets at the Best Western Inn and Suites of Middletown/Harrisburg.

The CPG operates on a consensus basis. In 2000 a CPG member skilled in negotiation provided technical assistance to the CPG relative to developing group consensus.
Rules for Respectful Engagement (developed in 2000).

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

Conflict of Interest
The CPG created a conflict of interest statement in 1998. A disclosure statement form is completed by each CPG member and kept on file. On issues where a CPG members' affiliate is the potential recipient of funds, that member may not vote or participate in the discussion. The minutes of the meeting shall reflect that a disclosure was made as well as the abstention from voting.

Structure
In January 2002 the CPG eliminated existing subcommittees and created four new subcommittees: (1) Needs assessment, (2) Evaluation, (3) Epidemiology, and (4) Interventions. Each subcommittee selects a Chairperson and Co-Chairperson, which are responsible for facilitating meetings and maintaining minutes. Subcommittees may recruit volunteers (including former members) to provide expertise. The efforts of subcommittees are clearly communicated at the Steering Committee meetings. Co-chairpersons attend the Steering Committee meetings, but have no vote unless their Chair is absent. The Steering Committee meets at the end of the day to better insure that the individual work of subcommittees is progressing and specific needs are being met. Health Department staff supports each subcommittee.

EVALUATION SUB-COMMITTEE (July 2003)

OBJECTIVE A: Implement an open recruitment process (outreach, nominations, and selection for CPG membership.)

The Pennsylvania HIV Community Planning Committee (CPG) has had an open selection process for new members since 1994. An Ad-Hoc Membership Nominations Committee consisting of volunteers from the CPG meets yearly in the fall to discuss the open recruitment process for new members.

Attribute 1 (Nominations): Presence of written procedures for nominations to the CPG

The CPG accepts nominations for new members in the fall of each year. An Application for Membership Package is distributed broadly statewide. Included in the Membership Package is the document, **NOMINATING AND SELECTING MEMBERSHIP ON THE PENNSYLVANIA HIV PREVENTION COMMUNITY PLANNING COMMITTEE** which includes written procedures for nominations to the CPG. Also, provided in the packet is a Letter of Invitation to Apply for Membership; a chart outlining the responsibilities of the CPG, the Health Department, and the Contract Facilitator; and a two page Nomination Form *(Appendix E*).

Attribute 2 (Nominations): Evidence that written procedures (above) were used for nominations.

Minutes documenting all meetings of the Nominations Committee are distributed to those volunteering as members. A distribution list is circulated at the September Meeting to all CPG members with a request to add any individual or agency not listed. Also, all current CPG members receive Application for Membership Packets to distribute them as desired to individuals and agencies throughout the Commonwealth. Members of the Nominations Committee provide a verbal report at the full CPG meeting and this report become part of the minutes of the CPG.

Attribute 3 (Selection): Evidence that a nominations committee has been established

CPG minutes reflect names of volunteers who serve on the Nominations Committee. Also, in May 2003, three CPG members volunteered for the Nominations Committee to discuss the possibility of former CPG members with individualized expertise to provide technical assistance to the CPG during the July and August 2003 Planning meetings. The Nominations Committee met to discuss the issue on 16 June 2003.

Attribute 4 (Nominations): Evidence that nominations target membership gaps as identified by the community planning groups.

The CPG membership completes the Community Planning Membership Survey – Part 1 *(Appendix F*) to identify CPG demographics of all members. The Nominations Committee utilizes the analysis of the survey for filling vacancies on the CPG. The Nominations Committee utilizes a scoring system which prioritizes identified membership gaps to ensure those applying for membership are the priority to fill membership positions on the CPG.

The Evaluation sub-Committee has recommended to the Nominations Committee to utilize an active approach for recruiting members from the prioritized groups. The recommendations included sending applications to groups and organizations that service the priority groups as well as speaking to and personally visiting representatives of those groups to generate interest in the CPG.

Attribute 5 (Nominations): Evidence that membership decisions involve more than health department staff.

Members of the Nominations Committee are volunteers from the CPG. The request for volunteers occurs each year at the September meeting of the CPG. Any member of the CPG who volunteers for the Nominations Committee is accepted for membership. The Health Department representative on the Nominations Committee does not participate in scoring the applications. Each member of the Nominations Committee independently scores the new applications and provides this score to the facilitator in the presence of all committee members.

Attribute 6 (Selection): Written documentation of the process for selection of CPG Members.

Minutes from the Nominations Committee reflect the process of selection and scoring of all candidates. Criteria are developed from the analysis of the CPG Membership Survey-Part I and it identifies gaps in membership. This criterion is used to score applicants. When the selection process is complete, the Health Department collects and maintains all applications, to preserve confidentiality.

Attribute 7 (Selection): Evidence that the process (above) was used in selection of CPG members.

Nominations Committee members voluntarily discuss the process for selection at the full CPG meeting and minutes of the CPG reflect the discussion.

OBJECTIVE B: Ensure that the CPG's membership is representative of the diversity of populations most at risk for HIV infection.

The Evaluation Sub-Committee will review the epidemiology report data and assure a process is followed to outreach to the appropriate representation in accordance with the community characteristics documented in the epidemiological profile for new membership applications**.**

Attribute 8 (Representation): CPG includes: (a) members who represent populations most at risk for HIV infection as reflected in the current and projected epidemic, as documented in the prior year's epidemiological profile, and (b) persons living with HIV/AIDS**.**

The Evaluation Sub-Committee will review the results of the Community Planning Membership Surveys, Part I and the Survey Reports to assure a process to evaluate

appropriate levels of representation in accordance with the community characteristics documented in the epidemiological profile.

Attribute 9 (Representation): CPG membership includes members who represent the afflicted community in terms of race/ethnicity, gender/gender identity, sexual orientation, and geographic distribution.

The Evaluation Sub-Committee will review results of the Community Planning Membership Surveys-Part I and the Survey Report to assure a process for evaluation of representation in terms of race/ethnicity, gender/gender identity, sexual orientation, and geographic distribution and make recommendations to the Nominations Sub-Committee as necessary for membership recruitment and scoring attributes of the applicants.

Attribute 10 (Representation): CPG membership includes, or has access to, professional expertise in behavioral/social science, epidemiology, evaluation, and service provision.

The Evaluation Sub-Committee will review professional/occupational criteria of members and maintain lists of individuals with varied professional expertise to assure a process for recruitment of new members to the CPG.

The Evaluation Sub-Committee has compiled a list of evaluators, available statewide; who are willing to assist the CPG upon request. This list is documented in *Appendix G.*

Attribute 11 (Representation): CPG membership includes, or has access to, key government agencies, including: health department HIV/AIDS program and the state/local health departments STD program staff.

The Health Department, Division of HIV/AIDS program staff is present at all CPG meetings and has a representative participant at all sub-committees meetings.

The Evaluation Subcommittee notes the state/local health departments STD program staff are not currently represented at CPG meetings and will request an STD consultant from either the state STD program office or local health department STD program to attend all CPG meetings.

Attribute 12 (Representation): CPG membership includes, or has access to, key governmental and non-governmental agencies with expertise in factors and issues relative to HIV prevention.

The Bureau of Drug and Alcohol Programs, Department of Education, House Republican Research Staff, Department of Corrections, local county and municipal health departments and HIV Regional Planning Coalitions has representatives present at CPG meetings. The CPG also includes a voting representative of the Philadelphia CPG. Members of the CPG also include representatives of non-governmental agencies with expertise in HIV prevention.

OBJECTIVE C: Foster a community planning process that encourages inclusion and parity among community planning members.

Attribute 13 (Inclusion): Evidence of that to gain input from representatives of marginalized groups, who would be hard to recruit and/or retain as CPG members, the CPG convened ad hoc committees, panels, and/or focus groups.

CPG minutes reflect discussions related to recruitment and retention of members representing marginalized groups. In the past, discussions occurred related to recruiting Transgender members and input from the CPG membership resulted in recruitment of two members representing the Transgender community. Attendance, however, was not consistent. The CPG is currently struggling with attendance issues and retention issues.

CPG members had a lengthy discussion related to member attendance at the July 2003 meeting. Mentors call members who are absent from meetings and share information. Co-Chairs mail all documents distributed at meetings to keep absent members' current on CPG business. The CPG will revisit attendance issues at the September meeting and consider an ad hoc committee to explore issues related to attendance, recruitment and retention.

Attribute 14 (Inclusion): Evidence that efforts were undertaken to accommodate or facilitate members who face challenging barriers (e.g., health care or economic needs) to their continued participation in the CPG.

In 1999 the Membership Sub-Committee met and proposed a system of excused absences for members. Those members who call one of the Co-Chairs or the Facilitator to request an excused absence are granted an excused absence.

The Health Department, through CDC grant funds, provides hotel vouchers for members and transportation vouchers for those needing airline tickets. Members are reimbursed for personal automobile mileage to and from all meetings per State guidelines, currently 36 cents per mile. A continental breakfast and lunch is provided at all meetings and members are reimbursed for all other meals while in overnight status.

During Orientation, all members receive information on securing hotel and travel vouchers and explanation and examples for completion of all reimbursement forms. The Health Department has a representative at every CPG meeting to assist members with paperwork related to reimbursement for personal automobile mileage and subsistence allowance.

Attribute 15 (Inclusion): Evidence of a clear decision-making process including conflict of interest rules.

The CPG loosely follows Roberts Rules of Order for all large group meetings. Each sub-committee has a Chairperson and co-Chairperson who represent the sub-committee at CPG Steering Committee meetings.

The CPG is regulated by written by-laws to include conflict of interest rules. At the March meeting an ad-hoc sub-committee was formed to review and revise the current by-laws. This process is continuing at the present time. Current and draft revised by-laws can be found in *Appendix D.*

Attribute 16 (Inclusion): Evidence of orientation, mentoring or training process for new CPG members.

All new members of the CPG are provided a full day Orientation on the first meeting day in January of each year. Following is the 2003 Orientation agenda:

Pennsylvania Department of Health
Pennsylvania HIV Prevention
Community Planning Committee
Best Western Inn & Suites
815 Eisenhower Boulevard
Harrisburg, Pennsylvania
717-939-1600

New committee Member Orientation
Tuesday 14 January 2003

8:30 AM	Continental Breakfast	
9:00 – 9:45 AM	Welcome and Introductions	Angi PeaceTree Joe Pease
	Opening Exercise	

9:45 –10:15 AM	Expectations	Angi PeaceTree
10:15 –10:30 AM	Break	
10:30 – 11:00 AM	Video: "HIV Prevention and Community Planning: Partners In Prevention Community Planning Overview	
11:00—11:15 AM	Why I'm a Committee Member	Ann Stuart Thacker
11:15—11:40 PM	Invoicing and Paper Work	Darlene Moore
11:40 –12:00 AM	PA Initiatives and Budgetary Overview	Joe Pease
12:00 – 1:00 PM	Lunch	
1:00 – 2:20 PM	Subcommittees	
	Epidemiology	Chris Whitney
	Evaluation	Steve Godin
	Interventions	Maggi Rambus
	Needs Assessment	Tracey Thomas
2:20 – 2:50 PM	Framework for HIV Prevention	Anthony Silvestre
2:50—3:00 PM	Evaluations	

Each new member is assigned a mentor who sits with the new member and guides the member through the Community Planning process during the first year or longer if necessary.

Mentor Roles

(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.

Each new member receives a personal Orientation manual.

Three Ring Binder Table of contents consists of: 1.Overall Programmatic Goals 2.Principles of HIV Prevention Planning 3 Inclusion-Representation-Parity 4.HIV Prevention Community Planning Charter 5.Committee Bibliographies 6.Mentor Roles 7.Subsistence and Support for Meeting Attendance 8. Meeting location and dates 9. Robert's Rules 10. General Rules of Governance 11. Ground Rules 12. Concurrence/non-concurrence 13. Meeting Rules of Respectful Engagement and Expectations 14.Committee Member Mailing List 15.Division of HIV/AIDS Contact List 16. Pennsylvania Prevention Project Contact List 17.Glossary of Terms	18.Definitions of Primary and Secondary HIV Prevention 19. Capacity Building Activities 20.Ryan White HIV/AIDS Planning Coalitions 21. Epidemiology and Behavioral Science 22.CDC Compendium of HIV Prevention Interventions That Work 23. Uniform Data Collection 24.Five-Year Strategic Evaluation Plan 25.Young Adult Roundtable Categories and Locations 26.YART Newsletter 27.Young Adult Roundtable Consensus Statement 28.Stophiv.com Web Site 29. Epidemiology 30.Needs assessment 31.Evaluation 32. Interventions Subcommittees 33.Agendas 34.Minutes 35.Community Planning Update Newsletter.

Attribute 17 (Inclusion): Evidence that CPG meetings are open to the public and allow time for public comment.

All meetings are advertised to the public in the Pennsylvania Bulletin in accordance with the Pennsylvania Sunshine Law for open meetings. Introductions occur at each meeting and as individuals enter the meeting area. The Community Co-Chair asks for comments and announcements from community attendees and provides the opportunity for comment. All comments are documented in the CPG minutes.

Attribute 18 (Parity): Evidence of ongoing training process for all CPG members.

The CPG has requested training from the Academy of Educational Development and training has been provided on Conflict Resolution and Priority Interventions. See *Appendix H.*

Young Adult Roundtables

During the summer of 1998 the Young Adult Roundtables conducted a statewide Summit to create a Consensus Statement document reflecting the HIV prevention needs and barriers for HIV prevention for youth and young adults. In December 2002 the Young Adult Roundtables began updating and reformatting the Consensus Statement to mimic the new format of the PA HIV Prevention Plan, comprised of four content areas: Epidemiology, Evaluation, Interventions and Needs Assessment. The purpose of this revision is to allow the CPG to clearly see the prevention needs of young people in Pennsylvania and integrate them into the state's HIV Prevention Plan. The full Consensus Statement is in *Appendix O*. In addition; the four content areas of the Statement are integrated within the 2004 Plan.

Young Adult Roundtable Consensus Statement: Evaluation

What should providers and others consider when evaluating and monitoring HIV prevention interventions for *young people* across the state to determine effectiveness in reducing HIV transmission? How should and from whom should this information be collected?

Meaningful evaluation information can and should be obtained from HIV prevention programs and participants to ensure that programs are effectively helping young people to reduce their risk of HIV infection/re-infection. First, program participants and program components should be **monitored** to ensure that significant numbers of young people from target populations are being reached and that implementation objectives are being met. Second, through **process evaluations**, young program participants should provide feedback about programs in order to determine participants' satisfaction with program staff and program implementation. Third, through **outcome evaluations**, program goals should be evaluated to ensure they are reached or to determine the challenges in reaching them. Fourth, **impact evaluations** can help to identify the long-term effects of programs on demographic and geographic communities. And finally, **cost-effectiveness** analyses can help to determine future funding issues for programs that are or are not effectively reducing HIV incidence/prevalence among high-risk target populations in Pennsylvania.

HIV prevention efforts must be comprehensive in scope and occur on various levels (Coates, 1997). Program monitoring and evaluation must, therefore, also occur at various levels: on **individual level interventions** (counseling and testing programs), on **group level interventions** (public school education programs), and on **community level interventions** (PSAs, billboards, media campaigns and web sites).

INDIVIDUAL LEVEL INTERVENTIONS (ILI):

HIV Counseling & Testing:

> **Goal #1:** Ensure that each county in Pennsylvania has free, anonymous, and accessible counseling and testing sites for young people.

Process Monitoring

Objective #1: Determine the number of free and anonymous HIV counseling and testing sites available in each county.

Objective #2: Determine the number of counseling and testing sites in each county that are open during evenings and on weekends.

Objective #3: Determine the number and demographics of young people tested at each counseling and testing site in each county.

Objective #4: Determine the number and demographics of young people returning for results at each counseling and testing site in each county.

Objective #5: Determine the number of counseling and testing sites in each county that offer OraQuick, OraSure, and other alternative tests to blood draws.

Objective #6: Determine the number of positive HIV test results among young people for each counseling and testing site in each county.

Process Evaluation

Objective #1: Obtain feedback from young people at each counseling and testing site in each county to determine the manner in which they became aware of the specific test site.

Objective #2: Determine whether or not counseling and testing sites in each county are doing outreach to high risk targeted population in the community.

Objective #3: Obtain feedback from each young person receiving services in each counseling and testing site in each county to determine "participant satisfaction" with: site accessibility (hours, location, etc.), staff sensitivity and cultural competence, time management and efficient staffing, and resource materials.

Objective #4: Determine whether or not counseling and testing sites in each county are publicizing services to high risk targeted populations of young people.

Objective #5: Determine whether or not counseling and testing sites are consistent with state standards, especially with regard to confidentiality and pre and post test counseling.

Objective #6: Determine whether or not counseling and testing sites are consistently offering OraSure, OraQuick, and other alternatives to blood drawn testing.

Objective #7: Determine whether or not counseling and testing sites are consistently open during evening and weekend hours.

Outcome Evaluation

Objective #1: Determine whether or not there are established free and anonymous counseling and testing sites in each county.

Objective #2: Assess the percentage of clients returning for HIV test results.

Objective #3: Determine the percentage of the at-risk populations receiving counseling and testing services.

Objective #4: Assess the effectiveness of pre and post test counseling.

Impact Evaluation

Objective #1: Determine the effectiveness of community level marketing by each counseling and testing sites in each county by interviewing clients to determine the method by which they became aware of the specific site.

Objective #2: Determine the percentage of the community that has been tested for HIV.

Objective #3: Determine the attitudes of community towards counseling and testing.

Goal #2: Determine the extent to which current State DOH certification training for HIV counselors meets the self-identified HIV prevention needs of young people in PA who are sexually-active and/or use drugs, those at greatest risk for HIV infection/re-infection.

Goal #3: Ensure that counseling and testing services are meeting the needs of young people who are sexually active and/or use drugs.

Process Monitoring

Objective #1: Determine the number of young (age 13-24), peer counselors working at each site.

Process Evaluation

Objective #1: Obtain feedback from young people at each counseling and testing site in each county to determine their comfort level during sessions and perceived level of acceptance by counselor.

Objective #2: Determine whether or not counseling and testing sites are consistent with state standards, especially with regard to confidentiality and pre and post test counseling.

Objective #3: Ensure that staff members are trained and qualified to counsel young people who are sexually active and/or use drugs.

Outcome Evaluation

Objective #1: Assess the percentage of young clients who are sexually active and/or use drugs, and who return for HIV test results.

Objective #2: Assess the effectiveness of pre and post test counseling, as determined by a reduction in clients' risk behaviors.

Impact Evaluation

Objective #1: Determine the attitudes of young people in a community towards counseling and testing.

Objective #2: Determine young people's changes in perceived stigma around being sexually active.

Objective #3: Determine young people's changes in perceived stigma around drug use.

Objective #4: Determine difference in number of young people who are sexually active and/or using drugs, who are tested in a given community.

Goal #4: Increase funding to counseling and testing sites that have documented effectiveness in targeting and testing *young people* who are sexually active and/or use drugs.

GROUP LEVEL INTERVENTIONS (GLI):

School-Based (Classroom) HIV Education:

Goal #1: Determine the extent to which current State DOE regulations (Chapter 4) meet the self-identified HIV prevention needs of young people in PA who are

sexually-active and/or use drugs, those at greatest risk for HIV infection/re-infection.

Goal #2: Monitor and evaluate all HIV education programs in each school district in Pennsylvania.

Process Monitoring

Objective #1: Determine if each young person in each school in each district is receiving (group-level) HIV prevention education.

Process Evaluation

Objective #1: Ensure that targeted populations are being reached through HIV education programs in all schools.

Objective #2: Ensure that HIV prevention resources (pamphlets, videos, etc.) are reaching those *young people* for whom they are targeted.

Objective #3: Assess whether HIV education information is consistent, current, and accurate.

Objective #4: Assess whether HIV/STI education information includes secondary prevention and unintended pregnancy prevention.

Objective #5: Assess whether participants are provided free condoms/safer sex and bleach kits.

Objective #6: HIV curricula in each school should be evaluated to determine its consistency with state standards.

Objective #7: Ensure that the content of HIV prevention resources (pamphlets, videos, etc.) is effective in reducing the risk of HIV transmission among *young people*.

Objective #8: Have targeted groups of young people evaluate the cultural, developmental and age appropriateness of respectively targeted HIV prevention resources (pamphlets, videos, etc.).

Outcome Evaluation

Objective #1: All students (including home-schooled) should be required to take a standardized pre/post test, measuring participants' acquisition of knowledge about HIV/AIDS, modes of transmission, and risk behaviors.

Objective #2: Assess whether HIV education curricula reduce risk behaviors among young people.

Objective #3: Assess whether HIV education curricula change students' attitudes toward HIV and those living with HIV/AIDS.

Objective #4: Assess whether HIV education curricula change students' perceptions of risk for infection/reinfection.

Objective #5: Evaluate the extent to which resource materials (pamphlets, videos, etc.) assist young people to reduce their risk of HIV infection/re-infection.

Community-Based/Other HIV Prevention Programs:

Goal #1: All publicly funded, community-based HIV prevention programs in PA that target young people must monitor and evaluate programmatic goals.

Process Monitoring

Objective #1: Measure by target population (demographics and risk behaviors) the number and percentage of young people reached quarterly by the program.

Process Evaluation

Objective #1: Ensure that populations reached are consistent with the targeted population goals of program.

Objective #2: Ensure that populations reached are consistent with target populations identified in most current Comprehensive HIV Prevention Plan.

Objective #3: Ensure that HIV prevention resources (pamphlets, videos, etc.) are reaching those *young people* for whom they are targeted.

Objective #4: HIV education information should be evaluated to determine its consistency with Intervention guidelines outlined in this document (see Interventions section, pages 42-149, *Appendix O*).

Objective #5: Ensure that the content of HIV prevention resources (pamphlets, videos, etc.) is effective in reducing the risk of HIV transmission among *young people*.

Objective #6: Have targeted groups of young people evaluate the cultural, developmental and age appropriateness of respectively targeted HIV prevention resources (pamphlets, videos, etc.).

Objective #7: Providers should obtain process evaluation data (comfort level, programmatic recommendations, etc.) from each participant and (young) peer educator. Anonymous surveys and comment boxes at intervention locations are two feedback collection methods.

Objective #8: Targeted community members should be surveyed periodically to determine their awareness of specific programs in the community.

Outcome Evaluation

Objective #1: Program participants should take pre/post tests, measuring participants' acquisition of knowledge about HIV/AIDS, modes of transmission, and risk behaviors.

Objective #2: Assess whether program content/curricula reduce risk behaviors among participants.

Objective #3: Assess whether program content/curricula change participants' attitudes toward HIV and those living with HIV/AIDS.

Objective #4: Assess whether program content/curricula change participants' perceptions of risk for infection/re-infection.

Objective #5: Evaluate the extent to which program resource materials (pamphlets, videos, etc.) assist participants to reduce their risk of HIV infection/re-infection.

Goal #2: Determine the extent to which the goals of HIV prevention programs meet the HIV prevention needs of young people who are sexually-active and/or use drugs, as identified in this document (see Needs Assessment section, *Appendix N*).

Goal #3: Increase funding to those interventions that have documented effectiveness in assisting *young people* to reduce their risk of HIV infection, re-infection and co-infection.

COMMUNITY LEVEL INTERVENTIONS (CLI):

Goal #1: To ensure that community level interventions are targeting young people who are sexually active and those who use drugs and are, therefore, at-risk for HIV infection.

Process Monitoring

Objective #1: Determine the number of media-based HIV prevention messages/programs that target young people in PA.

Goal #2: Community Planning identifies priority HV prevention needs (a set of priority target populations and intervention for each identified target population) in each jurisdiction.

HIV/AIDS EPIDEMIOLOGICAL PROFILE

Purpose:

The HIV/AIDS Epidemiological Profile describes the impact of the HIV epidemic in the jurisdiction and provides the foundation for prioritizing target populations.

The Current HIV/AIDS Epidemiological Profile

Attached in *Appendix I* is the1999 Epidemiological Profile and the 2000-1 Updates made during the last planning cycle. This profile serves as the **interim** basis for this 1-year prevention plan for the Calendar Year 2004 (1-year of 5-year cycle: CY2004-CY2008). The profile was presented to the Committee before the prioritization process and a summary has been presented at the beginning of each planning year and orientation of new members.

Development of a New Integrated HIV/AIDS Epidemiological Profile

(Appendix J)

A new Integrated Profile for Prevention and Care is under development that will replace the current profile attached and referenced above.

Phase I and II of the redeveloped Epidemiological Profile are expected to be complete and ready for incorporation into the planning process in the 2004 planning year during the development of the next 2-year plan expected for CY2005-CY2006. Pennsylvania recently began HIV reporting in October 2002. This new Integrated HIV/AIDS Epidemiological Profile under development will not be based on HIV reporting data until 2005/6 as the data will not be ready for use to make meaningful inference until then. As a bridging solution, this new profile will use a much wider range of data sources in addition to AIDS data in order to enable better inference on the progression of the HIV/AIDS Epidemic. The strengths and limitations of each data source used in the epidemiological profile will also be described. The new Integrated HIV/AIDS Epidemiological (epi) profile will provide better information about defined populations at high risk for HIV infection. The CPG will then consider in an update of the prioritization process that will refocus attention to persons who are living with HIV and at risk of transmitting HIV infection to others. Data gaps will be explicitly identified in the Epidemiological profile and plans for acquiring these data will be made. As is currently the case with the current profile, the epidemiological profile will contain a narrative

interpretation of data presented. A guideline for the process through which committee members may contribute suggestions of additional data sources and the epidemiological profile will be presented to the CPG members prior to the update of the prioritization of target populations to focus on persons living with HIV.

Appendix K contains an outline and Phase I of the New Integrated HIV/AIDS Epidemiological Profile;
Appendix L contains the timeline for: a) the development of the New Integrated HIV/AIDS Profile and b) for recruitment of a dedicated "Epidemiologist for HIV Public Health Programs" who will also be responsible of Phase II and II of the new profile.

Young Adult Roundtable Consensus Statement: <u>Epidemiology</u>

Epidemiology- This section of the Consensus Statement describes which statistics should be looked at when developing a view of HIV/AIDS infection among young people in Pennsylvania. Most of the information needed for accurate targeting of young people is not currently being collected in Pennsylvania. The Roundtables recognize this as a particularly severe problem and asks the question "How can programs and interventions be effectively targeted if no epidemiological data is available to support the targeting of these programs?"

Effective HIV prevention programs for young people in PA cannot be developed and targeted without accurate and sufficient epidemiological data. Although we know that half of all new HIV infections in the U.S. are among individuals under the age of 25, and half of these are among individuals under the age of 22 (CDC)(1), we do not know HIV incidence and prevalence data for young people in PA.

What information (data) should be used to help paint the most accurate picture that reflects the HIV epidemic among *young people* (13-24 years of age) in Pennsylvania? How much of this information is already available? How much is not known? Why is this information not known? How should all of this information (data) be gathered from *young people*?

Problem #1: HIV incidence and prevalence among *young people* in PA is unknown.

> **Goal #1:** Gather quarterly statistics to determine the **demographics** of *young people* who are being infected/re-infected by HIV and the **modes of transmission** by which infection occurred.
>
> > **Objective #1:** The age groups identified by this data should be subdivided as follows: 13-15, 16-17, 18-20, and 21-24 year olds. This breakdown reflects social factors, such as driving and legal drinking age, that influence behavior. Roundtable members agree that the age of 18 is important to recognize because many *young people* move away from home and gain more independence.

Objective #2: HIV data should be used to establish target populations (and interventions) in PA. Surrogate data suggests that young African Americans, young Latinos/Latinas, young men who have sex with men, and young women are at a particularly high risk of HIV infection. HIV infection data should be used to support or disprove the current findings that suggest that these groups are at high risk. HIV reporting (for *young people*) has only recently been implemented; therefore it is too early to draw any conclusions from this newly accumulated data. When sufficient data becomes available, it should be used to reevaluate target populations of *young people*.

Objective #3: It is imperative to determine the number of *young people* who are accessing HIV testing services, and in addition those who return for test results. Prevention programs can use this information to target and plan for *young people* who are not getting tested or who are not returning for test results. Data currently being collected at testing sites is not specific to *young people*.

Objective #4: Needle exchange programs should be used to gather demographic data about young users in PA.

Objective #5: sharing injection drug paraphernalia transmits HIV, and therefore, sharing infected blood. Injection drugs include but are not limited to heroin and steroids. Therefore, the drug-related behaviors through which *young people* contract HIV need to be identified.

Objective #6: Statistics regarding income, household size, geographic location, and religion should be collected. Again, this information would allow for proper targeting.

Goal #2: Gather statistics to determine the **demographics** of *young people* who are living with AIDS.

Objective #1: Determine the number of young people who are living with AIDS, in relation to the total number of people living with AIDS in PA.

Objective #2: Statistics regarding income, household size, geographic location, and religion should be collected. Again, this information would allow for proper targeting.

Goal #3: Data needs to be collected to identify the specific HIV risk (sexual and drug using) behaviors of *young people* in PA.

Objective #1: PA should reinstate and expand the YRBS to survey HIV risk (sexual and drug using) behaviors. Previously the state of Pennsylvania participated in the nationwide, CDC sponsored Youth Risk

Behavior Survey (YRBS). This survey collected information from high school students on a variety of risk behaviors including drug use and sexual practices. This data would allow for effective preventative measures.

Objective #2: Until sufficient HIV infection data among young people is available, surrogate data should be used to identify target populations. Useful statistics in determining the unprotected sexual behaviors of *young people* would be rates of STIs, pregnancies, abortions, and emergency contraceptive use. Statistics that have yet to be collected include frequency of protected and unprotected anal, oral, and vaginal sex; the age of first sexual encounter; and the number of partners per year. Trends among behaviors of *young people* should be extracted from this information, aiding in the formation of interventions.

Objective #3: Risk behavior data should be specific to demographics: race, gender, geographic location, and sexual orientation.

Prioritized Target Populations

This section focuses on the process of identifying and ranking a set of target populations that require prevention efforts due to high infection rates and high incidence of risky behavior.

The CPG established the following model to rank-prioritization of target populations/transmission groups, at the statewide level, in order to ensure that priority setting is fair. In pursuit of this goal, the CPG and the state HIV/AIDS Epidemiologist developed an empirically determined objective process as opposed to a method that relies on subjective perceptions of CPG members to set priorities. This model continues to undergo peer review and refinement.

The CPG acknowledges the CDC requirement to prioritize HIV-infected persons as the highest priority population, but recognizes that because the requirement was introduced late in the 2003 planning process, it was unable to complete a new process of prioritizing target populations. The CPG addressed this requirement by determining that for the current Plan, HIV-infected persons are also designated in each of the priority target populations. The Epidemiology Subcommittee has made a commitment to rank both HIV-infected high-risk populations (HIV-infected White MSM) and uninfected high-risk populations (Uninfected White MSM) as separate populations when conducting the process of prioritization of target populations in 2004. Potentially, there may be 26 priority populations.

Summary of the Methods for Application of the Prioritization of Target Populations Model (the complete process [from previous Plan] is included as (*Appendix M*) Transmission categories and factors by which the transmission categories would be ranked were established based on the main modes of transmission and races/ethnicity's

identified by the Epidemiological Profile.

Factors for prioritizing the target populations were determined. These factors included: predominant mode/risk behavior; estimated live HIV cases in transmission category as proportion of total living with HIV in Pennsylvania; estimated unadjusted relative risk or likelihood of death as an indicator of relative survival time for transmission category which is in turn an indicator of relative likelihood of increase/decrease in prevalent pool of infected persons (assuming no decline in other contributing factors); barriers to prevention; resources currently distributed to each target population; etc.

Data needed for each factor and target population were gathered if they existed, new data collection analyses were performed and made available, and data not readily available that needed to be collected were identified and plans are continuously under review to collect the needed data.

- The target population factors were assigned weights from 0-10, giving the most important or reliable greater weight, and the least important or reliable lesser weight.
- Categories within each factor were ranked and each factor assigned a relative weight compared to other factors in the model.
- The available data were inputted into the model and 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.
- The product for each factor by transmission category was then entered into the respective cell in the transmission category column.
- The totals for each transmission category column were calculated; based on the sum of the scores of the transmission category column, the percentage for each transmission category were calculated and entered.
- 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;
- The population-transmission group cross-tabulation yielded population-transmission groups that were ranked according to the percentage share of the total score for all population-transmission groups.

SUMMARY RESULTS OF PRIORITIZATION MODEL FOR HIV/AIDS
RANKED POPULATION/TRANSMISSION GROUPS: 2003 BY SEX/AGE/GROUP

Rank	Relative % (Overall Score)	Population/ Transmission Group	Population/ Transmission Group	Sex M=Male/F=Female Distribution	Age Group/ Miscellaneous
1	18.6% (165)	HIV+ White MSM	White - MSM	M	*20-39; 13-19, 40-49;
2	15.8% (140)	HIV+ Black - IDU	Black - IDU	M & F, Mostly Male	*20-39; 13-19
3	10.1% (90)	HIV+ Black - MSM/IDU	Black - MSM/IDU	M	*20-39
4	9.0% (80)	HIV+ White - MSM/IDU	White - MSM/IDU	M	*20-39
5	8.3% (74)	HIV+ Black - Hetero	Black - Hetero	F & M, Mostly Female sex partners of IDU	-history of STD, 13-19; -partners of IDU, 13-39;
6 (tie)	8.2% (73)	HIV+ White - IDU	White - IDU	M & F, Mostly Male	*20-39
6 (tie)	8.2% (73)	HIV+ White - Hetero	White - Hetero	F & M, Mostly Female sex partners of IDU	-history of STD, 13-19; -partners of IDU, 13-39; -(?white F<13?)
8	7.6% (67)	HIV+ Hispanic - IDU	Hispanic - IDU	M & F, Mostly Male	++13-19; *20-39
9	5.8% (52)	HIV+ Black - MSM	Black - MSM	M	13-(*20-29) -39
10	4.4% (39)	HIV+ Hispanic - Hetero	Hispanic - Hetero	F & M, Mostly Female sex partners of IDU	-history of STD, 13-19; -partners of IDU, 13-39;
11	3.0% (27)	HIV+ Hispanic – MSM/IDU	Hispanic – MSM/IDU	M	*20-29

12	1.0% (9)	Hispanic MSM	Hispanic MSM	M	*20-29
TOTAL ADULTS	100% - ?5%?				
13	1 %	Perinatal Transmission	Perinatal Transmission	Blacks & Hispanics Comparable, Whites 2%; See Table 1.	Hetero Females who are IDU and/or partners of IDU
	?4 %?	HIV+ Emerging Risk Group	Emerging Risk Group	Youth, Transgender, Homeless, Asian Pacific Islanders, Incarcerated	
TOTAL ALL GROUP	100%		ALL RISK GROUPS	ALL RISK GROUPS	ALL RISK GROUPS

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 1as 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.

PLEASE NOTE: The Pennsylvania Community HIV Prevention Planning Committee recognizes that the above prioritization of HIV risk populations is based on information pertaining to transmission groups. A number of other characteristics and life circumstances also define groups of individuals who are at risk of HIV; for instance: female sex partners of IDUs, female sex partners of MSMs, female young adults and adolescents, young MSMs, individuals experiencing poverty and/or homelessness, the incarcerated and those recently released from incarceration into local communities, non-IDU drug and alcohol users who have sex with people with HIV, individuals who are mentally ill, and transgender individuals. **When service providers and organizations use the above ranking to establish local prioritization of risk populations, the**

Committee requests that these other characteristics and life circumstances be taken into consideration, and included in local priority ranking.

COMMUNITY SERVICES ASSESSMENT

This section describes the prevention needs of populations at risk for HIV infection, the prevention activities/interventions implemented to address these needs, and the service gaps. The CSA is a combination of three products: Needs Assessment, Resource Inventory, and Gap Analysis.

Needs Assessment Summary Report

Complete Needs Assessment Reports can be found in *Appendix N.*

Overview:

Based upon the Epi Profile and the Prioritized Target Populations and in consultation with the PA Department of Health, Division of HIV/AIDS (DOH), the PA HIV Prevention Community Planning Committee (CPG) has identified the target populations to be assessed and the types of needs assessments to be implemented. The DOH commissioned researchers at the University of Pittsburgh/PA Prevention Project (PPP) to carry out these assessments.

Extensive needs assessments were conducted among a number of at-risk populations between 1994 and 1996. The findings of these assessments have been previously reported. This report covers needs assessments of subgroups of MSM, IDUs, heterosexuals, youth, HIV+ individuals, and other special populations carried out since 2000.

Problem:

HIV remains a threat to the health and well being of a variety of individuals. For example:

- After years of reductions in the transmission of HIV among MSM, studies have found increasing rates of HIV and other STDs among MSM.
- In most areas, transmission rates among IDUs remain high.
- People of color remain disproportionately affected by HIV.
- Half of all new HIV infections in the United States and, presumably, in Pennsylvania, are among young people under the age of twenty-five, with highest rates among young MSM and young people of color.
- MSM, IDUs, and subgroups of heterosexuals in PA report that little HIV prevention exists that specifically targets these individuals.

However, the context in which these problems occur has changed. A few examples: HIV is perceived of as being less threatening than it once was among many populations. Increasing numbers of individuals are living with HIV as a result of improved treatments

and, thus, can transmit HIV. The HIV-related attitudes, beliefs, behaviors, and prevention needs of at-risk populations have evolved and are often not well understood. These types of data are required to effectively plan HIV interventions.

In the 2001 work plan, the PA Prevention Planning Committee expressed their concern that HIV-positive individuals were not getting support for prevention. The Centers for Disease Control also began to acknowledge the need for HIV-positive individuals to be targeted for prevention. Studies suggest that anywhere from 20 to 40% of HIV-positive patients engage in high-risk behavior. In addition, sexually transmitted infections are still common among HIV-positives in care. A recent literature review described various factors that may be associated with high-risk behavior:

1) Recent treatment advances;
2) Having a sense of physical well-being;
3) Living with a monogamous or primary partner;
4) More frequent use of alcohol and illegal drugs, particularly prior to sex;
5) Having a poor relationship with a physician;
6) Disclosure of status; and,
7) Prevention burnout.

While these findings are revealing, they may not provide adequate information to plan effective prevention programs. Specifically, more specific information about the prevention needs of HIV-positive individuals in Pennsylvania is needed to support the development of effective HIV prevention programs. With the local and national concern growing on this issue, the Bureau of HIV/AIDS applied for supplemental funds to identify the needs and barriers to prevention with positives in Pennsylvania. The funds were received in January 2003.

As another example, members of the PA Young Adult Roundtables have voiced the belief that youth are increasingly less concerned about HIV/AIDS and that education within our public schools is inadequate and if improved, could help reduce transmission of HIV among adolescents. As a result, the Roundtables requested that the Community Planning Committee add objectives exploring the status and needs of adolescents with regard to HIV education within Pennsylvania's public schools. The Committee did so.

As a final example of the changing context of HIV and the resulting need for additional data, HIV testing data show that fewer young adults under 24 have been coming into HIV testing centers, presumably because of their decreasing sense of vulnerability with regard to HIV. However, a more complete understanding of why some adolescents seek HIV testing and others do not is required for effective HIV prevention planning. Thus the Committee asked that a small study be done to gather data from high-risk youth about their risk behaviors and about their reasons for getting or not getting tested. These data are currently being analyzed and will be available to the Committee in the Fall 2003.

Overall purpose of needs assessments and goals of specific projects:

The primary purpose of the need assessment activities is to provide data for the DOH and Committee to support their HIV-prevention planning processes and application to the CDC. It is also hoped that local health departments and community agencies can be provided with needs assessment findings to assist their prevention activities and that the assessments can serve as a model for others working across the U.S. in addition to providing information about needs and barriers to HIV prevention to individuals nationally.

1. A general needs assessment of subgroups of MSM, IDUs, and heterosexuals exhibiting high-risk behaviors (implemented in 2000 and 2001) and of special populations (i.e. African-American and Latino youth, Asian-Pacific-Islander, homeless, incarcerated, and transgender adults) (to be completed in 2003). The goals of the needs assessment of general and special populations are to: A) Identify priority needs and barriers regarding HIV prevention in PA as perceived by subpopulations of IDUs, MSM, and heterosexuals and the extent to which these perceptions coincide with what is already known from past needs assessments as well as national literature, B) Identify the relationship of the above risk categories to six sociocultural barriers as identified by the Committee, and, C) Identify perceptions of IDUs, MSM, and heterosexuals concerning HIV-prevention interventions with demonstrated effectiveness and, based on these perceptions, begin to prioritize interventions that appear promising but need further study.

2. A needs assessment of HIV+ women, HIV+ MSM, and HIV+ IDUs (to be completed in 2003). The needs assessment of HIV-positive individuals is intended to gather information from people in care and from providers of HIV services in order to better understand: A) Their knowledge and behaviors related to medical care, risks for transmitting HIV to others and risk for acquiring secondary infections, B) What medical and other providers can do to integrate prevention into their service and help their patients reduce their risk, and, C) The needs and barriers related to prevention with HIV-positive individuals in the service setting. While there are HIV-positive people unaware of their status or who are aware but are not in care, this assessment focuses on people receiving care from a physician or other AIDS service provider. HIV-positive individuals will differ somewhat in need than those who are unaware or not in care. Needs assessments for these other groups may be conducted in the future.

3. The Pennsylvania Young Adult Roundtables developed an HIV Prevention Consensus Statement that, in large part, describes the HIV prevention needs of young people in Pennsylvania, as articulated by members of the Pennsylvania Young Adult Roundtables.

4. An assessment of PA schools is: A) reviewing the literature to identify best practice states, effective interventions, and the status of HIV/AIDS education within the U.S., B) developing an HIV/AIDS education resource web page (to be added to PPP's stophiv.com web site) for health education practitioners within the PA school system and community based organizations responsible the development and or implementation of HIV/AIDS education, in addition to students and parents, C) networking with local state and federal personnel involved in HIV/AIDS education, and, D) gathering youth related HIV/AIDS data, including surrogate markers.

5. An assessment of the HIV testing- and counseling-related needs of youth being implemented by the Youth Empowerment Project (YEP). Youth are being surveyed to gather data about factors that facilitate and serve as barriers to HIV testing and counseling among young people. Information on whether participants have tested for STDs and HIV is also being accumulated as well as data about risk behaviors.

6. A gap-analysis that inventoried HIV prevention and education services available in PA.

Identification of strategies and populations to be assessed:

As stated above, the Committee has been responsible for identifying needs assessment strategies and, in consultation with the DOH, has been responsible for identifying populations to be assessed. The identification of populations has been generally based on a population's relative contribution to new HIV infections. More specifically, decisions were based on:

- An analysis of the epidemiological profile contained in the PA HIV Prevention Plan
- The relative amount that was known about a particular population (populations for whom little is known may be prioritized)
- Feedback from Committee members concerning their experiences and perceptions

Methods:

1. IDU, MSM, heterosexual, and special populations needs assessments:

A. Literature Review: Databases, web-sites, past needs assessments, and other data were searched to identify relevant themes, gaps in literature, and quality methods. Important issues and questions that needed to be assessed were identified.

B. Identification of Sample: Not all subgroups of populations identified by the Committee could be included due to funding limitations. A steering committee of PPP staff, committee members and other PA experts made preliminary recommendations of subgroups for study based on relevant epidemiological data, feedback from the Committee, and the literature review.

C. Development of Questions: Questions were based on: 1) needs of the Committee; 2) topics identified through the literature review; 3) past needs assessments, 4) discussions by the Committee; and, 6) outside expert input.

D. Identification of Methods: A panel consisting of the steering committee and additional Committee members identified the most appropriate methods (e.g., key-informant interviews for more marginalized and thus harder to reach populations).

E. Development of Budget: A detailed budget for the project was then developed.

F. Institutional Review Board: Application was made to and approval received from the University of Pittsburgh's Institutional Review Board.

G. Staffing and training: **Individuals** were identified based on their relationships with target populations and relevant skills to recruit participants, lead groups, or implement interviews. Training included purpose of the study, dynamics of each population, confidentiality, facilitation or interviewing skills, and, other issues.

H. Data Collection: **Focus** groups and interviews were tape-recorded. Pilot groups and interviews were implemented. Staff of PPP reviewed the tape recordings of these pilot groups and interviews and provided feedback to the facilitators and interviewers.

I. Analysis of Data: Three individuals listened to a cross-section of tapes and identified themes based on each theme's frequency, intensity, and level of consensus. Reliability was evaluated. A matrix system was utilized based on the work of Miles and Huberman. The lead reviewer then analyzed the remaining tapes to record the data based on the identified themes with a back-up reviewer listening to selected tapes to ensure high quality. Findings were then checked for validity in sessions with CPG members who were also representatives of the targeted populations.

J. Evaluation: Participants, facilitators and interviewers completed written evaluations. Facilitators and PPP staff met to evaluate the project. Data was presented to the CPG in part to have them provide evaluative feedback.

2. HIV+ individuals needs assessment:

The needs assessment of HIV-positive individuals will implement focus Groups, a provider survey, and a consumer survey. The methods and process being utilized is similar to that described above under #1. For example, 84 articles were reviewed from the following sources: Journal of AIDS; AIDS and Behavior; AIDS Reader; AIDS Care; American Journal of Public Health; Southern Medical Journal, Journal of Substance Abuse; Sexually Transmitted Diseases; Clinical Psychology, Science, and Practice; Social Science and Medicine; Archives of Internal Medicine; AIDS Education and Prevention; Health Psychology; and the

Journal of Sex Education and Therapy. In addition to peer-reviewed journals, web-sites were also reviewed including that of the Centers for Disease Prevention and the Center for AIDS Prevention Studies.

Focus group participants will be HIV positive adults from across the Commonwealth of Pennsylvania. Specifically there will be three groups of men who have sex with men, three of male injection drug users, three of women, and one group of spanish-speaking only Latinos. Participants will be individuals who maintain direct contact with various HIV prevention personnel across the state and will be treated as consultants and informants regarding the needs of their constituent populations. Diversity will be ensured by accounting for participation based on: race and ethnicity; regions across the state; types of care and providers; rural as well as urban and suburban; and age. In addition to group discussion, a brief and private questionnaire will be administered at each of the groups. The questionnaire is expected to allow for more detailed and pointed information about the individual's own behaviors and situations which otherwise they may be uncomfortable disclosing to the group.

Providers and Consumers will be given separate self-administered survey questionnaires exploring the same questions and concerns noted above. PPP will partner with Mid-Atlantic AIDS Education Training Center (AIDS ETC) to complete both of these surveys. AIDS ETC will conduct conferences with providers across the state to address the topics of prevention with positives and the role of the provider. Pitt will administer the provider survey at those conferences and also strategize how to survey other providers not able to attend a conference.

AIDS ETC and Pitt will partner in implementing the consumer survey. AIDS ETC has demonstrated success in 2002 assessing the issue of treatment adherence with HIV-positive individuals. A prior survey garnered over 1100 respondents and is to be conducted every two years. AIDS ETC and Pitt will develop and implement a mail-out survey to address the issue of Prevention with Positives. Diversity will also be ensured for the surveys by accounting for participation based on region, type of provider, and type of care received.

3. Young Adult Roundtable Consensus Statement

This Consensus Statement is a product of the Pennsylvania Young Adult Roundtables. The mission of the Roundtables, which began in 1995 with four groups (Allentown, Erie, Pittsburgh, and York), is to provide high-risk young people in our state (excluding Philadelphia) parity, inclusion and representation in the HIV prevention community planning process. Since its inception, the Roundtables have continued to expand with the changing needs of HIV prevention in PA. Roundtable groups have increased over the past nine years both in number and location throughout the state. Average individual Roundtable size has fluctuated around the goal of fifteen active members.

In 2003 there are ten Roundtable groups in 8 different cities. There are 159 Roundtable members, half (79) of whom are new to the project this year, ranging in age from 13 to 28 (average and median age=18). Fifty-two percent (82) of Roundtable members are female; 48% (77) are male. Seventy-two percent (114) identify themselves as "straight", 13% (20) as "bisexual", 9% (15) as "gay", 4% (6) as "unsure", and 2% (3) as 'lesbian". Roundtable members identify themselves as African American/Black (35% or 56), as Caucasian/White/European American (31% or 50), as Latino/Hispanic/Puerto Rican (25% or 39), as multiracial (8% or 13), and as Asian American (1% or 1).

This Consensus Statement came about as the result of the Young Adult Roundtable Summit. The concept of a Roundtable Youth Summit began in March 1997 with the realization that Roundtable and CPG members desired to meet one another and to produce a document that would exemplify the opinions of Roundtable members. The Youth Empowerment sub-committee of the CPG, in subsequent teleconferences, further developed the concept of a Summit, broadening its intention to include the development of an HIV prevention consensus statement both by and for youth. Furthermore, the Consensus Statement would be used in the community planning process, as well as distributed to state and local officials.

On March 14th-15th 1998, by way of funding from the Pennsylvania Department of Health, *Division of HIV/AIDS*, the Roundtable Youth Summit was held in Harrisburg, PA. This two-day planning conference, coordinated by the Pennsylvania Prevention Project at the University of Pittsburgh, *Graduate School of Public Health*, consisted of plenary sessions as well as small group didactic activities which facilitated the generation of data exclusively for this document. This was the first time Roundtable members from all over the state of Pennsylvania and from various backgrounds had the opportunity to come together and exchange ideas about how to improve HIV prevention planning in PA. Among the Summit sessions were: the presentation of AIDS epidemiological data, needs assessment data from the 1996 focus groups conducted among PA youth, and data from the 1997 Roundtables; presentations on peer education, risk reduction and outreach; personal perspectives from two young individuals living with HIV; and personal statements by Roundtable members were also included. By the end of this Summit, the Young Adult Roundtables had created the first draft of this document.

In December 2002, we began updating and reformatting the Consensus Statement to mimic the new format of the PA HIV Prevention Plan, comprised of four content areas: Epidemiology, Needs Assessment, Interventions, and Evaluation. These four topical areas do not exist independently for effective planning, but, rather, are inter-related and inter-dependent. The purpose of this revision is to allow the CPG to clearly see the prevention needs of young people in Pennsylvania and to integrate them into the state's Prevention Plan. The purposes of this document are to identify under-served target populations, to plan

interventions for young people, to identify the needs of young people, and to suggest evaluation strategies for current programs available to young people The full Consensus Statement is in *Appendix O*. In addition, the four content areas of the Statement are integrated within the 2004 Plan were appropriate.

The **Epidemiology** Section of this Consensus Statement describes the statistics that should be looked at when developing a view of HIV/AIDS infection among young people in Pennsylvania. Please note that most of the information needed is not being collected in Pennsylvania.

Needs Assessment Section is the largest section of this Statement. This is largely due to young people being an under-served population in Pennsylvania. Some of the barriers listed in Needs Assessments get addressed in the Interventions Section, however there are still a lot of barriers that need to be overcome.

The **Interventions** Section identifies the kinds of programs that are most needed to reduce HIV infection/re-infection among young people in PA. We also identify that certain programs may be best suited to certain groups of young people. Basically that it is necessary to tailor an intervention for the specific target group that you are attempting to reach.

In **Evaluation,** factors to determine the effectiveness of HIV prevention programs for young people and how this information should be collected are covered.

4. Assessment of Pennsylvania Schools:

The Public Schools needs assessment key goals are focused on assessing the status and needs of HIV prevention education within PA for the purpose of assisting the state departments of health and education to identify the status of HIV/AIDS education provided to school age youth; to develop an HIV/AIDS Intervention Resource Database; and to promote the dissemination and implementation of effective HIV/AIDS educational materials and curricula. This assessment incorporates the development of a questionnaire addendum to the School Health Education Profile, which monitors characteristics of health education in middle/junior and senior high schools in the United States. A review of policy, standards and activities of a sampling of states across the country identified by CDC as having effective public school HIV education programs provides information on the characteristics of effective state programs. The development and maintenance of an HIV education web page on the stophiv.com web site will allow for the promotion and dissemination of effective HIV/AIDS related educational materials as well as program funding sources. This web page targets parents, students, and health education practitioners responsible for HIV/AIDS education within the Pennsylvania school system and community-based organizations with accurate HIV/AIDS related information and resources.

5. Gap analysis:

The methods associated with the gap analysis differed by coalition region. Each description of methods is included in the findings section below.

6. YEP survey:

Four to six outreach staff at each outreach venue are informing young people about the study using signs and conversation. Outreach workers are screening youth by age and lack of prior participation in the survey. Those who meet the age criteria and volunteer to participate are taken to a private room at the outreach site. There they meet one of two YEP HIV prevention staff. YEP staff explain the purpose and confidentiality of the project. Young people who agree to participate are fill out the survey in a private space and then place it into a collection envelope, seal it and place it in the survey drop box. Participants then return to the staff person, and receive a five-dollar stipend. Any questions or concerns are addressed with the participant at this time and a copy of an information sheet and a card with local test-site information are given to each participant.

FINDINGS

IDU, MSM, HETEROSEXUAL, AND SPECIAL POPULATIONS NEEDS ASSESSMENTS:

A. (IDU)s: (*Female; Latino/a; MSM/IDU; Rural; Young (18-25); and Traditional)* (mainly African-American and some white men who typically had been in and out of treatment for some time).

1. Most participants initiated general drug use at young ages, between 11 and 18 years old, with the majority beginning before the age of 15. Alcohol and non-injection drugs were typical at first, eventually leading to use of injection drugs.

2. Most participants reported needle sharing and lack of practice with cleaning used needles.

3. Participants said they would definitely use clean needles if they were accessible, but these were not freely accessible to the majority of participants. They would also use other harm-reduction paraphernalia and would accept HIV-, STD-, hepatitis-, and other prevention messages from knowledgeable providers in needle exchange programs.

4. IDUs were generally very pessimistic about their ability to change behaviors (though youth and MSM were less pessimistic) explaining that their addiction to drugs was "so strong" so that they would continually and indefinitely put themselves at risk.

5. The most important desired characteristics of providers in these or other settings is that they be knowledgeable about HIV/AIDS and prevention issues and that they honor the confidentiality of clients. (Other demographic characteristics of providers mattered less).

6. The best places for prevention interventions to occur were in streets and community-agency settings where IDUs gather. Clubs, parks, and bookstores were also potential venues for prevention among MSM/IDUs; and peers would be important sources of information for young IDUs.

7. Barriers to condom use include:
   - free condoms were not easily accessible especially among rural and young IDUs, due to not knowing where to get them for free or because of embarrassment in acquiring them,
   - dislike for condoms due to perception of reduced sexual stimulation and loss of erection when using them,
   - drug addiction superceding concerns about safer sex,
   - low self-esteem and lack of assertiveness skills among MSM/IDUs and women, unsure about asking sexual partners to use condoms,

- ability for women and MSM/IDUs who trade sex for drugs/money to acquire higher payments for sex without condoms,
- unplanned nature of sex for traditional male IDUs. All subpopulations of IDUs participated in some level of unprotected sex on a regular basis.

Prevention needs as reported by IDUs:

1. Free, clean needles, easily accessible to IDUs, as well as, other harm-reduction items and messages made available in street and community settings.

2. Increase the availability of free condoms, or the availability of free condoms must be made better known, especially among young and rural IDUs.

3. The most effective prevention interventions would entail early intervention in the lives of young people at risk of eventual injection drug use.

4. HIV-prevention interventions need to intensely address issues of self-esteem, self-efficacy, and a cluster of negative life circumstances. Gender-related issues, as described above, are particularly important.

5. All interventions should incorporate discussion and assessment of sexual risks.

6. Current treatment and drug-and-alcohol services may provide good settings for more intensive skills building and behavior-change approaches.

B. MSM: *(African-American; Latino; Rural; Young (18-25); and Traditional* (mostly Caucasian, middle-class or affluent, and "out of the closet").

1. Poor self-esteem, internalized hate and shame about having sexual desires for men; fear of stigma related to same-sex behaviors and AIDS; and an inability to "come out" to families and communities because of fear of banishment and isolation was viewed as major barriers, especially among African American, Latino, and rural MSM. As a result, there are relatively few African-American, Latino, rural, and young MSM to organize prevention, to advocate for funds, and to serve as role models for their peers.

2. All subpopulations had very good knowledge about HIV risk behavior, except for rural MSM and some youth , though participants said that they were not necessarily representative of their peers.

3. African-American, Latino, rural, and young MSM suggested that most of their peers did <u>not</u> identify as being "gay," and did not place themselves in gay social situations. They also described other peers who <u>were</u> gay-identified, but who did not participate in the "gay community."

4. MSM described an “increasing silence” and a “retreat of prevention”, stating that there are currently far fewer prevention activities occurring in the gay community than in prior years. They also claimed there were a number of “missed opportunities” for including HIV-prevention services with community events sponsored by and attracting MSM. This was due to a growing perception that HIV/AIDS is no longer a significant concern and false idea that AIDS is no longer fatal (especially among young MSM). For instance, free condoms, which were once easily available in places like gay bars during the 1990s, were no longer as accessible.

5. Outside of urban areas, community institutions and providers were perceived to be “homophobic.” Even in AIDS services organizations (ASOs), activities and messages directed toward MSM were censored.

6. HIV-prevention and service providers were generally not trusted by MSM. African- Americans mistrusted governmental providers. Latinos mistrusted ASOs. Rural MSM questioned the ability of providers to maintain confidentiality. Illegal immigrants tended to avoid providers altogether. In all settings, churches were perceived to be “closed” to MSM and HIV-related issues.

7. MSM were seldom using condoms for oral sex and “some of the time” for anal sex. Reasons included drug and alcohol abuse; perceived loss of sexual sensation and erection; lack of access of free condoms, especially among rural and young; MSM cultural issues, such as a strong sense of “machismo” among Latinos; and lack of proper training in using condoms.

8. A number of MSM also have sex with women, and condom use is infrequent or sporadic in these encounters.

9. Some participants also reported that peers intentionally take sexual risks, such as barebacking” and a very small minority also intentionally attempted to become HIV infected because it gave them a sense of belonging to a community of people already infected and/or an entitlement (especially financial) to HIV-related treatment and services.

Prevention needs as reported by MSM:

1. Prevention directed at MSM need to included approaches that foster community connections as well as focusing on self-esteem, issues of stigma, and social isolation. Peer support and peer lead prevention programs are most needed. (Note: Community social-marketing programs and community- and peer-support interventions have been found to be most successful among a number of subpopulations of MSM. These approaches are detailed in the longer report

2. Many MSM are not gay-identified and/or do not frequent places and events that are gay-identified in nature. Therefore, the bulk of HIV-prevention interventions targeting MSM should include messages that are not gay-specific. These messages should be delivered in places where MSM who are not gay-identified gather (e.g., straight bars, parks, bookstores, and other community settings). At the same time, a portion of MSM are identified with local gay communities and have reported a "retreat from prevention" by both gay-identified MSM and community groups.

3. Local gay and other community leaders need to be "re-invigorated" to accept responsibility for HIV-prevention targeting MSM in a way that was identifiable from the late 1980s to mid-1990s. Current gay-affirming and entertaining events (e.g., drag shows, gay bingo, and no-alcohol events) need to be infused with HIV-prevention concerns and materials.

4. All prevention interventions directed to MSM should incorporate education components with the strong message that treatment for HIV-disease is not a cure for AIDS. This message is especially needed among young MSM who often feel invincible and believe that HIV is not a problem for them.

5. The most effective prevention was perceived to be the knowledge of someone who is HIV-infected and messages delivered by MSM who are infected.

6. Young MSM stressed the importance of providing clear, targeted, and non-judgmental HIV-prevention information in schools starting at young ages. Both young and rural MSM believed that the Internet was a viable place for providing information and peer support. Young MSM expressed a particularly strong need for programs that would build self-esteem and provide peer support. The availability of gay role models was also cited as being important. Participants believed a hotline or central information source should be available for MSM that provided details about HIV and other issues of interest.

C. Subpopulations of heterosexuals involved in this assessment included: Women who have Sex with MSM, Latino Females, Sex Workers, Non-Injecting Drug-Using Females, Young African-American Females (18-25), Young African-American Males (18-25), and Other At-Risk Females.

1. Among these subpopulations, a reasonable understanding about HIV risks existed. However, significant knowledge gaps about HIV/AIDS were apparent. For example, women of childbearing age seldom knew about the role of AZT or other treatments for pregnant women infected with HIV. Latinos expressed a more significant lack of knowledge. The women felt that, in general, information was not targeted to specific demographic groups (e.g., African-American women or pregnant women); and that clients typically needed to ask for information they did receive rather than having had it routinely provided.

2. Barriers to HIV prevention include: (1) the negative stigma associated with HIV/AIDS (especially among African-American women and Latinos); (2) lack of provider recognition that clients may have diverse expressions of sexuality (e.g., women who have sex with MSM, bisexuality among women); (3) low self-esteem that interferes with the ability or desire to attend to issues of one's health and risk-reduction activities (among all subpopulations, including African-American men); (4) male-dominated relationships, including sexual relationships, in which women have little voice or control (e.g., women who cannot ask their male sexual partners to use condoms without negative and potentially dangerous repercussions); (5) alcohol and drug addiction which interferes with the ability to practice less risky behaviors; (6) physical isolation that makes prevention activities difficult, if not impossible, to access; and (7) language barriers for Latinos.

3. A noticeable minority of African-American men and women had not been tested. More intensive types of HIV-prevention interventions, such as targeted, community outreach and attitude-change and skills-building activities, were rarely provided for any of the subpopulations.

4. Condom use ranged from sporadic to nonexistent among all subpopulations. Reasons for lack of condom use included: apathy about HIV and denial that HIV can affect heterosexuals (or people like themselves); perceived lack of accessibility of free condoms; resistance of male partners to use condoms (which, according to Latinos, is related to issues of "machismo" according to Latinos); and lack of knowledge about HIV status or risks taken by male sexual partners.

5. Two major issues that interfered with women's ability to negotiate condom use during risky sexual interactions involve: (1) the lack of positive self-esteem and self-efficacy to ask male sexual partners to use condoms; and, (2) alcohol, injection, and non-injection drug use that often "clouds" individuals' abilities to negotiate condom use.

Prevention needs as reported by subgroups of heterosexuals:

1. Participants conveyed that a comprehensive range of HIV-prevention services would be needed to effect them and their peers.

2. Culturally appropriate, language-specific, and targeted HIV information, education, and outreach are needed.

3. Intensive interventions that address self-esteem, self-efficacy, apathy and denial, issues of stigma.

4. Skills affecting behavior change would be necessary. (Women especially liked the idea of skills-building groups in which mutual support would be fostered.)

5. Free condoms should be a component of all HIV-prevention activities.

6. Heterosexual women purported the idea of free needle exchange for IDUs.

7. They encouraged increased and quality-controlled HIV-prevention through existing institutions, such as drug-treatment centers and schools.

8. All subpopulations (except women who were non-injecting drug users) expressed a desire for HIV-prevention providers with demographic characteristics similar to their own.

9. Providers would need to be knowledgeable, facile with teaching HIV prevention skills, and able to strictly honor confidentiality.

D. Homeless subpopulations - *MSMs, Sex Workers, Non-Injecting Drug-Users, African-Americans, and Other At-Risk Homeless Persons.*

1. Substance use and at-risk sexual behavior among homeless and run-away youth elevate the risk for HIV/AIDS infections.

2. Alarming rates of HIV infection among urban homeless men and women indicate that AIDS prevention interventions should be implemented quickly in programs that provide social services to the homeless population.

3. Large numbers of sexual partners, casual sexual contacts, survival sex and infrequent condom use were all identified as contributing factors for HIV & STD infections.

4. Multi-drug use is increasing among homeless persons living with HIV (PLWH). Many homeless PLWH have histories of incarceration.

Identified barriers to condom use as identified by the homeless:

- Limited negotiation skills.
- Day-to-day survival supercedes safer sex behaviors.
- Need for drugs and/or alcohol supercedes safer sex behaviors.
- Limited access to free condoms.
- Homeless persons have an inherent mistrust of community supportive services.

Prevention needs as identified by the homeless:

1. Mobile (street) prevention programming to provide condom distribution, clean injection equipment, as well as, on-site (shelter) programming.

2. Basic human needs supercede their need for HIV prevention (secondary, or otherwise.)

3. Homeless individuals view confidentiality with skepticism. Especially, when they "must" reveal intimate details about their need for shelter, prior to being accepted/admitted for services.

Gaps in services as identified by homeless persons:

1. Health care facilities are not perceived as being receptive to the physical and/or emotional needs of homeless persons. Homeless persons reported being skeptical of health care professionals. In addition, many homeless persons lack insurance coverage.

2. Homeless persons feel they are not included in HIV prevention programs, secondary to their transient status. Opportunities for HIV prevention (primary or secondary) are, generally, unavailable.

3. Many homeless people reported being unaware of their HIV status. Homeless people reported feeling stigmatized by their homeless status. To disclose an HIV+ status, would (by their report) be "double-jeopardy."

E. Asian Pacific Islanders (APIs) MSM:

1. AIDS is still not a commonly reported disease among Asian and Pacific Islanders.

2. APIs constitute 3% of the U.S. population, however HIV rates are increasing at a higher rate than found among Whites.

3. Within the API populations, the majority of those infected by AIDS are MSMs.

4. API/ MSMs reported under utilization of HIV prevention programs, secondary to the cultural stigma associated with HIV and homosexuality.

5. Since API / MSMs reported feeling that they are a minority with a minority, establishing and maintaining confidentiality is essential, if primary or secondary prevention programs are to be effective.

6. API / MSMs reported a need for peer support, since disclosure of their sexuality or disclosure of their HIV status would be viewed as "disgraceful."

Identified barriers to condom use as reported by API / MSMs:

- Lack of API service providers, with whom they could relate.
- For APIs who do not speak or comprehend the English language, the HIV prevention message is limited.
- API respondents identified the "cultural stigma" as being a major barrier. As long as APIs continue to believe that HIV is (only) associated with gays and prostitutes, the API community will continue to ignore the impact this disease is having on the API community, at large.

Prevention needs as identified by APIs:

1. Need for peer skills building.

2. Need for API celebrities (i.e.: Tiger Woods or Jackie Chan) to de-stigmatize HIV and increase community awareness.

3. Respondents felt that faith-based ministries would not be instrumental in providing HIV prevention information, secondary to their unwillingness to "come-out" to anyone in the religious sector.

4. API respondents reported that they would not be willing to discuss HIV prevention wit their medical providers. However, if the prevention information were in (private) exam rooms, they would be willing to take and read the literature.

F. HIV Positive Persons

The needs assessment of HIV + people is in process. Findings from these focus groups will be reported by the end of 2003. The survey of more than 1,000 people with HIV infection will be completed in early 2004.

YOUNG ADULTS ROUNDTABLE FINDINGS:

The following problems have been identified in the Roundtable Consensus Statement (additional goals and specific objectives are outlined in the document):

- Half of all new HIV infections in the U.S. are among individuals under 25, and half of these are among individuals under 22.
- Assuming half of all new HIV infections are among *young people*, epidemiological data should be collected and analyzed in order to broaden our understanding of who and where are they by demographics.
- Assuming half of all new HIV infections are among *young people*, epidemiological data needs to be collected and analyzed in order to broaden our understanding of how they are becoming infected (modes of transmission).
- Existing HIV intervention programs need to be more effective. What programs are most needed to reduce HIV infection/re-infection among *young people* in PA? Are certain programs best suited to certain groups of *young people*?
- An effective HIV intervention evaluation model has not been developed and consistently implemented. There are no clear, consistent guidelines as to what is considered effective in HIV interventions.
- Ensure the above model is accurately being followed.
- Many obstacles exist in effectively targeting certain populations for HIV prevention. Some of these barriers include language barriers, lack of funds, and cultural taboos. Gaps in information prevent important knowledge from being collected.

PUBLIC SCHOOLS:

A review of the literature underscores the urgency of the acquisition, development, training and implementation of more effective HIV/AIDS education within our schools and alternative facilities serving youth at increased risk. It is no longer a question of should all local school districts adopt an abstinence-based, as outlined in Chapter 4.29 of the Academic Standards and Assessment Curriculum and Instruction, or comprehensive approach in HIV/AIDS education but rather, how can they afford *not to*. Such an approach would ensure that the vast majority of school age youth are equipped with the necessary knowledge, life skills and behavioral strategies necessary to reduce their risk of acquiring or transmitting HIV infection. Home rule, the legal right of local school districts to determine what curricula will be taught makes this a daunting task. It is necessary however, because:

1. **Youth are being infected, *and* living longer, with HIV/AIDS at increasing rates** - Increased infection rates coupled with improved medical treatment guarantees that growing numbers of infected and affected youth, including children born HIV infected, will be attending our schools.

   To address this reality requires that students, teachers and administrators develop a working knowledge of not only HIV/AIDS but issues of confidentiality, tolerance, social and psychological needs, prevention -including skills-based learning, transmission, accurate infection control guidelines, human sexuality, and skill-based learning techniques.

As of June 2002, Pennsylvania had 484 (2%) diagnosed cases of AIDS below the age of 20 and 4,317 between the ages of 20 – 29. Given the latency period between HIV infection and its progression to AIDS, it is safe to say that a large percentage of the HIV/AIDS cases within the 20 – 29 age grouping probably reflects acquisition of the virus during the teen years.

Pennsylvania Annual AIDS Incidence by Age 1997-2002

(Source: Pennsylvania HIV/AIDS Quarterly Summary – June, 2002)

AGES	**1997**		**1998^**		**1999^**		**2000^**		**2001^***		**1980 -2002**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
All	1,703	100	1,611	100	1,841	100	1,482	100	1,260	100	27,278	100
0 – 12	20	1	15	1	16	1	6	0	4	0	335	1
13 – 19	7	0	9	1	5	0	8	1	8	1	149	1
20 – 29	240	14	182	11	219	12	160	11	133	11	4,317	16
30 – 39	721	42	650	40	700	38	531	36	472	37	11,719	43
40 – 49	514	30	533	33	603	33	528	36	413	33	7,597	28
≥ 50	205	12	222	14	298	16	249	17	230	18	3,161	12

^ Decline in AIDS incidence may be due to decrease in AIDS diagnosis attributable to improved antiretroviral therapy: *Partially due to reporting delays. Percentages may not add to 100% due to 'rounding.'

2. **Health risk behaviors commonly occur in combination with one another** – Marvin Eisen states in his report, *Teen Risk-Taking: Promising Prevention Programs and Approaches*, that teens engaging in risky behavior do not limit themselves to one behavior alone. Intervention strategies should therefore incorporate a abstinence-based/comprehensive approach that recognizes one specific behavior can be taken as a warning signal of likely involvement in additional risk behaviors. (Eisen M et al., Teen Risk-Taking: Promising Prevention Programs and Approaches, Washington DC: Urban Institute, September 2000)

3. **Youth possess a false sense of invincibility, often resulting in the development of risk taking behaviors -** During the adolescent years it is natural for teens to operate within a false sense of personal invulnerability. While this adolescent characteristic allows youth to spread their wings and "test the waters," a positive step toward maturity, it has a down side – increased risk taking. Of paramount concern is the development of risky behaviors in the areas of sexual activity and drug usage, particularly injecting drug use, exploration and experimentation. Research is increasingly documenting that these health risk behaviors commonly occur in combination with one another.

Sexual exploration and experimentation -Indulgence in sexually related risky behavior not only leads to unintended pregnancy but sexually transmitted infections (STIs) including HIV/AIDS.

Sexually Transmitted Infections -Every year 3 million teens, about 1 in 4 sexually experienced teens, acquire an STI.

Drug Use - A recent survey conducted by the Kaiser Family Foundation found a link between sexual promiscuity and alcohol consumption among youth ages 13 - 24. They were in fact found to be seven times more times likely to engage in sex, twice as likely to have sex with four or more partners, and one out of four sexually active youth engage in unprotected sex as a result of drug use. (Karen Thomas, "Alcohol, Sexual Promiscuity Connected but Not Treated - Programs Don't Link the Problems," USA Today, 2/7/02; The Kaiser Family Foundation)

Young Adult Roundtable Consensus Statement: <u>Needs Assessment</u>

What HIV prevention programs for *young people* exist in PA? What programs are needed for *young people* in PA? What are the gaps between needs and existing programs? What do we need to know about the HIV prevention needs of *young people* in PA? What barriers exist to these needs across the state? Other than Roundtables, what are some ways to find out this information from *young people*? What don't we know that we need to know.

Problem #1: Many *young people* in PA are still becoming infected/re-infected with HIV.

Goal #1: Determine what *young people* know about HIV risk reduction.

Objective #1: Assess young people's knowledge level regarding HIV/AIDS, HIV transmission, HIV risk reduction skills, HIV testing and testing facilities, and their levels of HIV risk behavior activity.

Objective #2: Statewide information should be gathered from young people through surveys distributed in schools across PA.

Objective #3: Statewide information should be gathered from young people through focus groups.

Goal #2: Determine why sexually active *young people* are not engaging in safer sexual behaviors.

Objective #1: Determine the impact of drug use (including alcohol) on decision making and safer sexual behaviors.

Objective #2: Determine the impact of religion on decision making and safer sexual behaviors. The role of religion in sexual decision-making needs to be examined to learn how to reach populations whose religion creates a barrier to HIV risk reduction. Many religions do not allow the use and/or promotion of latex condoms and discussion of sexual activity, sexuality, HIV, and STIs.

Objective #3: Determine the impact of socioeconomic factors on decision making and safer sexual behaviors.

Goal #3: Determine why *young people* who use injectable drugs (including steroids) are not engaging in risk reduction behaviors.

Goal #4: Determine methods by which young *people* effectively prevent HIV infection.

Objective #1: Assess young people's knowledge about condoms and dental dams, and condom use skills. Determine which condoms young people prefer.

Objective #2: Determine how *young people* living with HIV prevent their partners from becoming infected.

Objective #3: Determine what young people know about proper needle cleaning methods.

Problem #2: Many *young people* are not accessing existing HIV prevention programs.

Goal #1: Determine the barriers that young people in PA encounter when accessing existing HIV prevention programs for young people.

Problem #3: Sufficient epidemiological and needs assessment data to determine target populations among young people in PA does not exist or has not been compiled.

Goal #1: Create a complete epidemiological profile of young people at risk for HIV infection in PA.

Objective #1: Compile the primary and surrogate data that currently exists regarding young people in PA

Objective #2: Previous Youth Risk Behavior Survey (YRBS) data should be included in the epidemiological profile. This survey contains important information concerning risk behaviors among *young people*.

Objective #3: Determine what data is needed to complete an epidemiological profile of young people at risk of HIV infection in PA

Objective #4: The YRBS needs to be reinstated and made Pennsylvania. specific. The survey should be altered and additions need to be made to make it more appropriate to Pennsylvania's needs. It is imperative that the YRBS expands their sexual behavior section to include oral and anal sex.

Goal #2: Establish target populations of young people in PA.

Problem #4: Many existing HIV prevention programs in PA are not meeting the HIV prevention needs of *young people*.

Goal #1: Determine existing HIV prevention programs for young people (those in school and those not in school) in PA and their target populations.

Goal #2: Determine why high-risk populations of *young people* are not being targeted through existing HIV prevention programs.

Goal #3: Identify effective methods of targeting high-risk young people.

Goal # 4: Determine the extent to which existing HIV prevention programs for young people are integrated with existing STI and unintentional pregnancy prevention programs.

Resource Inventory

This section describes the assessment of the existing community resources for HIV prevention and provides an understanding of how the jurisdiction is currently addressing the epidemic in terms of interventions and targeted groups. The inventory was developed as a result of a survey of service providers (5 county and 4 municipal health departments, 7 Ryan White HIV/AIDS Regional Planning Coalitions) and a review of the University of Pittsburgh/PA Prevention Project's stophiv.com resource database. The Resource Inventory describes the geographic coverage of programs and details the target populations being served and the interventions provided to each target population. The Complete Resource Inventory is in *Appendix P.*

Definitions of CPG's Prevention Interventions:

Counseling, Testing and Referral (CTR)	Counseling and testing refers to a voluntary client-centered, interactive process that provides information about testing procedures and how to prevent the transmission and acquisition of HIV infection. Clients also learn their serostatus, participate in a personal risk assessment and develop a personal risk reduction plan. Referral links individuals with high-risk behaviors and those infected with HIV to prevention, psychological, and medical resources needed to meet their primary and secondary HIV prevention needs.
Individual- level Interventions (ILI)	Health education and risk-reduction counseling provided to one individual at a time. ILIs assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior and include skills building activities. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services. **Note: According to a strict categorization, outreach and prevention case management also are individual-level interventions. However, for the purposes of this reporting, ILI does *not* include outreach or prevention case management, which each constitutes their own intervention categories.**
Group-level Interventions (GLI)	Health education and risk-reduction counseling (see above) that shifts the delivery of service from the individual to groups of varying sizes. GLIs use peer and non-peer models involving a wide-range of skills, information, education and support. **Note: Many providers may consider general education activities to be group-level interventions. However, for the purposes of this reporting, GLI does *not* include "one-shot" educational presentations or lectures (that lack a skills component). Those types of activities should be included in the Health Communication/Public Information category.**
Outreach (OR)	HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the client's neighborhoods or other areas where clients typically congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials. Includes peer opinion leader models.
Prevention Case Management (PCM)	Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction need; a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support and service brokerage.
Partner Counseling and Referral Services (PCRS)	A systematic approach to notifying sex and needle sharing partners of HIV-infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.
Health Communications Public Information (HC/PI)	The delivery of planned HIV/AIDS prevention messages through one of more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services. **Electronic Media**: Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, infomercials, etc., which reach a large-scale

	(e.g., city-, region-, or statewide) audience. **Print Media**: These formats also reach a large-scale or nationwide audience; includes any printed material, such a newspapers, magazines, pamphlets, and "environmental media" such as billboards and transportation signage. **Hotline**: Telephone service (local or toll-free) offering up-to-date information and referral to local services, e.g., counseling/testing and support groups. **Clearinghouse**: Interactive electronic outreach systems using telephones, mail, and the Internet/Worldwide Web to provide responsive information service to the general public as well as high-risk populations. **Presentations/Lectures**: These are information-only activities conducted in-group settings; often called "one-shot" education interventions.
Other Interventions	Category to be used for those interventions that cannot be described by the definitions provided for the other six types of interventions (example forms A-F). This category includes community-level interventions (CLI). CLI are interventions that seek to improve the risk reductions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. Attempting to alter social norms, policies, or characteristics of the environment often does this. Examples of CLI include community mobilizations, social marketing campaigns, community-wide events, policy interventions, and structural interventions.

Appropriate Science-based Prevention Interventions and Gap Analysis

This section describes the process of synthesizing data from the epi-profile, needs assessment and resource inventory, to conduct a gap analysis that delineate both met and unmet needs of priority populations and identifies gaps in HIV prevention services by geographic area (county). Integral to this process was a concurrent process that identified a set of prevention interventions necessary to reduce transmission in prioritized target populations. This process also ensured that prevention interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended consumers for cultural appropriateness, relevance, and acceptability.

Following the completion of the process of prioritizing target populations, conducted by the Epidemiology Subcommittee, the Interventions Subcommittee requested technical assistance to develop a process for prioritizing a set of science-based prevention interventions for each of the priority populations. Technical assistance was arranged through the CDC project officer, and during a CPG meeting on July 17, 2002, Denise Raybon of the Academy for Educational Development, conducted technical assistance for the CPPG members on "Setting HIV Prevention Priorities".

The CPG and specifically, the Interventions Subcommittee found the technical assistance and prioritization examples from other states helpful, but had difficulty in making the examples meet our needs, especially since the ever-changing Community Planning Guidance (Guidance) no longer required the "prioritization" of interventions. The Interventions Subcommittee reviewed the draft Guidance during the August 2003 CPG

meeting, paying particular attention to the Attributes related to "Prevention Activities/Interventions", and developed a "grid" approach to identify a set of interventions for each of the priority populations, that meet the Prevention Activities/Interventions Attributes, and are identified as both "needed" by the target populations and "effective" for the target populations. The "grid" approach allowed the Interventions Subcommittee to develop a set of interventions (based upon the CDC's and CPG's list of intervention types) for each of the CPG's prioritized target populations, and then use this list to conduct the gap analysis.

Step 1

The Interventions Subcommittee constructed a Grid that listed the CPG ranked populations/transmission groups (x-axis) and the CDC/CPG list of prevention interventions (y-axis). This Grid format is the basis for all subsequent activities used to identify a set of science-based prevention interventions for each of the prioritized target populations and to identify met and unmet needs, and service gaps.

Grid #1

		CTR	PCRS	ILI	GLI	OR	PCM	HC/PI	Other (CLI)
Ranked Population Target Group	Ranked Population Target Group								
HIV+	HIV-								
1. White MSM	White MSM								
2. Black IDU	Black IDU								
3. Black MSM/IDU	Black MSM/IDU								
4. White MSM/IDU	White MSM/IDU								
5. Black Heterosexual	Black Heterosexual								
6. White IDU	White IDU								
7. White Heterosexual	White Heterosexual								
8. Hispanic IDU	Hispanic IDU								
9. Black MSM	Black MSM								
10. Hispanic Heterosexual	Hispanic Heterosexual								
11. Hispanic MSM/IDU	Hispanic MSM/IDU								
12. Hispanic MSM	Hispanic MSM								
13. Perinatal Transmission	Perinatal Transmission								

14. Emerging Risk Groups	Emerging Risk Groups								
Youth	Youth								
Transgender	Transgender								
Homeless	Homeless								
Asian Pacific Islander	Asian Pacific Islander								

Step 2

The Interventions Subcommittee reviewed the complete Needs Assessment reports *(Appendix N*) and identified the HIV prevention "needs" indicated by each prioritized target population. The Grid was completed by placing a check mark in the corresponding cell of the Grid for each intervention recommended by the prioritized target population in the Needs Assessment reports. The completed Grid identifies interventions needed/requested by each prioritized target population, as identified in the Needs Assessments report.

The Interventions Subcommittee believes that this process addresses Guidance Attribute #43 by providing evidence that the prevention intervention is acceptable to the target population.

Grid #2
HIV Prevention Intervention "Needs"
As identified in the Pennsylvania Prevention Project's Needs Assessments
Final Completed 5/22/03

		CTR	PCRS	ILI	GLI	OR	PCM	HC/PI	Other (CLI)
Ranked Population Target Group	Ranked Population Target Group								
HIV+	HIV-								
1.White MSM	White MSM			X	X	X		X	X
2.Black IDU	Black IDU	X		X	X	X	X	X	X
3.Black MSM/IDU	Black MSM/IDU	X		X	X	X	X	X	X
4.White MSM/IDU	White MSM/IDU	X		X	X	X	X	X	X
5.Black Heterosexual	Black Heterosexual			X	X	X		X	
6.White IDU	White IDU	X		X	X	X	X	X	X
7.White Heterosexual	White Heterosexual			X	X	X		X	
8.Hispanic IDU	Hispanic IDU	X		X	X	X	X	X	X
9.Black MSM	Black MSM			X	X	X		X	X
10.Hispanic Heterosexual	Hispanic Heterosexual			X	X	X		X	
Hispanic MSM/IDU	Hispanic MSM/IDU	X		X	X	X	X	X	X
Hispanic MSM	Hispanic MSM			X	X	X		X	X
Perinatal Transmission	Perinatal Transmission							X	
Emerging Risk Groups	Emerging Risk Groups								
Youth	Youth	X		X	X	X	X	X	X
Transgender	Transgender				X	X		X	
Homeless	Homeless					X			
Asian Pacific Islander	Asian Pacific Islander	Data incomplete – currently being collected.							

Note: Current needs assessment data is not specific to serostatus. Additional data will be collected in 2004, specific to HIV+ individuals in all target groups. Due to the CDC's mandate of making HIV+ individuals the #1 priority, needs assessment data has been generalized for both HIV+ and HIV- target groups.

Step 3

The Interventions Subcommittee utilized the CDC "Compendium of HIV Prevention Interventions with Evidence of Effectiveness", (*Appendix Q*), to identify interventions that demonstrate evidence of effectiveness for reducing sex and/or drug-related risks, for each of the prioritized target populations. The Grid was completed by placing a check mark in the corresponding cell of the Grid, for each intervention identified in the Compendium, for each specific priority population. The completed Grid identifies

science-based interventions effective for preventing HIV transmission, for each priority population.

The Interventions Subcommittee believes that this process addresses Guidance Attributes #42, 44, 45, and 46. The Interventions Subcommittee inferred that inclusion of an intervention in the CDC Compendium indicated that the intervention demonstrated: application of existing behavioral and social science, and pre- and post-test outcome evidence to show effectiveness in averting or reducing high-risk behavior within the target population (Attribute 42); evidence that the intervention is feasible to implement for the intended population in the intended setting (Attribute 44); evidence that the intervention was developed by or with input from the target population (Attribute 45); and, focus, level, factors expected to affect risk, setting, and frequency/duration (Attribute 46).

Grid #3
HIV Prevention Interventions with "Evidence of Effectiveness"
As identified in the CDC Compendium of Prevention Interventions
Final Completed 5/22/03

		CTR	PCRS	ILI	GLI	OR	PCM	HC/PI	Other (CLI)
Ranked Population Target Group	Ranked Population Target Group								
HIV+	HIV-								
1.White MSM	White MSM			X	X	X		X	X
2.Black IDU	Black IDU			X	X	X			X
3.Black MSM/IDU	Black MSM/IDU			X		X			X
4.White MSM/IDU	White MSM/IDU			X		X			X
5.Black Heterosexual	Black Heterosexual			X	X	X		X	X
6.White IDU	White IDU			X	X	X			X
7.White Heterosexual	White Heterosexual			X		X			X
8.Hispanic IDU	Hispanic IDU			X	X	X			X
9.Black MSM	Black MSM			X	X	X		X	X
10.Hispanic Heterosexual	Hispanic Heterosexual			X	X	X		X	X
11.Hispanic MSM/IDU	Hispanic MSM/IDU			X		X			X
12.Hispanic MSM	Hispanic MSM			X	X	X		X	X
13.Perinatal Transmission	Perinatal Transmission								
14.Emerging Risk Groups	Emerging Risk Groups								
Youth	Youth			X	X	X		X	X
Transgender	Transgender								
Homeless	Homeless			X	X		X		

Asian Pacific Islander	Asian Pacific Islander			X	X	X		X	

Note: Due to the CDC's mandate of making HIV+ individuals the #1 priority, data has been generalized for both HIV+ and HIV- target groups.

No CTR, PCRS or PCM interventions were indicated in the Compendium.
No interventions for perinatal or transgender target groups were indicated in the Compendium.

The Interventions Subcommittee recognizes that the CDC "New Strategies for a Changing Epidemic" recommends:

- CTR for all target groups
- PCRS for all HIV+ target groups
- Special emphasis on CTR for Perinatal

The Interventions Subcommittee also acknowledges that the CDC Guidelines on HIV Prevention Case Management (PCM) indicate that "priority for PCM services should be given to HIV seropositive persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV transmission and re-infection".

Step 4
The Interventions Subcommittee combined Grid #2 and Grid#3 to identify interventions for each priority population that are both "needed" and "effective". This resulted in the "Final Grid". This "Final Grid" provided the basis of the "Gap Analysis Grid".

Intervention Subcommittee's "Final Grid" (combination of GRID #2 & #3)
HIV Prevention Intervention **"Needs" (N)**: As identified in the Pennsylvania Prevention Project's Needs Assessments
&
HIV Prevention Interventions with **"Evidence of Effectiveness" (E)**:
As identified in the CDC Compendium of Prevention Interventions

Completed 5/22/03

		CTR	PCRS	ILI	GLI	OR	PCM	HC/PI	Other (CLI)
Ranked Population Target Group	Ranked Population Target Group								
HIV+	HIV-								
1.White MSM	White MSM	E	E	E N	E N	E N	E+	E N	E N
2.Black IDU	Black IDU	E N	E	E N	E N	E N	E+ N	N	E N
3.Black MSM/IDU	Black MSM/IDU	E N	E	E N	N	E N	E+ N	N	E N
4.White MSM/IDU	White MSM/IDU	E N	E	E N	N	E N	E+ N	N	E N

5.Black Heterosexual	Black Heterosexual	E	E	E N	E N	E N	E+	E N	E
6.White IDU	White IDU	E N	E	E N	E N	E N	E+ N	N	E N
7.White Heterosexual	White Heterosexual	E	E	E N	N	E N	E+	N	E
8.Hispanic IDU	Hispanic IDU	E N	E	E N	E N	E N	E+ N	N	E N
9.Black MSM	Black MSM	E	E	E N	E N	E N	E+	E N	E N
10.Hispanic Heterosexual	Hispanic Heterosexual	E	E	E N	E N	E N	E+	E N	E
11.Hispanic MSM/IDU	Hispanic MSM/IDU	E N	E	E N	N	E N	E+ N	N	E N
12.Hispanic MSM	Hispanic MSM	E	E	E N	E N	E N	E+	E N	E N
13.Perinatal Transmission	Perinatal Transmission	E	E				E+	N	
14.Emerging Risk Groups	Emerging Risk Groups	E	E				E+		
Youth	Youth	E N	E	E N	E N	E N	E+ N	E N	E N
Transgender	Transgender	E	E		N	N	E+	N	
Homeless	Homeless	E	E	E	E	N	E+		
Asian Pacific Islander	Asian Pacific Islander	E	E	E	E	E	E+	E	

Notes:

- Current "Needs Assessment" or "Effectiveness" data is not specific to serostatus.

- Due to the CDC's mandate of making HIV+ individuals the #1 priority, data has been generalized for both HIV+ and HIV- target groups.

- No CTR, PCRS or PCM interventions were indicated in the Compendium.
- No interventions for perinatal or transgender target groups were indicated in the Compendium.

- The Interventions Subcommittee recognizes that the CDC "New Strategies for a Changing Epidemic" recommends:

    1. CTR for all target groups (marked with an *E*)
    2. PCRS for all HIV+ target groups (marked with an *E*)
    3. Special emphasis on CTR for Perinatal (marked with an ***E***)

The Interventions Subcommittee also acknowledges that the CDC Guidelines on HIV Prevention Case Management (PCM) indicate that "priority for PCM services should be given to HIV seropositive persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV transmission and re-infection". (Marked with an *E+)*

Additional "Needs Assessment" data will be collected in 2004, specific to HIV+ individuals in all target groups.

This "Final Grid" identifies a set of appropriate science-based prevention interventions necessary to reduce transmission for each prioritized target population, that have been identified as both "effective" (intervention effectiveness as identified by the CDC) and "needed" (cultural/ethnic appropriateness as identified by the target population needs assessments).

Step 5 (Gap Analysis)
The next step in completing the CSA is to use the "Final Grid" (What interventions are needed and effective) and compare this to the Resource Inventory (what is being provided) and determine met and unmet needs, and service gaps.

To facilitate the use of the "Final Grid" as a data collection tool, the interventions that were identified as both "needed" and "effective" have been shaded. The resulting grid is identified as the "Gap Analysis Grid".

Intervention Subcommittee's "Gap Analysis Grid"

Key: The dark shaded cells denote the prevention interventions that have been identified by the Interventions Subcommittee as necessary to reduce HIV transmission in prioritized target populations (based on effectiveness and appropriateness). The lighter shaded cells denote interventions recommended by the CDC.

A check mark in a cell indicates that this intervention is occurring ("met need").
The absence of a check mark in a dark shaded cell indicates an "unmet need".

COUNTY _____ RANK _____

		CTR	PCRS	ILI	GLI	OR	PCM	HC/PI	Other (CLI)
Ranked Population Target Group	Ranked Population Target Group								
HIV+	HIV-								
1.White MSM	White MSM								
2.Black IDU	Black IDU								
3.Black MSM/IDU	Black MSM/IDU								
4.White MSM/IDU	White MSM/IDU								
5.Black Heterosexual	Black Heterosexual								
6.White IDU	White IDU								
7.White Heterosexual	White Heterosexual								
8.Hispanic	Hispanic IDU								

IDU									
9.Black MSM	Black MSM								
10.Hispanic Heterosexual	Hispanic Heterosexual								
11.Hispanic MSM/IDU	Hispanic MSM/IDU								
12.Hispanic MSM	Hispanic MSM								
13.Perinatal Transmissio n	Perinatal Transmission								
14.Emerging Risk Groups	Emerging Risk Groups								
Youth	Youth								
Transgender	Transgender								
Homeless	Homeless								
Asian Pacific Islander	Asian Pacific Islander								

Instructions for Completing the "Gap Analysis Grid"

Tools Required:

- Epidemiological Profile/Recommendation from EPI Subcommittee: list of "High Outcome" counties.
- Resource Inventory
- Gap Analysis Grid

Process:

- Assign a rank to each of the "High Outcome" counties, based on a data source recommended by the EPI Subcommittee. This will prioritize the counties where interventions will have the greatest impact on reducing HIV transmission.

- Fill out one Grid sheet, for each county, with the county name and corresponding rank assigned in Step 1.

- For each county, find the county in the Resource Inventory. Complete a Gap Analysis Grid for each county by reviewing the interventions and target groups listed in the Resource Inventory. If an intervention is noted in the Resource Inventory for the target group, place a check mark in the corresponding cell of the Grid. Cells may have multiple check marks. This indicates, "met needs".

- After all interventions for target groups from the Resource Inventory are marked on the Grid for the county, shaded areas without check marks will indicate "unmet needs".

- From each completed Grid, compile a list of the unmet needs (interventions) for target groups identified by this process. This will be your list of prioritized interventions for each target group by geographic area (county).

Step 6 (Gap Analysis)
The final step of the CSA process consisted of identifying gaps in service of the set of prevention interventions identified as necessary to reduce transmission in the prioritized target populations. The Gap Analysis synthesized data from the epi-profile, needs assessment and resource inventory. The actual identification of the service gaps was accomplished by completing a "Gap Analysis Grid" for geographic locations (counties) in the jurisdiction, using epi-profile data to identify where prevention interventions will have the greatest impact in reducing HIV transmission. The Interventions Subcommittee and the Needs Assessment Subcommittee collaborated on this task.

As stated above, an integral part of this process was to consider where geographically in the jurisdiction to target interventions, in order to have the greatest impact on reducing HIV transmission. The Interventions Subcommittee and the Needs Assessment Subcommittee consulted the Epidemiology Subcommittee for a recommendation on prioritizing the counties. The Epidemiology Subcommittee recommended targeting the following "High Outcome" counties: Allegheny, Cumberland, Dauphin, Delaware, Erie, Huntington, Lehigh, Lycoming, Northumberland, Philadelphia, Somerset, Union, Wayne, and York. Philadelphia was excluded because it is not in the purview of this CPG. "High Outcome" counties were defined as counties with high average annual case rates (>7.3 cases/100,000; 50^{th} percentile) AND high average annual rate of change (> +15%; 62^{nd} percentile) due to all cases diagnosed 1993-1997. The epidemiological analysis and source of this recommendation is included in the Epidemiological Profile, (Appendix) 2002-2003 Update.

The Interventions Subcommittee and the Needs Assessment Subcommittee conducted the Gap Analysis at the CPG meeting on July 16 and 17, 2003.

The process was as follows:

- The Needs Assessment and Interventions Subcommittees approved the prioritization data source recommended by the Epi Subcommittee to identify geographic locations within the jurisdiction where prevention interventions will have the greatest impact in reducing HIV transmission. Both Subcommittees agreed to use the "14 High Overall Outcome Counties" data. This list was reduced to "13 High Overall Outcome Counties" because Philadelphia was excluded.
- The Subcommittee members agreed to re-evaluate this process next year to see how to "fine tune" the process and what new data may be available to us – i.e. HIV reporting, improved process monitoring data, etc.
- The "tools" needed to do the gap analysis (prevention definitions, resource inventory, 13 gap grids with county names and rank, and gap analysis

instructions) were distributed, instructions for completing the "Gap Grid" were discussed and an example was demonstrated.

- Members of the two Subcommittees formed work groups, assigned counties and completed the gap analysis grids by reviewing the resource inventory for each county and indicating on the grid what prevention interventions are available (met needs) for those at risk within the county. Subcommittee members indicated on the Gap Grid if the intervention is being provided multiple times.
- Subcommittee members completed Gap Analysis Grids on counties they were familiar with. During this process, Subcommittee members noted that there was some inaccurate information in the Resource Inventory. Adjustments were made as the Gap Analysis Grids were completed, based upon the knowledge of the Subcommittee members.
- A list of unmet needs (interventions identified as "needed & effective" for each target population, but not indicated on the resource inventory) was collected from the completed Gap Grids and listed on newsprint for each of the "13 High Outcome Counties".
- Subcommittee members discussed the need to further prioritize these unmet needs, according to interventions and target populations, within each county.
- The Needs Assessment Committee decided to leave this work to the Interventions Subcommittee.
- Epi data on the "Incidence of AIDS in PA", for each of the "13 High Outcome Counties" was distributed and discussed with the Interventions Subcommittee members. Subcommittee members agreed to consider this data in prioritizing target populations, within each of the "13 High Outcome Counties".
- In addition, the Subcommittee members agreed to prioritize the unmet needs within each of the "13 High Outcome Counties" by intervention type, based upon best practices, as recommended by the CDC.
- The Subcommittee members reviewed all of the unmet needs for each of the "13 High Outcome Counties" and ranked the unmet interventions by intervention type and target population.
- A completed list of ranked unmet needs was compiled.
- The Interventions Subcommittee provided a verbal presentation of the Gap Analysis process to the CPG and a written report was distributed to all CPG members.

Met and Unmet Needs:

Intervention Subcommittee's Gap Analysis Grids

Key: The dark shaded cells denote the interventions that have been identified by the Subcommittee as priority interventions ("effective" and "needed"). The lighter shaded cells denote interventions recommended by the CDC.

A check mark in a cell indicates that this intervention is occurring ("met need"). Multiple check marks were translated into numbers. The absence of a mark in a dark shaded cell indicates an "unmet need".

COUNTY: SOMERSET RANK: 1

		CTR	PCRS	ILI	GLI	OR	PCM	HC/PI	Other (CLI)
Ranked Population Target Group	Ranked Population Target Group								
HIV+	HIV-								
White MSM	White MSM	***2***	***2***	***1***		***1***		***1***	
Black IDU	Black IDU	***2***	***2***	***1***		***1***		***1***	
Black MSM/IDU	Black MSM/IDU	***1***	***1***						
White MSM/IDU	White MSM/IDU	***1***	***1***						
Black Heterosexual	Black Heterosexual	***4***	***2***	***1***		***1***		***1***	
White IDU	White IDU	***2***	***2***	***1***		***1***		***1***	
White Heterosexual	White Heterosexual	***4***	***2***	***1***		***1***		***1***	
Hispanic IDU	Hispanic IDU	***1***	***1***						
Black MSM	Black MSM	***2***	***2***	***1***		***1***		***1***	
Hispanic Heterosexual	Hispanic Heterosexual	***1***	***1***						
Hispanic MSM/IDU	Hispanic MSM/IDU	***1***	***1***						
Hispanic MSM	Hispanic MSM	***1***	***1***						
Perinatal Transmission	Perinatal Transmission	***1***	***1***						
Emerging Risk Groups	Emerging Risk Groups								
Youth	Youth	***1***	***1***						
Transgender	Transgender	***1***	***1***						
Homeless	Homeless	***2***	***1***						
Asian Pacific Islander	Asian Pacific Islander	***1***	***1***						

COUNTY: WAYNE RANK: 2

		CTR	PCRS	ILI	GLI	OR	PCM	HC/PI	Other (CLI)
Ranked	Ranked								

Population Target Group	Population Target Group								
HIV+	HIV-								
White MSM	White MSM	***1***	***1***	***1***	***1***	***1***		***1***	
Black IDU	Black IDU	***1***	***1***	***1***					
Black MSM/IDU	Black MSM/IDU	***1***	***1***						
White MSM/IDU	White MSM/IDU	***1***	***1***						
Black Heterosexual	Black Heterosexual	***3***	***1***	***1***	***1***	***1***		***1***	
White IDU	White IDU	***1***	***1***	***2***	***1***	***1***		***1***	
White Heterosexual	White Heterosexual	***3***	***1***	***1***	***1***	***1***		***1***	
Hispanic IDU	Hispanic IDU	***1***	***1***						
Black MSM	Black MSM	***1***	***1***						
Hispanic Heterosexual	Hispanic Heterosexual	***1***	***1***	***1***	***1***	***1***		***1***	***1***
Hispanic MSM/IDU	Hispanic MSM/IDU	***1***	***1***						
Hispanic MSM	Hispanic MSM	***1***	***1***						
Perinatal Transmission	Perinatal Transmission	***1***	***1***	***1***	***1***	***1***		***1***	
Emerging Risk Groups	Emerging Risk Groups								
Youth	Youth	***1***	***1***	***2***	***2***	***2***		***2***	***1***
Transgender	Transgender	***1***	***1***						
Homeless	Homeless	***2***	***1***	***1***	***1***	***1***		***1***	
Asian Pacific Islander	Asian Pacific Islander	***1***	***1***						

COUNTY: HUNTINGDON RANK: 3

		CTR	PCRS	ILI	GLI	OR	PCM	HC/PI	Other (CLI)
Ranked Population Target Group	Ranked Population Target Group								
HIV+	HIV-								
White MSM	White MSM	***1***	***2***	***1***				***2***	
Black IDU	Black IDU	***1***	***2***	***1***				***2***	
Black MSM/IDU	Black MSM/IDU		***1***						
White MSM/IDU	White MSM/IDU		***1***						

Black Heterosexual	Black Heterosexual	***3***	***2***	***1***				***2***	
White IDU	White IDU	***1***	***2***	***1***				***2***	
White Heterosexual	White Heterosexual	***3***	***2***	***1***				***2***	
Hispanic IDU	Hispanic IDU		***1***					***1***	
Black MSM	Black MSM	***1***	***2***	***1***				***2***	
Hispanic Heterosexual	Hispanic Heterosexual		***1***						
Hispanic MSM/IDU	Hispanic MSM/IDU		***1***						
Hispanic MSM	Hispanic MSM		***1***					***1***	
Perinatal Transmission	Perinatal Transmission		***1***					***1***	
Emerging Risk Groups	Emerging Risk Groups								
Youth	Youth	***1***	***1***						
Transgender	Transgender		***1***						
Homeless	Homeless	***1***	***1***						
Asian Pacific Islander	Asian Pacific Islander		***1***						

COUNTY: DAUPHIN RANK: 4

		CTR	PCRS	ILI	GLI	OR	PCM	HC/PI	Other (CLI)
Ranked Population Target Group	Ranked Population Target Group								
HIV+	HIV-								
White MSM	White MSM	***3***	***3***	***4***	***2***	***3***		***2***	
Black IDU	Black IDU	***17***	***2***	***13***	***1***	***1***		***1***	
Black MSM/IDU	Black MSM/IDU	***1***	***1***	***2***	***1***	***2***			
White MSM/IDU	White MSM/IDU	***2***	***1***	***2***	***2***	***2***			
Black Heterosexual	Black Heterosexual	***17***	***3***	***13***	***2***	***1***	***1***	***1***	
White IDU	White IDU	***12***	***2***	***11***	***1***	***1***		***1***	
White Heterosexual	White Heterosexual	***14***	***2***	***11***	***2***	***1***	***1***	***1***	
Hispanic IDU	Hispanic IDU	***7***	***1***	***7***	***2***	***3***		***3***	
Black MSM	Black MSM	***4***	***3***	***3***	***1***	***2***		***1***	
Hispanic Heterosexual	Hispanic Heterosexual	***9***	***1***	***8***	***2***	***4***		***3***	

Hispanic MSM/IDU	Hispanic MSM/IDU	***1***	***1***	***1***	***1***	***1***			
Hispanic MSM	Hispanic MSM	***3***	***1***	***3***	***2***	***3***		***2***	
Perinatal Transmission	Perinatal Transmission	***7***	***1***	***5***	***3***	***2***	***1***		
Emerging Risk Groups	Emerging Risk Groups								
Youth	Youth	***4***	***1***	***3***	***1***	***1***	***1***		
Transgender	Transgender	***1***	***1***						
Homeless	Homeless	***3***	***1***	***1***					
Asian Pacific Islander	Asian Pacific Islander	***1***	***1***						

COUNTY: UNION RANK: 5

		CTR	PCRS	ILI	GLI	OR	PCM	HC/PI	Other (CLI)
Ranked Population Target Group	Ranked Population Target Group								
HIV+	HIV-								
White MSM	White MSM	***2***	***1***	***1***	***1***	***1***			
Black IDU	Black IDU	***2***	***2***	***1***	***1***	***1***			
Black MSM/IDU	Black MSM/IDU	***1***	***1***						
White MSM/IDU	White MSM/IDU	***1***	***1***						
Black Heterosexual	Black Heterosexual	***4***	***2***	***1***	***1***	***1***			
White IDU	White IDU	***2***	***2***	***2***	***2***	***2***			
White Heterosexual	White Heterosexual	***4***	***2***	***2***	***2***	***2***			
Hispanic IDU	Hispanic IDU	***1***	***1***						
Black MSM	Black MSM	***2***	***1***	***1***	***1***	***1***			
Hispanic Heterosexual	Hispanic Heterosexual	***1***	***1***						
Hispanic MSM/IDU	Hispanic MSM/IDU	***1***	***1***						
Hispanic MSM	Hispanic MSM	***1***	***1***						
Perinatal Transmission	Perinatal Transmission	***1***	***1***	***2***	***2***	***2***			
Emerging Risk Groups	Emerging Risk Groups								

Youth	Youth	***1***	***1***	***2***	***2***	***2***			
Transgender	Transgender	***1***	***1***						
Homeless	Homeless	***2***	***1***						
Asian Pacific Islander	Asian Pacific Islander	***1***	***1***						

COUNTY: LYCOMING RANK: 6

		CTR	PCRS	ILI	GLI	OR	PCM	HC/PI	Other (CLI)
Ranked Population Target Group	Ranked Population Target Group								
HIV+	HIV-								
White MSM	White MSM	***3***	***2***	***3***	***1***	***2***		***2***	
Black IDU	Black IDU	***2***	***2***	***3***	***2***	***1***		***1***	
Black MSM/IDU	Black MSM/IDU	***1***	***1***						
White MSM/IDU	White MSM/IDU	***1***	***1***						
Black Heterosexual	Black Heterosexual	***4***	***2***	***3***	***2***	***1***		***1***	
White IDU	White IDU	***3***	***3***	***4***	***2***	***2***		***2***	
White Heterosexual	White Heterosexual	***4***	***2***	***3***	***2***	***1***		***1***	
Hispanic IDU	Hispanic IDU	***1***	***1***						
Black MSM	Black MSM	***3***	***2***	***3***	***1***	***2***		***2***	
Hispanic Heterosexual	Hispanic Heterosexual	***1***	***1***						
Hispanic MSM/IDU	Hispanic MSM/IDU	***1***	***1***						
Hispanic MSM	Hispanic MSM	***1***	***1***						
Perinatal Transmission	Perinatal Transmission	***2***	***1***	***3***	***2***	***2***		***1***	
Emerging Risk Groups	Emerging Risk Groups								
Youth	Youth	***1***	***1***	***2***	***2***	***1***		***1***	
Transgender	Transgender	***1***	***1***						
Homeless	Homeless	***2***	***1***						
Asian Pacific Islander	Asian Pacific Islander	***1***	***1***						

COUNTY: CUMBERLAND RANK: 7

		CTR	PCRS	ILI	GLI	OR	PCM	HC/PI	Other (CLI)
Ranked Population Target Group	Ranked Population Target Group								
HIV+	HIV-								
White MSM	White MSM	***4***	***2***	***3***	***2***	***1***	***1***	***1***	
Black IDU	Black IDU	***3***	***2***	***2***	***1***		***1***	***1***	
Black MSM/IDU	Black MSM/IDU	***2***	***1***	***1***	***1***		***1***		
White MSM/IDU	White MSM/IDU	***2***	***1***	***2***	***2***	***1***	***1***		
Black Heterosexual	Black Heterosexual	***7***	***2***	***2***	***2***	***1***	***2***	***2***	
White IDU	White IDU	***3***	***2***	***3***	***2***	***1***	***1***	***1***	
White Heterosexual	White Heterosexual	***7***	***2***	***2***	***2***	***1***	***2***	***2***	
Hispanic IDU	Hispanic IDU	***2***	***1***	***2***	***2***	***1***	***1***	***1***	
Black MSM	Black MSM	***4***	***2***	***2***	***1***		***1***	***1***	
Hispanic Heterosexual	Hispanic Heterosexual	***2***	***1***	***2***	***2***	***1***	***1***	***1***	
Hispanic MSM/IDU	Hispanic MSM/IDU	***2***	***1***	***1***	***1***		***1***		
Hispanic MSM	Hispanic MSM	***2***	***1***	***1***	***1***		***1***		
Perinatal Transmission	Perinatal Transmission	***1***	***1***	***2***	***3***	***2***	***1***	***1***	
Emerging Risk Groups	Emerging Risk Groups								
Youth	Youth	***3***	***1***	***3***	***4***	***2***	***2***	***1***	
Transgender	Transgender	***2***	***1***	***1***	***1***		***1***		
Homeless	Homeless	***3***	***1***	***1***	***1***		***1***		
Asian Pacific Islander	Asian Pacific Islander	***2***	***1***	***1***	***1***		***1***		

COUNTY: LEHIGH RANK: 8

		CTR	PCRS	ILI	GLI	OR	PCM	HC/PI	Other (CLI)
Ranked Population Target Group	Ranked Population Target Group								
HIV+	HIV-								
White MSM	White MSM	***2***	***3***	***3***	***1***	***2***		***2***	

Black IDU	Black IDU	***3***	***3***	***5***	***3***	***3***		***3***	
Black MSM/IDU	Black MSM/IDU	***1***	***2***	***2***	***1***	***2***		***1***	
White MSM/IDU	White MSM/IDU	***1***	***2***	***2***	***1***	***2***		***1***	
Black Heterosexual	Black Heterosexual	***7***	***3***	***4***	***3***	***3***		***3***	
White IDU	White IDU	***4***	***3***	***5***	***3***	***3***		***3***	
White Heterosexual	White Heterosexual	***7***	***3***	***4***	***3***	***3***		***3***	
Hispanic IDU	Hispanic IDU	***5***	***2***	***6***	***4***	***4***		***2***	
Black MSM	Black MSM	***2***	***3***	***3***	***1***	***2***		***2***	
Hispanic Heterosexual	Hispanic Heterosexual	***7***	***2***	***5***	***4***	***4***		***2***	
Hispanic MSM/IDU	Hispanic MSM/IDU	***1***	***2***	***2***	***1***	***2***		***1***	
Hispanic MSM	Hispanic MSM	***2***	***3***	***4***	***2***	***3***		***2***	
Perinatal Transmission	Perinatal Transmission	***2***	***2***	***3***	***4***	***3***		***1***	
Emerging Risk Groups	Emerging Risk Groups								
Youth	Youth	***3***	***2***	***2***	***1***	***2***		***1***	
Transgender	Transgender	***3***	***2***	***2***	***1***	***2***		***1***	
Homeless	Homeless	***3***	***2***	***2***	***1***	***2***		***1***	
Asian Pacific Islander	Asian Pacific Islander	***3***	***2***	***2***	***1***	***2***		***1***	

COUNTY: DELAWARE RANK: 9

		CTR	PCRS	ILI	GLI	OR	PCM	HC/PI	Other (CLI)
Ranked Population Target Group	Ranked Population Target Group								
HIV+	HIV-								
White MSM	White MSM	***7***	***1***	***8***		***4***		***5***	
Black IDU	Black IDU	***8***	***1***	***9***	***1***	***3***		***6***	
Black MSM/IDU	Black MSM/IDU	***3***	***1***	***4***		***2***		***4***	
White MSM/IDU	White MSM/IDU	***3***	***1***	***3***		***2***		***4***	
Black Heterosexual	Black Heterosexual	***9***	***2***	***9***	***1***	***3***		***7***	
White IDU	White IDU	***6***	***2***	***9***		***4***		***7***	
White	White								

Heterosexual	Heterosexual	***8***	***2***	***8***		***3***		***6***	
Hispanic IDU	Hispanic IDU	***6***	***1***	***7***	***1***	***2***		***5***	
Black MSM	Black MSM	***5***	***2***	***7***	***1***	***3***		***5***	
Hispanic Heterosexual	Hispanic Heterosexual	***6***	***1***	***6***	***1***	***2***		***5***	
Hispanic MSM/IDU	Hispanic MSM/IDU	***3***	***1***	***4***		***2***		***4***	
Hispanic MSM	Hispanic MSM	***3***	***1***	***5***	***1***	***2***		***4***	
Perinatal Transmission	Perinatal Transmission	***3***	***1***	***4***		***2***		***4***	
Emerging Risk Groups	Emerging Risk Groups								
Youth	Youth		***1***						
Transgender	Transgender		***1***						
Homeless	Homeless	***1***	***1***						
Asian Pacific Islander	Asian Pacific Islander		***1***						

COUNTY: YORK RANK: 10

		CTR	PCRS	ILI	GLI	OR	PCM	HC/PI	Other (CLI)
Ranked Population Target Group	Ranked Population Target Group								
HIV+	HIV-								
White MSM	White MSM	***2***	***3***	***3***	***1***	***1***	***1***	***2***	
Black IDU	Black IDU	***3***	***3***	***4***	***2***	***1***	***1***	***3***	
Black MSM/IDU	Black MSM/IDU		***2***	***1***	***1***		***1***	***1***	
White MSM/IDU	White MSM/IDU		***2***	***1***	***1***		***1***	***1***	
Black Heterosexual	Black Heterosexual	***3***	***3***	***5***	***2***	***3***	***3***	***3***	
White IDU	White IDU	***3***	***3***	***4***	***2***	***1***	***1***	***3***	
White Heterosexual	White Heterosexual	***3***	***3***	***5***	***1***	***3***	***3***	***3***	
Hispanic IDU	Hispanic IDU	***1***	***2***	***2***	***1***	***1***	***1***	***2***	
Black MSM	Black MSM	***2***	***3***	***3***	***1***	***1***	***1***	***2***	
Hispanic Heterosexual	Hispanic Heterosexual	***2***	***2***	***4***	***1***	***3***	***3***	***3***	
Hispanic MSM/IDU	Hispanic MSM/IDU		***2***	***1***	***1***		***1***	***1***	
Hispanic MSM	Hispanic MSM	***1***	***2***	***2***	***1***	***1***	***1***	***2***	

Perinatal Transmission	Perinatal Transmission		***2***	***4***	***4***	***1***	***1***	***2***	***1***
Emerging Risk Groups	Emerging Risk Groups								
Youth	Youth	***1***	***2***	***2***	***2***	***2***	***1***	***2***	
Transgender	Transgender	***1***	***2***	***2***	***2***	***2***	***1***	***2***	
Homeless	Homeless	***1***	***2***	***2***	***2***	***2***	***1***	***2***	
Asian Pacific Islander	Asian Pacific Islander	***1***	***2***	***2***	***2***	***2***	***1***	***2***	

COUNTY: ALLEGHENY RANK: 11

		CTR	PCRS	ILI	GLI	OR	PCM	HC/PI	Other (CLI)
Ranked Population Target Group	Ranked Population Target Group								
HIV+	HIV-								
White MSM	White MSM	***12***	***4***	***7***	***6***	***6***		***8***	
Black IDU	Black IDU	***26***	***3***	***20***	***6***	***9***	***1***	***10***	
Black MSM/IDU	Black MSM/IDU	***7***	***3***	***2***	***2***	***2***		***4***	
White MSM/IDU	White MSM/IDU	***8***	***3***	***3***	***2***	***2***		***4***	
Black Heterosexual	Black Heterosexual	***26***	***9***	***22***	***10***	***10***		***12***	
White IDU	White IDU	***24***	***3***	***19***	***4***	***10***	***1***	***11***	
White Heterosexual	White Heterosexual	***29***	***3***	***20***	***20***	***6***		***5***	
Hispanic IDU	Hispanic IDU	***5***	***4***	***4***	***4***	***3***		***4***	
Black MSM	Black MSM	***12***	***4***	***7***	***7***	***5***		***8***	
Hispanic Heterosexual	Hispanic Heterosexual	***13***	***3***	***3***	***3***	***4***		***8***	
Hispanic MSM/IDU	Hispanic MSM/IDU	***8***	***3***	***1***	***1***	***1***		***3***	
Hispanic MSM	Hispanic MSM	***7***	***4***	***3***	***2***	***2***		***4***	
Perinatal Transmission	Perinatal Transmission	***12***	***5***	***3***	***2***	***3***		***6***	
Emerging Risk Groups	Emerging Risk Groups								
Youth	Youth	***16***	***3***	***6***	***1***	***3***		***4***	
Transgender	Transgender	***5***	***3***	***1***	***1***	***1***		***3***	
Homeless	Homeless	***11***	***3***	***1***	***1***	***3***		***7***	

Asian Pacific Islander	Asian Pacific Islander	***6***	***3***	***1***	***1***	***1***		***3***	

COUNTY: ERIE RANK: 12

		CTR	PCRS	ILI	GLI	OR	PCM	HC/PI	Other (CLI)
Ranked Population Target Group	Ranked Population Target Group								
HIV+	HIV-								
White MSM	White MSM	***6***	***3***	***5***	***2***	***1***		***2***	
Black IDU	Black IDU	***15***	***4***	***15***	***11***	***1***		***5***	
Black MSM/IDU	Black MSM/IDU	***1***	***1***						
White MSM/IDU	White MSM/IDU	***1***	***1***	***1***					
Black Heterosexual	Black Heterosexual	***20***	***4***	***19***	***11***	***5***		***11***	
White IDU	White IDU	***16***	***4***	***15***	***11***	***5***		***6***	
White Heterosexual	White Heterosexual	***18***	***3***	***17***	***2***	***3***		***9***	
Hispanic IDU	Hispanic IDU	***14***	***4***	***14***	***11***	***4***		***4***	
Black MSM	Black MSM	***5***	***2***	***4***	***2***	***1***		***4***	
Hispanic Heterosexual	Hispanic Heterosexual	***18***	***3***	***17***	***11***	***5***		***3***	
Hispanic MSM/IDU	Hispanic MSM/IDU	***1***	***1***	***1***					
Hispanic MSM	Hispanic MSM	***7***	***4***	***6***	***3***	***3***		***5***	
Perinatal Transmission	Perinatal Transmission	***1***	***1***	***1***	***1***	***1***			
Emerging Risk Groups	Emerging Risk Groups								
Youth	Youth	***5***	***2***	***6***	***2***	***2***		***4***	
Transgender	Transgender	***1***	***1***						
Homeless	Homeless	***3***	***1***	***1***					
Asian Pacific Islander	Asian Pacific Islander	***1***	***1***						

COUNTY: NORTHUMBERLAND RANK: 13

		CTR	PCRS	ILI	GLI	OR	PCM	HC/PI	Other (CLI)
Ranked	Ranked								

Population Target Group	Population Target Group								
HIV+	HIV-								
White MSM	White MSM	***2***	***2***	***2***	***1***	***1***		***1***	
Black IDU	Black IDU	***2***	***2***	***2***	***1***	***1***		***1***	
Black MSM/IDU	Black MSM/IDU	***1***	***1***						
White MSM/IDU	White MSM/IDU	***1***	***1***						
Black Heterosexual	Black Heterosexual	***4***	***2***	***2***	***1***	***1***		***1***	
White IDU	White IDU	***2***	***2***	***3***	***2***	***2***		***1***	
White Heterosexual	White Heterosexual	***4***	***2***	***3***	***2***	***2***		***1***	
Hispanic IDU	Hispanic IDU	***1***	***1***						
Black MSM	Black MSM	***2***	***2***	***1***					
Hispanic Heterosexual	Hispanic Heterosexual	***1***	***1***						
Hispanic MSM/IDU	Hispanic MSM/IDU	***1***	***1***						
Hispanic MSM	Hispanic MSM	***1***	***1***						
Perinatal Transmission	Perinatal Transmission	***1***	***1***	***1***	***1***				
Emerging Risk Groups	Emerging Risk Groups								
Youth	Youth	***1***	***1***	***2***	***2***	***1***			
Transgender	Transgender	***1***	***1***						
Homeless	Homeless	***1***	***1***						
Asian Pacific Islander	Asian Pacific Islander	***1***	***1***						

Service Gaps

As a result of the gap analysis process, the Intervention Subcommittee and the Needs Assessment Subcommittee identified and presented the following list of unmet prioritized interventions to the CPG:

1. Somerset

Interventions that are “effective” and “needed”, but an unmet need:

1. PCM:
    1. Black IDU
    2. White IDU
    3. Black MSM/IDU
    4. White MSM/IDU
    5. Hispanic IDU
    6. Hispanic MSM/IDU
    7. Youth

2. ILI:
   1. Black MSM/IDU
   2. White MSM/IDU
   3. Hispanic IDU
   4. Hispanic MSM
   5. Hispanic MSM/IDU
   6. Hispanic Heterosexual
   7. Youth

3. GLI:
   1. Black IDU
   2. White IDU
   3. Black MSM
   4. White MSM
   5. Hispanic IDU
   6. Hispanic MSM
   7. Black Heterosexual
   8. Hispanic Heterosexual
   9. Youth

4. OR:
   1. Black MSM/IDU
   2. White MSM/IDU
   3. Hispanic IDU
   4. Hispanic MSM
   5. Hispanic MSM/IDU
   6. Hispanic Heterosexual
   7. Youth

5. HC/PI:
   1. Hispanic MSM
   2. Hispanic Heterosexual
   3. Youth

6. Other:
   1. Black IDU
   2. White IDU
   3. Black MSM
   4. White MSM
   5. Black MSM/IDU
   6. White MSM/IDU
   7. Hispanic IDU
   8. Hispanic MSM
   9. Hispanic MSM/IDU
   10. Youth

2. Wayne

Interventions that are “effective” and “needed”, but an unmet need:

1. PCM:
   1. White IDU
   2. Hispanic IDU

3. Black IDU
4. White MSM/IDU
5. Hispanic MSM/IDU
6. Black MSM/IDU
7. Youth

2. ILI:
1. Hispanic IDU
2. Hispanic MSM
3. Black MSM
4. White MSM/IDU
5. Hispanic MSM/IDU
6. Black MSM/IDU

3. GLI:
1. Hispanic IDU
2. Black IDU
3. Hispanic MSM
4. Black MSM

4. OR:
1. Hispanic IDU
2. Black IDU
3. Hispanic MSM
4. Black MSM
5. White MSM/IDU
6. Hispanic MSM/IDU
7. Black MSM/IDU

5. HC/PI:
1. Hispanic MSM
2. Black MSM

6. Other:
1. White IDU
2. Hispanic IDU
3. Black IDU
4. White MSM
5. Hispanic MSM
6. Black MSM
7. White MSM/IDU
8. Hispanic MSM/IDU
9. Black MSM/IDU

3. Huntingdon

Interventions that are “effective” and “needed”, but an unmet need:

1. CTR:
1. Black MSM/IDU
2. White MSM/IDU
3. Hispanic IDU
4. Hispanic MSM
5. Hispanic Heterosexual

6. Hispanic MSM/IDU
7. Perinatal, Transgender, Asian/Pacific Islander

2. PCM:
1. Black IDU
2. White IDU
3. Black MSM/IDU
4. White MSM/IDU
5. Hispanic IDU
6. Hispanic MSM/IDU
7. Youth

3. ILI:
1. Black MSM/IDU
2. White MSM/IDU
3. Hispanic IDU
4. Hispanic MSM
5. Hispanic Heterosexual
6. Hispanic MSM/IDU
7. Youth

4. GLI:
1. Black IDU
2. White IDU
3. Black MSM
4. White MSM
5. Black Heterosexual
6. Hispanic IDU
7. Hispanic MSM
8. Hispanic Heterosexual
9. Youth

5. OR:
1. Black IDU
2. White IDU
3. Black MSM
4. White MSM
5. Black Heterosexual
6. White Heterosexual
7. Black MSM/IDU
8. White MSM/IDU
9. Hispanic IDU
10. Hispanic MSM
11. Hispanic Heterosexual
12. Hispanic MSM/IDU
13. Youth

6. HC/PI:
1. Youth

7. Other:
1. Black IDU

2. White IDU
3. Black MSM
4. White MSM
5. Black MSM/IDU
6. White MSM/IDU
7. Hispanic IDU
8. Hispanic MSM
9. Hispanic MSM/IDU
10. Youth

4. Dauphin

Interventions that are "effective" and "needed", but unmet needs:

1. PCM:
   1. Black IDU
   2. White IDU
   3. Black MSM/IDU
   4. White MSM/IDU
   5. Hispanic IDU
   6. Hispanic MSM/IDU

2. HC/PI:
   1. Youth

3. Other:
   1. Black IDU
   2. White IDU
   3. Black MSM
   4. White MSM
   5. Black MSM/IDU
   6. White MSM/IDU
   7. Hispanic MSM
   8. Hispanic IDU
   9. Hispanic MSM/IDU
   10. Youth

5. Union

Interventions that are "effective" and "needed", but are unmet needs:

1. PCM:
   1. Black IDU
   2. White IDU
   3. Black MSM/IDU
   4. White MSM/IDU
   5. Hispanic IDU
   6. Hispanic MSM/IDU
   7. Youth

2. ILI:
   1. Black MSM/IDU
   2. White MSM/IDU
   3. Hispanic MSM
   4. Hispanic MSM/IDU

5. Hispanic MSM
6. Hispanic Heterosexual

3. GLI:
1. Hispanic IDU
2. Hispanic MSM
3. Hispanic Heterosexual

4. OR:
1. Black MSM/IDU
2. White MSM/IDU
3. Hispanic IDU
4. Hispanic MSM/IDU
5. Hispanic MSM
6. Hispanic Heterosexual

5. HC/PI:
1. Black MSM
2. White MSM
3. Hispanic MSM
4. Black Heterosexual
5. Hispanic Heterosexual
6. Youth

6. Other:
1. Black IDU
2. White IDU
3. Black MSM/IDU
4. White MSM/IDU
5. Hispanic IDU
6. Hispanic MSM/IDU
7. Black MSM
8. White MSM
9. Hispanic MSM
10. Youth

6. Lycoming

Interventions that are "effective" and "needed, but are unmet needs:

1. PCM:
1. Black IDU
2. White IDU
3. Black MSM/IDU
4. White MSM/IDU
5. Hispanic IDU
6. Hispanic MSM/IDU
7. Youth

2. ILI:
1. Black MSM/IDU
2. White MSM/IDU
3. Hispanic IDU
4. Hispanic MSM

5. Hispanic Heterosexual
6. Hispanic MSM/IDU

3. GLI:
1. Hispanic IDU
2. Hispanic MSM
3. Hispanic Heterosexual

4. OR:
1. Black MSM/IDU
2. White MSM/IDU
3. Hispanic IDU
4. Hispanic MSM
5. Hispanic Heterosexual
6. Hispanic MSM/IDU

5. HC/PI:
1. Hispanic MSM
2. Hispanic Heterosexual

6. Other:
1. Black IDU
2. White IDU
3. Black MSM
4. White MSM
5. Black MSM/IDU
6. White MSM/IDU
7. Hispanic IDU
8. Hispanic MSM
9. Hispanic MSM/IDU
10. Youth

7. Cumberland

Interventions that are “effective” and “needed”, but are unmet needs:

1. OR:
1. Black IDU
2. Black MSM
3. Black MSM/IDU
4. Hispanic MSM
5. Hispanic MSM/IDU

2. HC/PI:
1. Hispanic MSM

3. Other:
1. Black IDU
2. White IDU
3. Black MSM
4. White MSM
5. Black MSM/IDU
6. White MSM/IDU
7. Hispanic IDU
8. Hispanic MSM

9. Hispanic MSM/IDU
10. Youth

8. Lehigh

Interventions that are "effective" and "needed", but are unmet needs:

1. PCM:
   1 Hispanic IDU
   2 White IDU
   3 Black IDU
   4 Hispanic MSM/IDU
   5 White MSM/IDU
   6 Black MSM/IDU
   7 Youth

2. Other (CLI):
   1 Hispanic IDU
   2 White IDU
   3 Hispanic MSM
   4 White MSM
   5 Black MSM
   6 Hispanic MSM/IDU
   7 White MSM/IDU
   8 Black MSM/IDU
   9 Youth

9. Delaware

Interventions that are recommended by the CDC, but are unmet needs:

1. CTR:
   Transgender
   Asian/Pacific Islander
   Youth

2. PCM:
   1. Black IDU
   2. White IDU
   3. Black MSM/IDU
   4. White MSM/IDU
   5. Hispanic IDU
   6. Hispanic MSM/IDU
   7. Youth

3. ILI:
   1. Youth

4. GLI:
   1. White IDU
   2. White MSM
   3. Youth

5. OR:
   1. Youth

6. HC/PI:
   1. Youth

7. Other:
   1. Black IDU
   2. White IDU
   3. Black MSM
   4. White MSM
   5. Black MSM/IDU
   6. White MSM/IDU
   7. Hispanic IDU
   8. Hispanic MSM
   9. Hispanic MSM/IDU
   10. Youth

10. York

Interventions that are "effective" and "needed", but are unmet needs:

1. CTR:
   1. White MSM/IDU
   2. Black MSM/IDU
   3. Hispanic MSM/IDU
   4. Perinatal

2. OR:
   1. White MSM/IDU
   2. Black MSM/IDU
   3. Hispanic MSM/IDU

3. Other (CLI):
   1. White IDU
   2. Black IDU
   3. White MSM
   4. Black MSM
   5. Hispanic IDU
   6. Hispanic MSM
   7. White MSM/IDU
   8. Black MSM/IDU
   9. Hispanic MSM/IDU
   10. Youth

11. Allegheny

Interventions that are "effective" and "needed", but are unmet needs:

1. PCM:
   1. Black MSM/IDU
   2. White MSM/IDU
   3. Hispanic IDU
   4. Hispanic MSM/IDU

2. Other:
   1. Black MSM
   2. White MSM
   3. Black IDU
   4. White IDU

5. Black MSM/IDU
6. White MSM/IDU
7. Hispanic MSM
8. Hispanic IDU
9. Hispanic MSM/IDU
10. Youth

12. Erie

Interventions that are "effective" and "needed", but are unmet needs:

1. PCM:
   1. White IDU
   2. Black IDU
   3. Hispanic IDU
   4. White MSM/IDU
   5. Black MSM/IDU
   6. Hispanic MSM/IDU
   7. Youth

2. ILI:
   1. Black MSM/IDU

3. OR:
   1. White MSM/IDU
   2. Black MSM/IDU
   3. Hispanic MSM/IDU

4. Other:
   1. White MSM
   2. Black MSM
   3. White IDU
   4. Black IDU
   5. Hispanic MSM
   6. Hispanic IDU
   7. White MSM/IDU
   8. Black MSM/IDU
   9. Hispanic MSM/IDU
   10. Youth

13. Northumberland

Interventions that are "effective" and "needed", but are unmet needs:

1. PCM:
   1. Black IDU
   2. White IDU
   3. Black MSM/IDU
   4. White MSM/IDU
   5. Hispanic IDU
   6. Hispanic MSM/IDU
   7. Youth

2. ILI:
   1. Black MSM/IDU

2. White MSM/IDU
3. Hispanic IDU
4. Hispanic MSM
5. Hispanic MSM/IDU
6. Hispanic Heterosexual

3. GLI:
1. Hispanic IDU
2. Hispanic MSM
3. Hispanic Heterosexual

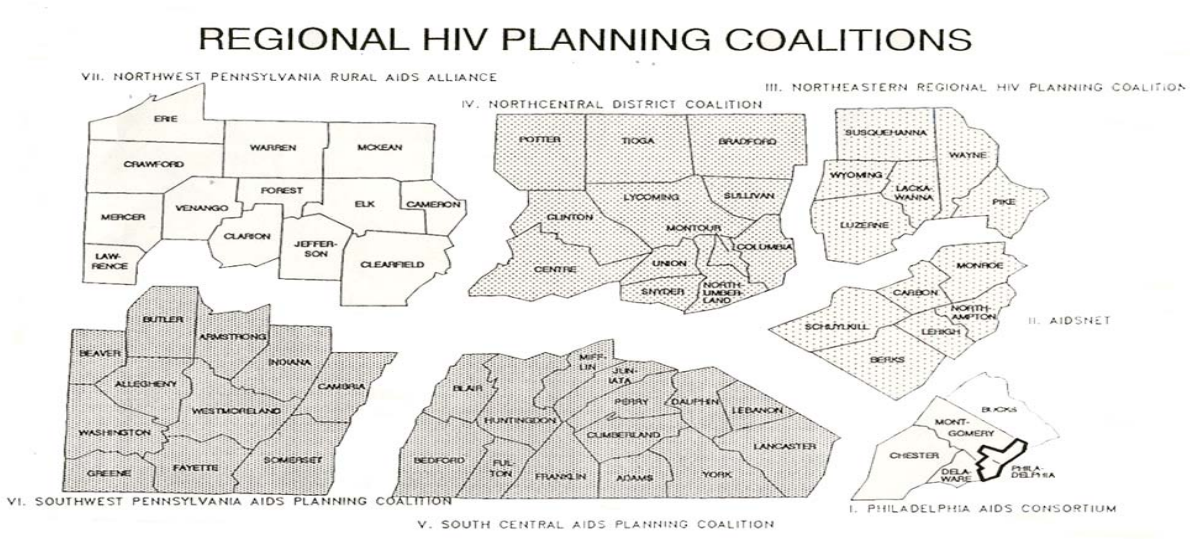
4. OR:
1. Black MSM
2. Black MSM/IDU
3. White MSM/IDU
4. Hispanic IDU
5. Hispanic MSM
6. Hispanic MSM/IDU
7. Hispanic Heterosexual

5. HC/PI:
1. Hispanic MSM
2. Hispanic Heterosexual
3. Youth

6. Other:
1. Black IDU
2. White IDU
3. Black MSM
4. White MSM
5. Black MSM/IDU
6. White MSM/IDU
7. Hispanic IDU
8. Hispanic MSM
9. Hispanic MSM/IDU
10. Youth

Coalition Gap Analyses

In addition to the CSA process completed by the CPG, the Ryan White HIV/AIDS Regional Planning Coalitions completed their own gap analyses. This information was provided to the CPG and the results are noted below.



North East Pennsylvania (NE)

- NE gap analysis has traditionally resulted from information obtained directly from clients of their existing system, from the case managers who serve them, and from the analysis of primary and secondary data.

- Over the years, NE has gathered a considerable amount of information which has directed their work in both care and prevention interventions. This is the method used to recognize infection rates were increasing among women and racial/ethnic minorities and that funds needed to address those populations.

  Resource Inventory:
  - Fiscal Agent staff recently began the process of updating the regional Resource Directory of HIV/AIDS services. With regional representation on the Coalition, NE believes that they know all HIV-related service providers. They have also expanded their newsletter distribution to include OB-GYN Physicians in all six counties. This should help with Coalition awareness and referrals.
  - There are several formalized methods available to determine the number of people not in care. NE's objective is to review these and other methods so that one could be adopted for regional and statewide use.

- Testing Partners – As a result of NE's process, they know that clients can be effective in having others with risk tested. For example, people associate with other who share their activities and behaviors. If an infected IDU can bring in a friend or associate for testing, we believe that there is a greater likelihood that the second person will also test positive based on their pattern of risky behaviors. NE is prepared to offer stipends for these referrals. This could lead to early intervention for those infected.
- Secondary Prevention – Prevention specialists have encouraged NE to develop a better way to provide prevention education to those already infected and in care. NE recognizes the importance of secondary prevention through the use of clients to help bring in others for testing and have them enroll in care. The case management outreach position will be refined to include this initiative, which will blend nicely with the testing and referral mechanism.
- Home Maintenance and Repair – From the statewide client satisfaction survey NE learned of the unmet need of home maintenance and repair services. Fiscal agent staff prepared a grant application to seek outside funding (for materials) using volunteers for labor to meet this need.

AIDSNET

Process:

The gap analysis project was funded by the PA-DOH in March 2002 as a demonstration of a Gap analysis methodology that uses secondary data to identify and address the HIV prevention and service gaps within the AIDSNET geographic region. Unique to this project was the use of geographic mapping software to demonstrate geographic location of HIV risk and HIV consumers, and potential consumers. Unique to this study was the attempt to map variables by zip code and zip code extension. While some mapping conducted by zip code was useful, mapping by zip code extensions could provide very specific information useful in AIDS service and prevention/education efforts.

Preliminary Findings:

- Regional data from the PA DOH: Regional Incidence of AIDS Diagnoses
  - Lehigh County witnessed the fourth highest AIDS incidence rate in the state during the 1996-1999 period with a rate of 17.68 x 100,000 residents. Furthermore, Schuylkill County had the greatest one-year increase (2.4X) in AIDS incidence out of all Pennsylvania counties with data reported in the December 2000 and 2001 Surveillance Reports. AIDS incidence has also increased within Carbon and Monroe Counties. AIDS incidence has remained stable with Berks and Northampton Counties

- Modes of Transmission Data:
  - Lehigh and Berks Counties also had the highest number of new AIDS cases due to heterosexual sex as mode of transmission. Lehigh, Northampton and Monroe had the highest number of new AIDS cases due to "undetermined" mode of transmission.
  - When looking at the percentage of AIDS cases within each County by mode of HIV transmission data (years 1998-2000) for the AIDSNET region, the range of percentage of MSM mode of transmission is fairly equal across all counties but is highest within Carbon and Monroe Counties and lowest within Northampton County.
  - The percentage of IDU mode of transmission is greatest within Schuylkill and Berks Counties and lowest within Carbon and Monroe Counties.
  - The percentage of heterosexual sex mode of transmission is greatest within Monroe and Northampton Counties and lowest within Carbon County.
  - When looking at the total number of consumers living with AIDS, Lehigh and Berks Counties have the highest number of residents living with AIDS, with Carbon County having the lowest.

Findings and Recommendations:

Berks County

- It is suggested service agencies examine the need to pursue enrolling more HIV consumers within zip code 19602.
- Prevention efforts need to target the IDU populations, at risk heterosexual and MSM populations in Berks.

Carbon County

- Prevention efforts need to target the at risk heterosexual and MSM populations in Carbon.

Lehigh County

- It is suggested service agencies examine the need to pursue enrolling more HIV consumers within zip code 18101.
- Prevention efforts need to target the IDU; at risk heterosexual and MSM populations in Lehigh.

- Efforts are needed to determine the etiology of "undetermined" modes of AIDS transmission and develop an intervention plan to address this problem.
- Efforts are needed to determine strategies for improving the large number of uninsured consumers in Lehigh County (i.e., determine the plausibility of enrolling these residents into Medicaid, etc.).
- It is suggested that future prevention efforts focus on residents within zip codes 18102, 18103, and 18015 to collaborate with organizations in their efforts to reduce the incidence of STDs.

Monroe County

- It is suggested that efforts be made to identify the increasing number of residents with AIDS residing in zip code 18466 ("west-end") in order to engage them into case management services. Efforts also need to be made to enroll HIV consumers residing in zip code 18360. Furthermore, HIV prevention efforts need to be made within these zip codes.
- Prevention efforts need to target the at-risk MSM populations in Monroe;
- Efforts are needed to determine the etiology of "undetermined" modes of AIDS transmission and develop an intervention plan to address this problem; and
- It is suggested that future prevention efforts focus on residents within zip code 18360, and collaborate with organizations in their efforts to reduce the incidence of STDs.

Northampton County

- Given these data, it is suggested service agencies examine the need to pursue enrolling more HIV consumers within zip code 18017.
- Efforts are needed to determine the etiology of "undetermined" modes of AIDS transmission and develop an intervention plan to address this problem.
- Prevention efforts need to target IDU population in Northampton.
- Efforts are needed to determine strategies for improving the large number of uninsured consumers in Northampton County
- It is suggested that future prevention efforts focus on residents within zip code 18015, 18045, and collaborate with organizations in their efforts to reduce the incidence of STDs.

Schuykill County

- Given these data, it is suggested service agencies examine the need to pursue enrolling more consumers within zip codes 17980 and 17931.
- Prevention efforts need to target the IDU populations in Schuykill.
- It is suggested that continued efforts be made to provide primary, secondary and tertiary prevention for these correctional institutions.

The Northwest Pennsylvania Rural AIDS Coalition

Process:

- Survey of consumers was performed across six of the seven regions of the state to determine the adequacy of case management surveys.

- A review of the previous CRSSPs to determine gaps was also performed.
- Survey of case managers was conducted to determine consumer needs, and whether those needs were met.
- The continuum of care was done throughout the region, and identification of dental providers was a primary focus.
- A review of all research projects undertaken by the Alliance/Coalition was also performed.
- HIV test data was requested from Clearfield County area hospitals and the county health department.
- Statistics from the Department of Health epidemiological surveys and health profiles were included.
- The informational sources consulted were resource directories, previous Coalition Regional Services and Strategic Plans (CRSSP), Statewide Coordinated Statement of Need (SCSN), past surveys and medical records. Although consumers and providers were consulted in many of the surveys their involvement in the in-depth interview process of Clearfield County was extensive.
- The number of drug and alcohol and mental health providers interviewed was very small, despite numerous efforts to obtain feedback from several different sources. NW was unable to identify or access representatives from substance abuse support groups.
- A regional resource inventory was consulted and the most recent Clearfield County, published in 1999 with an update in April 2002, was utilized to identify service providers.

Findings:

- Case managers reviewed files of all consumers to report detailed data on met and unmet needs. The needs that were most consistently met were as follows:
- Assistance in applying for Medicare and Special Pharmaceutical Benefit Program
- Assistance in applying for cash assistance and food stamps
- Referrals for home delivered meals
- Obtaining dietary supplements/special dietary needs
- Counseling about birth control/safer sex
- Help in finding primary care physicians/pharmacists
- The needs that were most frequently unmet:
- Home health care
- Support groups for consumer or family members
- Body index fat assessment
- Legal advice
- Consumer credit counseling
- Psychological counseling/relationship counseling
- Buddy support or care team support
- Dental services
- Additional unmet needs were noted, unique to Erie County, they included:
    - Homemaker services
    - Legal advice

- Employment opportunities/schooling
- 90% of transportation requests were met in Erie County, a sharp variance from the remainder of the region
- The Needs Assessment across counties as reported that financial assistance; food vouchers, dental care and transportation are largely unmet needs.

- A catholic volunteer organization operating from Bethany Center provides two free health clinics and operates both shelters in the county. They also provided transportation to medical appointments through their volunteer network. Presumably, these services were developed to fill a pressing need within the county. Although there are many dentists in Clearfield County, not one of the 16 accepts Medical Assistance for dental care. During an interview with a family planning clinic, it was learned that they had gone without condoms for over two months.
- Transportation continues to be extremely limited in the county and is significant barrier to access in healthcare. Although the area transportation authority operates within the region, it only serves the larger towns on a limited basis. Consumers requiring specialized care must travel a significant distance, usually over an hour from Clearfield County.
- Many different clinicians are providing care to a very limited number of HIV/AIDS patients. The availability of expert consultation to these clinicians is unknown.

The North Central District AIDS Coalition

Process:

The NCDAC uses various methodologies to identify gaps in service. These activities are conducted as part of needs assessment activities utilized surveys, focus groups and key informant interviews. These were conducted with a variety of social service, medical and dental providers as well as with targeted consumers and caregivers. In addition, the Consumer Satisfaction Survey also listed services and asked consumers to rate them according to need and awareness.

Resource Inventory

- Great care was taken in the 2000 needs assessment to determine which services, were in fact, needed by persons living with HIV in the region as opposed to those services that were available but not used. The reason for non-use being clients and other providers were not aware of them, or logistically it was impossible to utilize them.

- The provider's survey listed approximately 58 different services that could be utilized by someone living with HIV. Respondents were asked to list whether the services were "available and adequate", "available but not adequate", "not available" or respondents could indicate that they were not sure.

Services Not Available or Not Adequate at Available Levels

Pet care assistance	20%
Relocation assistance	20%
Money for OTC meds	22%

Money for burials	27%
Soup kitchens	28%
Furniture	28%
HIV counseling and testing	28%
Transportation, non-MA	30%
Adult day care	30%
Mental health, inpatient	32%
Mental health, outpatient	36%
Dental care	48%

The consumer satisfaction survey conducted in 2002 also had a resource inventory that included a list of 29 components and consumers were asked to also respond to availability of services. NCDAC was able to determine that lack of knowledge about services was not a large issue.

Findings:
Based on these findings, NCDAC conducted a number of activities designed to, if not eliminate the gaps, bridge them. Those activities were as follows:

- Dental care – NCDAC took over the administration of all oral health care funds. This assures that funds for dental care are available to the part of the region where they are needed and not in the sub-grants where they could be tied up and not utilized. This also reduced the administrative cost for the use of these funds.
- Inpatient and outpatient mental health care – NCDAC recruited several board members representing the Mental Health community to provide input into solution to this issue. NCDAC also organized a conducted a Mental Health Summit where providers from both the Mental Health and HIV field were brought together for cross training. This has helped tremendously in both referral process and the treatment area where we now know that people are getting care from more HIV knowledgeable providers.
- Adult Day Care – NCDAC has seen very little use or need for this service. When assistance is needed for the care of someone with HIV it is usually a hospice or home health issue and has surpassed the need for Adult Day Care. However, a small amount of funds are budgeted for this service should the need arise.
- Transportation – transportation appears to be the biggest issue facing providers of any kind of service in this rural region. NCDAC has an ad-hoc committee of the board of directors focusing on this issue and developing a plan. This first step in the plan was to survey agencies and clients and determine more specific transportation needs. More service recipients are aware that assistance is available for transportation, but many agencies are opting not to have staff transporting clients for liability reasons. This seriously impacts transportation services. While all counties have Medicaid funded transportation systems, they often do not run on a schedule that is useful for many clients. Many systems do not cross county lines and this

limits the use of these services especially to access HIV specialty care. Many clients must travel one to three hours to get to an HIV specialist in another county. Allocating additional funding for transportation is not the issue as much as finding the means of transportation.

The Southwestern Pennsylvania AIDS Planning Coalition (SWPAPC)

Process:

Identification of resources available to individuals living with HIV/AIDS in the southwest region was accomplished through relationships afforded by the diverse membership of the SWPAPC. The coalition is comprised of individual members who are associated with all Ryan White Titles as well as individuals who work in behavioral health agencies, housing service agencies, other human services agencies, Universities, medical providers, consumers and other interested individuals.

Information on the resources came from these persons. However, this gap analysis is limited by the inability to access quantitatively, the resources in non-HIV/AIDS systems such as mental health and drug and alcohol services. These AIDS related organizations are not able to separate out from their budgets; the resources available for HIV/AIDS related services within their systems. The gap analysis is also severely limited by the inability to estimate the resources needed for individuals who are HIV positive and not in care.

Findings:

The southwest region appears to have diverse funding for HIV services although there are many gaps in the resources for HIV/AIDS related services such as mental health and drug and alcohol services. Despite this encouraging picture, the region is aware that the distribution of services across the 11 counties remains uneven. Moreover, certain population groups are underrepresented in service especially minorities and women. The region will continue to address issues of barriers to service.

Previous Plan and Current Impact

The region's short and long term goals and objectives for 2002/2003 were:

- Assessing the needs of hidden population (Hispanic and elderly)
- Increasing access for individuals who are HIV positive and not in care
- Increasing HIV/AIDS prevention and care services in rural communities
- Increasing access of minority populations to HIV/AIDS services with inclusion of the Black churches in this effort
- Collaborate with behavioral health service providers in the care of dual diagnosed individuals, including emerging health issues of the substance abusing population, such as Hepatitis C infections.
- Increase technical assistance to smaller organizations with emphasis on evaluation
- Market the coalition to increase its visibility in the region

Progress was made in outreach to the African American community, especially through the African American churches. Partnership was established with 4 new churches and the capacity of 5 minority and rural providers for HIV/AIDS services were increased. Technical assistance, training, increased networking and opportunities for peer review assisted in the improvements. The Coalition formed a partnership with a radio station for the 2002 National HIV Testing Day that helped to improve the visibility slightly.

Profile of Provider Capacity and Capability:

- A few established agencies in the region appear to have the capacity and capability for HIV service provision. The experiences of these agencies were acquired in service to populations first impacted by the HIV/AIDS, that is White non-Hispanic MSM. The face of the disease has changed and even these agencies must now develop the capacity to assist the emerging HIV/AIDS population. This will involve gaining the trust of the emerging populations through respect for the client and by offering culturally competent services. Additionally, expansion of HIV/AIDS services to rural and minority communities through faith based and other smaller community based organizations means that these agencies will need assistance to develop the capacity and capability to provide these services.

Barrier to Access:

- The region is aware that location of services may constitute a barrier to accessing HIV services. There is a dearth of service points in rural communities and in minority communities. Also, culturally incompetent services may pose a barrier. The Coalition has supported efforts to extent HIV services to the Sickle Cell Society clinic in the African American community of Pittsburgh. Through the SAMHSA planning and capacity building grant, the Coalition has assessed the needs for substance abuse and HIV prevention services in African American churches in Allegheny County. These churches will help improve access.

Barriers to Provision of Service:

- Restrictions in the kinds of services that can be funded sometimes poses barriers. However, alternative funding could be explored. Small agencies especially newer minority agencies are not funded at the level that they can attract and pay experienced staff. While the region is committed to building capacity and to training these staff, invariably, we are training them for bigger agencies that can offer better salaries, full time employment and staff benefits. Staff turnover is a critical barrier to service provision.

AIDS Planning Coalition of South Central Pennsylvania and Family Health Council of Central Pennsylvania

Process:

To identify existing and potential gap three primary foci need to be analyzed

- The target population, namely persons with HIV/AIDS
- Existing resources

- Current data and/or gaps/needs

Findings:
Identified Gaps in Services per County

Adams

- Limited social service network/resources

Bedford

- Recruitment and retention of an infectious disease medical specialist
- Lack of prevention/education services
- Lack of anonymous testing

Blair

- Lack of prevention education services

Cumberland

- Does the overall population size merit their own ASO or increased funding into area?

Dauphin

- Significant population reports out of pocket medical expanses; many living on disability yet their rent requires more than half of their entire monthly income
- Consumers wish to stay at home versus going to a place for HIV living arrangements

Franklin

- Keystone Health Center partner with or recruit infectious disease specialist
- Expand prevention/education services

Fulton

- Keystone Health Center continue to provide services
- Expand prevention/education services to human service providers/clients

Huntingdon

- AIP integrate efforts with existing AIDS Task Force
- Lack of prevention/education efforts
- Lack of HIV medical specialist in the area

Juniata

- Growing substance abuse population

Mifflin

- Significant drug using population

Lancaster

- Out of pocket medical expenses
- Spiritual needs of long term survivors are not being met
- Further benefits impact study for consumers returning to work
- Study effects of secondary prevention education
- Lack of effective collaboration among HIV providers
- Zero prevalence tracking

Lebanon

- Significant Hispanic population

Perry

- Rising surrogate marker data
- Very limited social/network/resources

York

- Lack of outreach/education/prevention efforts in African American communities
- Lack of church involvement
- Lack of medical care/social services for African Americans
- Use of African American community based organization to provide HIV services
- More culturally based provider training is need

Findings:

- Dental care services throughout the region need to be increased
    - Medicaid reimbursement rate needs to be raised to recruit new dental service providers to enroll in the Medicaid dental program
    - Dental providers need to be educated further about dental management/social interaction with the HIV positive population
- Medical providers who are knowledgeable in HIV medical management need to be recruited throughout the region, and special emphasis must be put on the western/smaller counties in the region.
    - Medical providers need more training in cultural competency
- More financial assistance through social service agencies is needed
    - Greater flexibility around what financial assistance can cover must be explored
    - More housing/housing related costs need to be supplemented
- Transportation assistance needs to increase
    - Transportation through mass transit must become more accessible and easier to use
    - People in rural areas need services closer to their place of residence
    - Broken down automobiles owned by consumers can overwhelm personal finances
- Increase in substance abuse treatment admissions is needed throughout the entire region.

Pennsylvania's Statewide Coordinated Statement of Need: Critical Gaps in Care and Treatment

All 23 gaps in care and treatment included in the Department of Health document submitted to HRSA in 2001 are gaps that have been identified by consumers, providers and other community players within the south central Pennsylvania region. Following is a list of these gaps:

- Serious health professional shortages, particularly clinicians skilled in the care and treatment of HIV exist statewide
- Medicaid fails to provide early intervention and treatment of HIV despite current clinical best practices.
- Some private insurance carriers place caps and limitations reducing access to treatment and medications
- Insufficient slots for drug and alcohol treatment
- Funding for long term care services for persons with HIV is limited
- Funding for a continuum of housing including personal care and transitional housing is extremely limited. Care and supportive services in these venues are non-reimbursable from medical assistance
- Increased need for regular, on-going clinical education for primary care providers, to maintain a minimum standard of care and current "best practices".
- Institutional barriers between correctional institutions and public health services
- Linkages and training in medically under-served and rural areas
- Lack of uniform, statewide data across titles
- Need for increased case finding and provision of care and prevention services to hard to reach populations (substance users, migrant farm workers, documented and undocumented immigrants, recently incarcerated, disabled, youth, sex workers, transgendered, homeless, SPMI)
- Large number of Pennsylvanians with HIV remain without pharmaceuticals and/or clinical medical coverage
- Continued lack of availability of dental services
- Consumers require access to the most recent information along the prevention care continuum
- Wrap around supportive services (child and adult day care, respite care, home and community based care) are virtually unfunded and difficult to access
- Sterile syringes and other harm reduction protocols remain very difficult to access
- Individuals, especially in rural regions, find public transportation to be unavailable or inaccessible to HIV related care facilities and services
- Many people living with HIV remain nutritionally under-served
- Mental health and clinical needs are often confused, resulting in denial of care
- The needs of individuals living with HIV often extend greatly beyond issues stemming from their HIV infection
- Lack of adequate insurance payment in both and private health systems
- Culturally and linguistically competent provision of care remains spotty, and in many cases, inadequate
- Diagnosis and successful treatment of other co-morbidity factors (heart disease, diabetes, cancer, depression, etc.)

The Philadelphia AIDS Consortium (TPAC)

No Gap Analysis for October 2001. PPP did not receive CRSSP for October 2002.

Positives:
The Focus Groups are underway and expected to be completed in the summer of 2003. Group facilitators and recorders have been identified. Recruiters have begun to assess possible participants and are expected to schedule groups to occur in July and possibly August.

Upon completion of the groups, three members of the research team will independently listen to the tape recordings to identify relevant themes and codes. These individuals will then meet to compare their analyses to evaluate reliability, to identify areas of disagreement, and to reach consensus concerning themes. The Principle Investigator will then listen to all focus group tape recordings and will use the agreed upon themes and codes to analyze this data using a matrix-display analytic process.

Initial planning has begun for the Provider and Consumer Surveys. The provider conferences are expected to occur in October of 2003, at which time the Provider Survey will be administered. It is expected that the Consumer Survey will be administered in January of 2004.

As they become available, all results and analysis will be presented to the Needs Assessment Subcommittee. It is expected that sometime afterward the Subcommittee will report to the Planning Committee who will make recommendations to the Bureau of HIV/AIDS.

6. The HIV counseling and testing survey will be completed during mid-2003.
    - Explain how the EPI profile describes the impact of the HIV epidemic in the jurisdiction.
    - Explain how did the EPI profile provided the foundation for prioritizing target populations.
    - Explain the target population prioritization process and how it focused on a set of target populations (identified through the epidemiological profile and community services assessment) that require prevention efforts due to high infection rates and high incidence of risky behavior.
    - Describe the CSA process (Needs Assessment/Resource Inventory/Gap Analysis) and how this process identified: (1) the needs of populations at risk for HIV infection (Needs assessment); (2) the prevention activities/interventions implemented to address these needs/"met needs" (Resource inventory); and, "unmet needs"/service gaps (Gap analysis).
    - Describe how the EPI profile, priority population and CSA process identified a set of science-based prevention activities/interventions (based on intervention effectiveness and cultural/ethnic appropriateness) necessary to reduce transmission in prioritized target populations.

Linkage between the Plan and Interventions Funded through the Application:

The following are lists of services supported by 2004 CDC funding: (additional services supported by state and other funding sources are listed in the Department's Application)

Given the extensive list of unmet needs and the lack of additional CDC funding, the CPG supports the continued funding of the following existing interventions. All of these interventions were funded and implemented based upon previous CPG recommendations. The following lists, and the lists of state-supported and other-supported interventions was provided to the CPG during the August meeting and thoroughly reviewed. Copies of the lists of services were also distributed to all CPG members through e-mail.

The only funding set-aside for a "new" intervention is the implementation of a prevention case management project for HIV seropositive individuals, through the University of Pittsburgh contract.

CDC-Supported Providers of CTR Services:

Provider	**Primary Target Population** **Men who have sex with men (MSM)** **Men who have sex with men and are injection drug users (MSM/IDU)** **Injection drug user (IDU)** **Heterosexual** **Mother with/at risk for HIV** General Public	**Geographic Service Area**
12 HIV Prevention Field Staff		
Southeastern Health District E. Davis J. Foster N. Martinez-King	MSM, IDU, MSM/IDU, Heterosexual, partners of HIV+	Delaware, Berks, Schuylkill, Chester, Montgomery, Bucks
	MSM (prisoner/detained), IDU (prisoner/detained), Heterosexual (prisoner/detained, non-IDU abuse), partners of HIV+	Delaware Co. Prison Berks Co. Prison Chester Co. Prison
Northeastern Health District C. Yozviak C. Zaleppa	MSM, IDU, MSM/IDU, Heterosexual, partners of HIV+	Luzerne, Carbon, Monroe, Northampton, Lehigh, Lackawanna, Wyoming, Susquehanna, Pike, Wayne
	MSM (prisoner/detained), IDU (prisoner/detained), Heterosexual	Luzerne Co. Prison

	(prisoner/detained, alcohol/non-IDU abuse), partners of HIV+	Carbon Co. Prison Monroe Co. Prison Northampton Co. Prison Lehigh Co. Prison Lackawanna Co. Prison Wyoming Co. Prison Pike Co. Prison
North Central Health District D. Eberle Vacant	MSM, IDU, MSM/IDU, Heterosexual, partners of HIV+	Bradford, Clinton, Centre, Columbia, Northumberland, Montour, Lycoming, Potter, Snyder, Sullivan, Tioga, Union
	MSM (prisoner/detained), IDU (prisoner/detained), Heterosexual (prisoner/detained, non-IDU abuse), partners of HIV+	Bradford Co. Prison Clinton Co. Prison Centre Co. Prison Columbia Co. Prison Northumberland Co. Prison Montour Co. Prison Lycoming Co. Prison Potter Co. Prison Snyder Co. Prison Sullivan Co. Prison Tioga Co. Prison Union Co. Prison
South Central Health District N. Cabasquin S. Dussinger	MSM, IDU, MSM/IDU, Heterosexual, partners of HIV+	Adams, Bedford, Blair, Cumberland, Dauphin, Franklin, Fulton, Huntington, Juniata, Lebanon, Mifflin, Perry, York
	MSM (prisoner/detained), IDU (prisoner/detained), Heterosexual (prisoner/detained, non-IDU abuse), partners of HIV+	Adams Co. Prison Bedford Co. Prison Blair Co. Prison Cumberland Co. Prison Dauphin Co. Prison Franklin Co. Prison Fulton Co. Prison Huntington Co. Prison Juniata Co. Prison Lebanon Co. Prison Mifflin Co. Prison Perry Co. Prison
Southwestern Health District B. Hoza R. Fuhrman	MSM, IDU, MSM/IDU, Heterosexual, partners of HIV+	Indiana, Cambria, Somerset, Fayette, Beaver, Butler, Armstrong, Washington, Westmoreland, Green, Allegheny
	MSM (prisoner/detained), IDU (prisoner/detained), Heterosexual (prisoner/detained, non-IDU abuse), partners of HIV+	Indiana Co. Prison Cambria Co. Prison Somerset Co. Prison Fayette Co. Prison Butler Co. Prison

Northwestern Health District A. McCowien	MSM, IDU, MSM/IDU, Heterosexual, partners of HIV+ MSM (prisoner/detained), IDU (prisoner/detained), Heterosexual (prisoner/detained, non-IDU abuse), partners of HIV+	Armstrong Co. Prison Washington Co. Prison Westmoreland Co. Prison Cameron, Clearfield, Clarion, Crawford, Elk, Forest, Jefferson, Lawrence, McKean, Mercer, Venango, Warren, Erie Clearfield Co. Prison Clarion Co. Prison Crawford Co. Prison Elk Co. Prison Jefferson Co. Prison Lawrence Co. Prison Mercer Co. Prison Venango Co. Prison Warren Co. Prison York Co. Prison
County/Municipal Health Departments:		
Allegheny County Health Department	MSM, IDU, MSM/IDU, Heterosexual, Partners of HIV+ MSM (prisoner/detained), IDU (prisoner/detained), Heterosexual (prisoner/detained, non-IDU abuse), partners of HIV+	Allegheny County Allegheny County Prison
Allentown City Health Bureau	MSM, IDU, MSM/IDU, Heterosexual, Partners of HIV+	Allentown City
Bethlehem City Health Bureau	MSM, IDU, MSM/IDU, Heterosexual, Partners of HIV+	Bethlehem City & parts of Northampton County
Bucks County Health Department	MSM, IDU, MSM/IDU, Heterosexual, Partners of HIV+ MSM (prisoner/detained), IDU (prisoner/detained), Heterosexual (prisoner/detained, non-IDU abuse), partners of HIV+ MSM, IDU, MSM/IDU, Heterosexual, Partners of HIV+	Bucks County Bucks Co. Prison
Chester County Health Department	MSM, IDU, MSM/IDU, Heterosexual, Partners of HIV+	Chester County
Erie County Health Department	MSM (prisoner/detained), IDU (prisoner/detained), Heterosexual (prisoner/detained, non-IDU abuse),	

	partners of HIV+	Erie County
	MSM, IDU, MSM/IDU, Heterosexual, Partners of HIV+	
	MSM (prisoner/detained), IDU (prisoner/detained), Heterosexual (prisoner/detained, non-IDU abuse), partners of HIV+	Erie Co. Prison
Montgomery County Heath Department	MSM, IDU, MSM/IDU, Heterosexual, Partners of HIV+	Montgomery County
	MSM, IDU, MSM/IDU, Heterosexual, Partners of HIV+	Montgomery Co. Prison
Wilkes-Barre City Health Department		Wilkes-Barre City
York City Health Bureau		York City
21 Participating Provider Agreements:		
AIDS Community Alliance	Heterosexual	Cumberland
AIDS Community Alliance	Heterosexual (minority)	Lancaster
AIDS Community Alliance		
AIDS Resource Alliance	Heterosexual	Lebanon
AIDS Service Center	MSM, Heterosexual (minority, alcohol/non-IDU abuse)	Lycoming
Beaver County AIDS Service Organization	HIV+, partners of HIV+	Northampton
	Heterosexual (African American)	Beaver
	MSM (prisoner/detained), IDU (prisoner/detained), Heterosexual (prisoner/detained, non-IDU abuse), partners of HIV+	Beaver Co. Prison
Carbon/Monroe/Pike Drug and Alcohol Commission	IDU, Heterosexual (alcohol/non-IDU abuse)	
ChesPenn Health Services	IDU (prisoner/detained), MSM (prisoner/detained), Heterosexual (prisoner/detained, alcohol/non-IDU	Carbon, Monroe Delaware

	abuse)	
Community Health Clinic	Heterosexual (minority)	
Southwest Behavioral Care	IDU, Heterosexual (alcohol/non-IDU abuse)	Westmoreland
Delaware County AIDS Network	MSM	Westmoreland
Easton Hospital	Heterosexual (minority)	Delaware
Latinos for Healthy Communities	Heterosexual (minority)	Northampton
Life and Liberty	Heterosexual (African American)	Lehigh
Mon Yough Community Services	Heterosexual (African American, alcohol/non-IDU abuse), IDU	Beaver
The AIDS Project	MSM	Allegheny
Schuylkill Wellness Service	Heterosexual (alcohol/non-IDU abuse)	
Ujima Outreach	Heterosexual (African American)	Centre
United Neighborhood Centers	Heterosexual (minority, alcohol/non-IDU abuse)	Schuylkill
Urban League	Heterosexual (minority)	Lancaster
Wyoming Valley AIDS Council	MSM, HIV+, partners of HIV+	Lackawanna
		Lancaster
		Luzerne

STD Clinics:		
Adams County Family Planning	Heterosexual (STD clients)	Adams
Herr's Ridge Family Practice	Heterosexual (STD Clients)	Adams
Planned Parenthood of Central PA	Heterosexual (STD Clients)	Adams
Allegheny County STD Clinic	Heterosexual (STD Clients)	Allegheny
State Health Center STD Clinic	Heterosexual (STD Clients)	Armstrong
State Health Center STD Clinic	Heterosexual (STD Clients)	Beaver
State Health Center STD Clinic	Heterosexual (STD Clients)	Bedford
Planned Parenthood of Northeast PA	Heterosexual (STD Clients)	Berks
State Health Center STD Clinic	Heterosexual (STD Clients)	Blair
Guthrie Family Planning	Heterosexual (STD Clients)	Bradford
Bucks County STD Clinic	Heterosexual (STD Clients)	Bucks
Butler Family Health Council	Heterosexual (STD Clients)	Butler
Butler Memorial Hospital	Heterosexual (STD Clients)	Butler
Family Health Council of Slippery Rock	Heterosexual (STD Clients)	Butler
Planned Parenthood of Western PA	Heterosexual (STD Clients)	Cambria
State Health Center STD Clinic	Heterosexual (STD Clients)	Cameron
Planned Parenthood State College	Heterosexual (STD Clients)	Centre
Bellefonte Family Health Service	Heterosexual (STD Clients)	Centre
State College Medical Services	Heterosexual (STD Clients)	Centre
Chester County Health Department STD Clinic		
Family Health Council – Clarion		
Family Health Council – Clearfield		

Lock Haven Family Planning	Heterosexual (STD Clients)	Chester
Dr. Ali Alley	Heterosexual (STD Clients)	Clarion
Family Health Services – Bloomsburg	Heterosexual (STD Clients)	Clearfield
Conneaut Valley Health Services	Heterosexual (STD Clients)	Clinton
Meadville Family Planning	Heterosexual (STD Clients)	Columbia
Carlisle Planned Parenthood	Heterosexual (STD Clients)	Columbia
Shippensburg Planned Parenthood	Heterosexual (STD Clients)	Crawford
Dr. Bakari	Heterosexual (STD Clients)	Crawford
Hamilton Health Center	Heterosexual (STD Clients)	Cumberland
Pinnacle Health System	Heterosexual (STD Clients)	Cumberland
Planned Parenthood	Heterosexual (STD Clients)	Dauphin
State Health Center STD Clinic	Heterosexual (STD Clients)	Dauphin
Family Health Council	Heterosexual (STD Clients)	Dauphin
Erie County Health Department STD Clinic	Heterosexual (STD Clients)	Dauphin
State Health Center STD Clinic	Heterosexual (STD Clients)	Delaware
Uniontown Family Health Council	Heterosexual (STD Clients)	Elk
State Health Center STD Clinic	Heterosexual (STD Clients)	Erie
Chambersburg Family Health Services	Heterosexual (STD Clients)	Fayette
State Health Center STD Clinic	Heterosexual (STD Clients)	Fayette
State Health Center STD Clinic	Heterosexual (STD Clients)	Forest
Indiana Family Health Council	Heterosexual (STD Clients)	Franklin
State Health Center STD Clinic		
Punxsutawney Family Planning		
State Health Center STD Clinic		

Scranton Planned Parenthood	Heterosexual (STD Clients)	Fulton
Lancaster General Hospital	Heterosexual (STD Clients)	Greene
Lancaster Planned Parenthood	Heterosexual (STD Clients)	Huntingdon
Southeast Lancaster Health Center	Heterosexual (STD Clients)	Indiana
New Castle Family Planning	Heterosexual (STD Clients)	Jefferson
Good Samaritan Family Planning	Heterosexual (STD Clients)	Jefferson
Lebanon Family Health	Heterosexual (STD Clients)	Juniata
State Health Center STD Clinic	Heterosexual (STD Clients)	Lackawanna
Allentown Health Bureau STD Clinic	Heterosexual (STD Clients)	Lancaster
Williamsport Hospital Family Center	Heterosexual (STD Clients)	Lancaster
Hazelton Planned Parenthood	Heterosexual (STD Clients)	Lancaster
Wyoming Valley Family Practice	Heterosexual (STD Clients)	Lawrence
Wilkes-Barre City Health Department STD Clinic	Heterosexual (STD Clients)	Lebanon
McKean Family Planning	Heterosexual (STD Clients)	Lebanon
Family Planning of Mercer County	Heterosexual (STD Clients)	Lehigh
Farrell Primary Health Network	Heterosexual (STD Clients)	Luzerne
Greenville Family Planning	Heterosexual (STD Clients)	Luzerne
Grove City Family Planning	Heterosexual (STD Clients)	Lycoming
State Health Center STD Clinic	Heterosexual (STD Clients)	Mercer
Montgomery County Health Department STD Clinic	Heterosexual (STD Clients)	Mifflin
Stroudsburg Planned Parenthood	Heterosexual (STD Clients)	Monroe
State Health Center STD Clinic	Heterosexual (STD Clients)	Montgomery
Community Care Center	Heterosexual (STD Clients)	Montgomery

Easton Planned Parenthood		
Bethlehem City Health Bureau STD Clinic	Heterosexual (STD Clients)	Wilkes-Barre City
State Health Center STD Clinic	Heterosexual (STD Clients)	McKean
Newport Planned Parenthood	Heterosexual (STD Clients)	Mercer
State Health Center STD Clinic	Heterosexual (STD Clients)	Mercer
Shamokin Family Planning		
State Health Center STD Clinic	Heterosexual (STD Clients)	Mercer
Somerset Planned Parenthood		
Blossburg Laurel Health Center	Heterosexual (STD Clients)	Mercer
Elkland Laurel Health Center	Heterosexual (STD Clients)	Mifflin
Lawrenceville Health Center		
Mansfield Laurel Health Center	Heterosexual (STD Clients)	Montgomery
Wellsboro Laurel Health Center		
Westfield Laurel Health Center	Heterosexual (STD Clients)	Monroe
State Health Center STD Clinic	Heterosexual (STD Clients)	Montour
State Health Center STD Clinic	Heterosexual (STD Clients)	Northampton
Family Health Council	Heterosexual (STD Clients)	Northampton
State Health Center STD Clinic		
State Health Center STD Clinic	Heterosexual (STD Clients)	Bethlehem City
Hanna Penn Health Center		
Hanover Health Center	Heterosexual (STD Clients)	Northumberland
Homer Hetrick Center	Heterosexual (STD Clients)	Perry
Planned Parenthood	Heterosexual (STD Clients)	Potter
	Heterosexual (STD Clients)	Schuylkill
	Heterosexual (STD Clients)	Snyder
	Heterosexual (STD Clients)	Somerset

	Heterosexual (STD Clients)	Tioga
	Heterosexual (STD Clients)	Tioga
	Heterosexual (STD Clients)	Tioga
	Heterosexual (STD Clients)	Tioga
	Heterosexual (STD Clients)	Tioga
	Heterosexual (STD Clients)	Union
	Heterosexual (STD Clients)	Venango
	Heterosexual (STD Clients)	Warren
	Heterosexual (STD Clients)	Washington
	Heterosexual (STD Clients)	Westmoreland
	Heterosexual (STD Clients)	York
	Heterosexual (STD Clients)	York
	Heterosexual (STD Clients)	York
	Heterosexual (STD Clients)	York City
	Heterosexual (STD Clients)	York City

Other: (support for HIV lab services only)		
Carnegie Mellon University	Heterosexual	Allegheny
Pittsburgh Men's Study	MSM, IDU	Allegheny
The Seven Project	MSM (minority)	Allegheny
Strength, Inc.	Heterosexual	Allegheny
Faith Based HIV Prevention Program	Heterosexual (minority)	Allegheny
Taylor Alldendice HS	Heterosexual	Allegheny
Brasher HS	Heterosexual	Allegheny
Gladstone Middle School	Heterosexual	Allegheny
Mercy Hospital Van (Operation Safety Net)	Heterosexual (minority)	Allegheny
Sickle Cell Society, Inc.	Heterosexual (minority)	Allegheny
Pittsburgh AIDS Center for Treatment	HIV+	Allegheny
Kutztown University (Berks AIDS Network)	Heterosexual	Berks
Red Cross Hispanic Center Mobile Unit (Berks AIDS Network	Heterosexual (minority)	Berks
Slippery Rock University	Heterosexual	Butler
Ritenour Health Center, Penn State University	Heterosexual	Centre
Lincoln University	Heterosexual (minority)	Chester
Dickinson University	Heterosexual	Cumberland
Children's Resource Center (Polyclinic Hospital)	Mothers with/at risk	Dauphin
Bethesda Mission (Visiting Nurse Association)	Heterosexual/homeless, IDU/homeless	Dauphin
Harrisburg YMCA/YWCA (Visiting Nurse Association)	Heterosexual/alcohol non-IDU abuse	Dauphin

Program for Female Offenders	Heterosexual/alcohol non-IDU abuse	Dauphin
Sexual Assault Forensics Evidence Unit	Heterosexual (abused women & children)	Dauphin
Community Corrections Center (Visiting Nurse Association	Heterosexual/alcohol non-IDU abuse	Dauphin
Shalom House (Visiting Nurse Association)	Heterosexual Mother with/at risk	
Harambee/Church Youth Group (Visiting Nurse Association)	Heterosexual (minority youth)	Dauphin
ChesPenn Outreach	Heterosexual (minority)	Dauphin
STOP Outreach Erie	Heterosexual, IDU, MSM	
Behrend College	Heterosexual	Delaware
Edinboro University	Heterosexual	Erie
Community Health Net/Homeless Outreach	Heterosexual/homeless, Heterosexual/ alcohol non-IDU abuse, IDU	Erie
Mercyhurst College	Heterosexual	Erie
Hispanic-American Council Community Center	Heterosexual (minority)	Erie
SHOUT Outreach	Heterosexual/alcohol non-IDU abuse	Erie
Keystone College	Heterosexual	
Millersville University	Heterosexual	Erie
Elizabethtown College (AIDS Community Alliance)	Heterosexual	Lackawanna
Thaddeus Stevens (Urban League)	Heterosexual	Lancaster
New Directions Treatment Services Outreach	Heterosexual/alcohol/non-IDU abuse, IDU	Lancaster
Family Service Project Hope	Heterosexual	Lancaster
Moravian College	Heterosexual	Lehigh
SUN Family Planning (White Deer Run /Prenatal)	Heterosexual	Montgomery
California University	Heterosexual/alcohol non-IDU abuse	

York Health Corporation Outreach	Heterosexual IDU, MSM, Heterosexual/alcohol non-IDU abuse, Heterosexual	Northampton Union Washington York

CDC-Supported Providers of PCRS

Provider	**Primary Target Population** HIV seropositive individuals (HIV+)	**Geographic Service Area**
12 HIV Prevention Field Staff Southeastern Health District E. Davis J. Foster N. Martinez-King	HIV+, partners of HIV+	Delaware, Berks, Schuylkill, Chester, Montgomery, Bucks Delaware Co. Prison Berks Co. Prison Chester Co. Prison Participating Provider Agreements (CTR sites) STD/HIV CTR sites TB/HIV CTR sites Drug and Alcohol Treatment CTR sites Other HIV CTR sites
Northeastern Health District C. Yozviak C. Zaleppa	HIV+, partners of HIV+	Luzerne, Carbon, Monroe, Northampton, Lehigh, Lackawanna, Wyoming, Susquehanna, Pike, Wayne Luzerne Co. Prison Carbon Co. Prison Monroe Co. Prison Northampton Co. Prison Lehigh Co. Prison Lackawanna Co. Prison Wyoming Co. Prison Pike Co. Prison Participating Provider Agreements (HIV CTR sites)

North Central Health District D. Eberle Vacant	HIV+, partners of HIV+	STD/HIV CTR sites TB/HIV CTR sites Drug and Alcohol Treatment CTR sites Other HIV CTR sites Bradford, Clinton, Centre, Columbia, Northumberland, Montour, Lycoming, Potter, Snyder, Sullivan, Tioga, Union Bradford Co. Prison Clinton Co. Prison Centre Co. Prison Columbia Co. Prison Northumberland Co. Prison Montour Co. Prison Lycoming Co. Prison Potter Co. Prison Snyder Co. Prison Sullivan Co. Prison Tioga Co. Prison Union Co. Prison Participating Provider Agreements (HIV CTR sites) STD/HIV CTR sites TB/HIV CTR sites Other HIV CTR sites
South Central Health District N. Cabasquin S. Dussinger	HIV+, partners of HIV+	Adams, Bedford, Blair, Cumberland, Dauphin, Franklin, Fulton, Huntington, Juniata, Lebanon, Mifflin, Perry, York Adams Co. Prison Bedford Co. Prison Blair Co. Prison Cumberland Co. Prison Dauphin Co. Prison Franklin Co. Prison Fulton Co. Prison Huntington Co. Prison Juniata Co. Prison Lebanon Co. Prison Mifflin Co. Prison Perry Co. Prison York Co. Prison

Southwestern Health District B. Hoza R. Fuhrman	HIV+, partners of HIV+	Participating Provider Agreements (HIV CTR sites) STD/HIV CTR sites TB/HIV CTR sites Drug and Alcohol Treatment CTR sites Other HIV CTR sites Indiana, Cambria, Somerset, Fayette, Beaver, Butler, Armstrong, Washington, Westmoreland, Green, Allegheny Indiana Co. Prison Cambria Co. Prison Somerset Co. Prison Fayette Co. Prison Butler Co. Prison Armstrong Co. Prison Washington Co. Prison Westmoreland Co. Prison
Northwestern Health District A. McCowien	HIV+, partners of HIV+	Participating Provider Agreements (HIV CTR sites) STD/HIV CTR sites TB/HIV CTR sites Drug and Alcohol Treatment CTR sites Other HIV CTR sites Cameron, Clearfield, Clarion, Crawford, Elk, Forest, Jefferson, Lawrence, McKean, Mercer, Venango, Warren, Erie Clearfield Co. Prison Clarion Co. Prison Crawford Co. Prison Elk Co. Prison Jefferson Co. Prison Lawrence Co. Prison Mercer Co. Prison Venango Co. Prison Warren Co. Prison STD/HIV CTR sites TB/HIV CTR sites

		Drug and Alcohol Treatment CTR sites Other HIV CTR sites
County/Municipal Health Departments:		
Allegheny County Health Department	HIV+, partners of HIV+	Allegheny County Allegheny Co. Prison Participating Provider Agreements (HIV CTR sites) STD/HIV CTR sites TB/HIV CTR sites Drug and Alcohol Treatment CTR sites Other HIV CTR sites
Allentown City Health Bureau	HIV+, partners of HIV+	Allentown City Participating Provider Agreements (HIV CTR sites) STD/HIV CTR sites TB/HIV CTR sites Drug and Alcohol Treatment CTR sites
Bethlehem City Health Bureau	HIV+, partners of HIV+	Bethlehem City & parts of Northampton County Participating Provider Agreements (HIV CTR sites) STD/HIV CTR sites TB/HIV CTR sites Drug and Alcohol Treatment CTR sites
Bucks County Health Department	HIV+, partners of HIV+	Bucks County Bucks Co. Prison Participating Provider Agreements (HIV CTR sites)

Chester County Health Department	HIV+, partners of HIV+	STD/HIV CTR sites TB/HIV CTR sites Drug and Alcohol Treatment CTR sites Chester County Participating Provider Agreements (HIV CTR sites) STD/HIV CTR sites TB/HIV CTR sites Drug and Alcohol Treatment CTR sites
Erie County Health Department	HIV+, partners of HIV+	Erie County Erie Co. Prison Participating Provider Agreements (HIV CTR sites) STD/HIV CTR sites TB/HIV CTR sites Drug and Alcohol Treatment CTR sites
Montgomery County Heath Department	HIV+, partners of HIV+	Montgomery County Montgomery Co. Prison Participating Provider Agreements (HIV CTR sites) STD/HIV CTR sites TB/HIV CTR sites Drug and Alcohol Treatment CTR sites
Wilkes-Barre City Health Department		Other HIV CTR sites Wilkes-Barre City Participating Provider Agreements (HIV CTR sites) STD/HIV CTR sites

York City Health Bureau	HIV+, partners of HIV+ HIV+, partners of HIV+	TB/HIV CTR sites Drug and Alcohol Treatment CTR sites York City Participating Provider Agreements (HIV CTR sites) STD/HIV CTR sites TB/HIV CTR sites Drug and Alcohol Treatment CTR sites

2004 CDC-Supported HE/RR Providers: (data from 2004 Intervention Plans)

***Note: When indicated by the contractor, the sub-populations and/or secondary populations are included.**

Provider **PA DOH Contractors**	Primary Target Population* **Men who have sex with men (MSM)** **Men who have sex with men and are injection drug users (MSM/IDU)** **Injection drug user (IDU)** **Heterosexual** **Mother with/at risk for HIV** **General Public**	Intervention **Individual Level Intervention (ILI)** **Group Level Intervention (GLI)** **Outreach (OR)** **Prevention Case Management (PCM)** **Health Communication/Public Information (HC/PI)**
Allegheny County Health Department & subcontractors: **Kingsley Associates** **Pittsburgh AIDS Task Force** **Mon Yough Community Services** **The Seven Project**		
	MSM	**ILI** **280 interventions** **280 individuals**
	MSM	**GLI**

		18 interventions **180 individuals**
	MSM	**OR** **110 interventions** **2,000 contacts**
	IDU	**ILI** **150 interventions** **150 individuals**
	IDU	**OR** **55 interventions** **1,000 contacts**
	Heterosexual **Mother with/at risk**	**ILI** **200 interventions** **200 individuals**
	Heterosexual	**GLI** **85 interventions** **850 individuals**
	Heterosexual	**OR** **385 interventions** **7,000 contacts**
	Heterosexual **General Public**	**HC/PI** **4 electronic media campaigns** **5 print media campaigns** **701 presentations/lectures** **40 clearinghouse**
Allentown City Health Bureau		
	MSM	**ILI** **375 interventions** **375 individuals**
	MSM	**GLI** **16 interventions** **450 individuals**
	MSM	**OR** **2 interventions** **800 contacts**
	IDU	**ILI** **759 interventions** **759 individuals**
	IDU	**GLI** **20 interventions** **960 individuals**
	Heterosexuals	**ILI** **1030 interventions** **1030 individuals**

	Heterosexual	**GLI** **24 interventions** **280 individuals**
	Heterosexual	**OR** **4 interventions** **1000 contacts**
	Heterosexual	**HC/PI** **3 media campaigns**
		Other interventions: **2 Community-wide events - Faith-based symposium, AIDS walk**
Bethlehem City Health Bureau		
	MSM	**ILI** **25 interventions** **50 individuals**
	MSM	**GLI** **12 interventions** **120 individuals**
	MSM	**OR** **6 interventions** **80 contacts**
	MSM	**HC/PI** **5 presentations**
	IDU	**ILI** **40 interventions** **225 individuals**
	IDU	**GLI** **36 interventions** **175 individuals**
	IDU	**OR** **25 interventions** **200 contacts**
	IDU	**HC/PI** **2 print media campaign** **3 presentations** **4 clearinghouse**
	Heterosexual **Alcohol/non-IDU abuse** **Homeless** **Sex Workers** **Female Partner of MSMs** **Female Partner of IDU**	**ILI** **50 interventions** **325 individuals**
	Heterosexual **Alcohol/non-IDU abuse**	**GLI** **25 interventions**

	Homeless **Sex Workers** **Female Partner of MSMs** **Female Partner of IDU**	**500 individuals**
	Heterosexual **Alcohol/non-IDU abuse** **Homeless** **Sex Workers** **Female Partner of MSMs** **Female Partner of IDU**	**OR** **50 interventions** **1000 contacts**
	Heterosexual **Alcohol/non-IDU abuse** **Homeless** **Sex Workers** **Female Partner of MSMs** **Female Partner of IDU**	**HC/PI** **1 electronic media campaign** **2 print media campaigns** **3 presentations** **5 clearinghouse**
	Mother with/at risk **Alcohol/non-IDU abuse** **Homeless** **Sex Workers** **Female Partner of MSMs** **Female Partner of IDU**	**ILI** **20 interventions** **90 individuals**
	Mother with/at risk **Alcohol/non-IDU abuse** **Female Partner of IDU**	**GLI** **4 interventions** **30 individuals**
	Mother with/at risk **Alcohol/non-IDU abuse** **Homeless** **Sex Workers** **Female Partner of MSMs** **Female Partner of IDU**	**OR** **12 interventions** **75 contacts**
	Mother with/at risk **Alcohol/non-IDU abuse** **Homeless** **Sex Workers** **Female Partner of MSMs** **Female Partner of IDU**	**HC/PI** **2 presentations** **3 clearinghouse**
Bucks County Health Department		
	MSM **MSM/IDU**	**ILI** **100 interventions** **100 individuals**
	MSM	**GLI** **15 interventions** **90 individuals**
	MSM	**OR**

		2 interventions **400 contacts**
	IDU **Heterosexual**	**ILI** **40 interventions** **40 individuals**
	Heterosexual **Youth**	**GLI** **35 interventions** **200 individuals**
	Heterosexual **Youth**	**OR** **3 interventions** **600 contacts**
Chester County Health Department		
	MSM	**ILI** **275 interventions** **275 individuals**
	MSM	**OR** **50 interventions** **500 individuals**
	IDU	**ILI** **275 interventions** **275 individuals**
	IDU	**GLI** **6 interventions** **400 individuals**
	IDU	**50 interventions** **500 individuals**
	Heterosexual **MSM**	**ILI** **275 interventions** **275 individuals**
	Heterosexual	**GLI** **6 interventions** **400 individuals**
	Heterosexual	**GLI** **6 interventions** **400 individuals**
	Heterosexual **MSM**	**HC/PI** **3 electronic media campaigns** **4 print media campaigns** **24 presentations/lectures** **1 clearinghouse**
	Heterosexual	**OR** **50 interventions** **500 contacts**
		Other Interventions

		20 health fairs
Erie County Health Department & subcontractors: **Minority Health Education Delivery Systems** **Hispanic American Council**		
	MSM	**ILI** **3 interventions** **3 individuals**
	MSM	**GLI** **1 intervention** **10 individuals**
	MSM	**OR** **1 intervention** **6 contacts**
	MSM/IDU	**ILI** **3 interventions** **3 individuals**
	IDU	**ILI** **65 interventions** **65 individuals**
	IDU	**GLI** **15 interventions** **360 individuals**
	IDU	**OR** **2 interventions** **36 contacts**
	Heterosexual	**ILI** **268 interventions** **268 individuals**
	Heterosexual	**GLI** **160 interventions** **3840 individuals**
	Heterosexual	**OR** **118 interventions** **2069 contacts**
	Mother with/at risk	**ILI** **14 interventions** **14 individuals**
	Mother with/at risk	**GLI** **5 interventions** **120 individuals**
	Mother with/at risk	**OR**

		6 interventions **72 contacts**
	General Public	**HC/PI** **490 presentations/lectures**
		Other Interventions: **23 materials distribution**
Erie County Health Department Subcontractor: Multi-Cultural Health Evaluation Delivery System, Inc.		
	IDU	**ILI** **7 interventions** **7 individuals**
	IDU	**GLI** **4 interventions** **79 individuals**
	Heterosexual	**ILI** **43 interventions** **43 individuals**
	Heterosexual	**GLI** **50 interventions** **535 individuals**
	Heterosexual	**OR** **15 interventions** **223 contacts**
	Mother with/at risk	**ILI** **31 interventions** **31 individuals**
	Mother with/at risk	**GLI** **9 interventions** **127 individuals**
	Mother with/at risk	**OR** **3 interventions** **151 contacts**
		Other interventions: **4 distribution of materials**
Erie County Health Department Subcontractor: Hispanic American Council		
	MSM	**ILI** **2 interventions** **2 individuals**
	MSM	**GLI** **1 intervention** **18 individuals**

	MSM	**OR** **1 intervention** **18 contacts**
	IDU	**ILI** **11 interventions** **11 individuals**
	IDU	**GLI** **4 interventions** **33 individuals**
	Heterosexual	**ILI** **107 interventions** **107 individuals**
	Heterosexual	**GLI** **178 interventions** **2541 individuals**
	Heterosexual	**OR** **49 interventions** **434 contacts**
	Heterosexual	**HC/PI** **4 presentations/lectures**
	Mother with/at risk	**ILI** **8 interventions** **8 individuals**
	Mother with/at risk	**GLI** **2 interventions** **20 individuals**
	General Public	**HC/PI** **4 presentations/lectures**
Montgomery County Health Department		
	MSM	**ILI** **25 interventions** **25 individuals**
	MSM	**OR** **20 interventions** **50 contacts**
	IDU	**ILI** **25 interventions** **50 individuals**
	IDU	**GLI** **10 interventions** **120 individuals**
	IDU **Mother with/at risk**	**GLI** **20 interventions** **25 individuals**
	IDU	**OR**

		25 interventions **100 contacts**
	Heterosexual	**ILI** **25 interventions** **100 individuals**
	Heterosexual	**GLI** **10 interventions** **120 individuals**
	Heterosexual **Alcohol/Non-IDU**	**GLI** **20 interventions** **50 individuals**
	Heterosexual **Prisoner/Detained**	**GLI** **44 interventions** **500 individuals**
	Heterosexual	**OR** **20 interventions** **125 contacts**
	Mother with/at risk	**GLI** **20 interventions** **25 individuals**
	General Public	**HC/PI** **75 presentations**
		Other interventions **10 health fairs**
Wilkes-Barre City Health Department		
	MSM **Heterosexual**	**ILI** **75 interventions** **75 individuals**
	MSM **Heterosexual**	**GLI** **12 interventions** **75individuals**
	MSM **Heterosexual**	**OR** **12 interventions** **360 contacts**
	MSM	**HC/PI** **6 electronic media campaigns** **2 print media campaigns** **4 presentations/lectures** **50 hotline** **10 clearinghouse**
	IDU	**ILI** **60 interventions** **60 individuals**
	IDU	**GLI**

		12 interventions **75 individuals**
	IDU	**OR** **12 interventions** **360 contacts**
	IDU	**HC/PI** **6 electronic media campaigns** **2 print media campaigns** **4 presentations/lectures** **30 hotline** **10 clearinghouse**
York City Health Department		
	IDU	**HC/PI** **12 presentations/lectures** **250 individuals**
	General Public	**Other: Mass media distribution, print medium** **Distribute Positively Aware magazines** **6 copies bi-monthly (36)** **1000 individuals exposed**
York City Health Department Contractor: York Health Corporation	**MSM**	**OR** **30 interventions** **600 contacts**
	IDU	**OR** **70 interventions** **1,400 contacts**
York City Health Department Contractor: York Health Corporation	**MSM**	**PCM** **36 interventions** **20 individuals**
	IDU	**PCM** **85 interventions** **47 individuals**
University of Pittsburgh/PA Prevention Project Stophiv.com website	**General Public**	**HC/PI** **Electronic media campaign 825,089 contacts**
University of Pittsburgh/PA Prevention Project Primary & Secondary School Prevention Education Project	**General Public** **Youth**	**HC/PI** **Website under development.**
University of Pittsburgh/PA Prevention Project Young Adult Roundtable	**MSM** **Youth**	**GLI** **18 interventions** **144 individuals**

	Heterosexual **Youth**	**GLI** **52 interventions** **762 individuals**
	IDU **Youth**	**GLI** **12 interventions** **48 individuals**
University of Pittsburgh/PA Prevention Project Young Adult Roundtable's Peer Prevention Intervention demonstration project	**Heterosexual/Youth** **MSM/Youth** **IDU/Youth**	**GLI** **36 interventions** **720 individuals**
University of Pittsburgh/PA Prevention Project Subcontractor: SHOUT Outreach/Gaudenzia Crossroads (Erie)	**MSM**	**ILI** **350 interventions** **350 individuals**
	MSM **Heterosexual**	**GLI** **25 interventions** **275 individuals**
	MSM **Heterosexual**	**OR** **200 interventions** **500 contacts**
	MSM **General Public**	**HC/PI** **1 electronic media campaign** **200 presentations/lectures**
		Other: **Community mobilization**
University of Pittsburgh/PA Prevention Project Subcontractor: New Directions Treatment Services	**Heterosexual**	**ILI** **295 interventions** **295 individuals**
	Heterosexual	**GLI** **75 interventions** **506 individuals**
	Heterosexual	**OR** **192 interventions** **1495 contacts**
	Heterosexual	**PCM** **33 interventions** **33 individuals**
	Mother with/at risk	**ILI** **92 interventions**

		92 individuals
	Mother with/at risk	**GLI** **16 interventions** **100 individuals**
	Mother with/at risk	**OR** **52 interventions** **165 contacts**
	Mother with/at risk	**PCM** **43 interventions** **43 individuals**
University of Pittsburgh/PA Prevention Project Subcontractor: To be determined thru competitive award.	**HIV+`**	**PCM** **To be determined.**

Young Adult Consensus Statement: <u>Interventions</u>

What kinds of programs are most needed to reduce HIV infection/re-infection among young people in PA? Are certain programs best suited to certain groups of young people?

Problem #1: Existing HIV prevention programs need to be more effective.

Goal #1: Monitor and determine whether all schools have HIV prevention education.

Objective #1: Ensure all students are receiving HIV education.

Goal #2: Existing HIV prevention education in all schools should be made more effective.

Objective #1: Eliminate abstinence-only and abstinence-plus education.

Roundtable members agree that **abstinence-only education** (which promotes abstinence as the only option outside marriage and either prohibit discussion of contraception or limit discussion to contraception failure) and **abstinence-plus education** (which promotes abstinence as the preferred option, but also allows the discussion of contraception as effective in protecting against unintended pregnancy and STIs/HIV) (Landry et al, 1999) do not work for most *young people*, the majority of whom are sexually active. Various studies indicate that the vast majority (82%) of young people in America are sexually active by the age of 18 (The Kaiser Foundation, 2003). Abstinence-only and abstinence-plus education promote sexual activity only in the context of marriage. These models discriminate against homosexuals, who cannot legally marry in the

state of PA. These models also stigmatize any and all individuals who choose not to marry.

Objective #2: PA Department of Education regulations governing HIV education in public schools should not espouse abstinence-based (abstinence-only or abstinence-plus) philosophies because these discriminate against and stigmatize young people who are sexually active and those who choose not to or cannot marry.

"Programs discussing transmission through sexuality shall stress that abstinence from sexuality is the only completely reliable means of preventing sexual transmission." (022 PA Code, § 4.29)

Objective #3: Institute a comprehensive HIV prevention program (which address abstinence as one option in a broader context designed to prepare young people to become sexually healthy adults) (Landry et. al., 1999) in all schools. Roundtable members endorse comprehensive HIV education. Comprehensive education addresses abstinence as one option in a broader education program designed to prepare adolescents to become sexually healthy adults.

Schools should be mandated to include a comprehensive HIV education curriculum each year before sexual behavior is practiced (no later than 5th grade). The curriculum should be based on risk reduction and cover topics such as self-esteem enhancement, STIs (and co-infection), and unintended pregnancy prevention. This curriculum should also include information about secondary prevention (preventing re-infection/co-infection) for *young people* living with HIV.

Objective #4: Peer education (young people who can teach their peers about HIV/AIDS) should be offered in all schools. Peer education programs should be publicized and provide incentives to *young people* to encourage their sustained participation.

Four focus groups recommend establishing peer education programs. Most groups state that adolescents respond to speakers, who are like them, including speakers who are HIV+ since they can give the message that "if it happened to me, then it can happen to you."

Objective #5: Groups of HIV prevention /risk reduction specialists should visit all schools and have assemblies/performances with question & answer sessions and materials to distribute. The presenters should reflect the population they are targeting.

Objective #6: Information should be made available in all schools about HIV concerning, but not limited to what it is, how it is transmitted, and

where to get tested. A resource list of local HIV/STI testing sites should be distributed to all students and should include both confidential and anonymous sites. HIV prevention messages need to be consistent and repeated.

Educational resources, including posters and pamphlets, should be made available throughout the school, not just in the nurse's office. This way, students can pick them up inconspicuously and without being stigmatized.

Objective #7: HIV prevention education curricula should be constantly updated to include current statistics and scientific data.

Objective #8: HIV prevention education must be accurate, current, interactive, fun, multi-media, and developmentally and linguistically appropriate.

Objective #9: HIV prevention education should be cross-disciplinary. Related information should be presented in other subjects, e.g., math charts could illustrate HIV statistics.

Objective #10: All school districts should be mandated to collect local statistics annually, and report to the state, about the HIV/STI risk related behaviors of their students. A risk assessment survey, such as the **Youth Risk Behavior Survey (YRBS)** could be implemented to obtain such information and link data to national statistics.

Objective #11: Local and statewide HIV risk assessment and epidemiological data about *young people* should be used to identify target populations and risk behaviors, corresponding methods of intervention, and effective allocation of resources.

Objective #12: Condoms should be distributed in all schools. Latex and polyurethane condoms, both male and female, and dental dams should be made available (along with proper usage information) for free without students having to ask for them. Studies have proven that comprehensive HIV prevention programs that include availability of latex condoms do not increase sexual activity among *young people* (CDC's Compendium of Effective HIV Prevention Programs).

Objective #13: The proper use of latex and polyurethane condoms, both male and female, and dental dams should be demonstrated in all schools (grades five through twelve and in colleges) and reinforced through hands-on skill development.

Objective #14: Voluntary and confidential HIV counseling and testing programs should be implemented in all schools. *Young people* often are not able or willing to seek these resources on their own.

Testing MUST be voluntary. Furthermore, schools MUST safeguard the confidentiality of students by (for example) utilizing an outside AIDS service organization (ASO) or community-based organization (CBO) to perform testing during on site visits throughout the year in grades five through twelve and in college.

Objective #15: All teachers should be trained to deal effectively with and to be sensitive to HIV/AIDS issues and students impacted by these issues. School personnel who implement HIV education programs and school counselors who interact with affected students should be properly trained and/or certified in HIV/AIDS education and prevention.

School personnel who implement HIV education programs and school counselors who interact with affected students should be culturally competent (sensitive to the needs of all types of people of all ages, races, ethnicities, genders, sexual orientations, economic backgrounds, etc.). Roundtable members have consistently listed lack of cultural competency as a barrier to program efficiency and to young people's willingness to access them.

All schools should create and publicize a "safe zone" made up of staff and teachers who are sensitive to the needs of GLBT *young people*. Roundtable members feel there is a need for teachers who are "out" and/or gay friendly so those students who identify with homosexuality will have role models and resources regarding sexual orientation. Schools should refer to effective models to determine how to implement such safe zones.

Goal #3: Create additional HIV prevention **interventions** for *young people* that move beyond HIV prevention **education (information)** and focus on developing risk reduction **skills**.

Objective #1: Epidemiological and other needs assessment data should be used in the development and targeting of interventions for *young people* in Pennsylvania.

Objective #2: HIV prevention interventions should have specific (measurable) goals to reduce risk behaviors.

Objective #3: Young people at-risk should be involved in creating and designing HIV prevention interventions.

Objective #4: HIV prevention interventions must include proper condom use and syringe sterilization skills.

Objective #5: Complete and pilot the Roundtable HIV Prevention Intervention.

Objective #6: Information provided and utilized in interventions should be: based on harm-reduction strategies (not abstinence-based and/or abstinence-plus), science based, current, constantly updated, consistent, and used in all media that the interventions make available, such as literature, Web sites, and videos.

Objective #7: The facilitators of the interventions should be properly trained and/or certified, constantly updated, and culturally competent (sensitive to the needs of all types of people of all ages, races, ethnicities, genders, sexual orientations, economic backgrounds, etc.). Roundtable members have consistently listed facilitator lack of cultural competency as a barrier to the efficiency of interventions.

Goal #4: The media should be utilized more effectively to target the HIV prevention needs of *young people*.

Objective: #1: HIV prevention related Public Service Announcements (PSAs) that target *young people* need to be created.

Objective: #2: HIV prevention related television commercials that target *young people* need to be created.

Objective: #3: HIV prevention related radio commercials that target *young people* need to be created.

Objective: #4: HIV prevention related periodicals that target *young people* need to be created.

Objective: #5: HIV prevention related billboards that target *young people* need to be created.

Objective #6: The media should promote the involvement of parents in the HIV prevention risk reduction efforts of their children.

Objective #7: Diverse groups of young people should be utilized in the design and production of community-wide HIV prevention media campaigns (commercials, billboards, posters, etc.).

Objective #8: Accurate, reliable web sites should be promoted through the media. Some recommended web sites include cdc.gov, siecus.org,

advocatesforyouth.org, youthresource.com, youthhiv.org, stophiv.com, thebody.com, and unaids.org.

Objective #9: Media should utilize positive role models (celebrities, peers, and other advocates) for *young people* to deliver HIV prevention messages.

Objective #10: The OraSure and OraQuick HIV tests need more publicity in all schools and in other places where young people will see them. Many people are too afraid of needles to get tested for HIV and need to know that there are alternative, non-invasive tests available.

Objective #11: Locations of **anonymous and free** HIV/STI counseling and testing sites should be widely publicized in all schools and in other places where young people will see them. Advertisements should include the hours of operation.

Objective #12: Locations of anonymous and free HIV counseling and testing sites that give **rapid results** should be widely publicized in all schools and in other places where young people will see them.

Objective #13: Statewide and local media campaigns need to be developed to encourage *young people* to be tested for sexually transmitted infections and pregnancy. *Young people* at risk of HIV infection/re-infections are also at risk of sexually transmitted infections and/or unintended pregnancy.

Objective #14: Media should advertise local and other resources (web sites, hotlines, etc.) available to parents who are interested in talking to their children about HIV risk reduction.

Goal #5: Community level interventions (those that target geographic and demographic populations of *young people*) should be utilized more efficiently to target the HIV prevention needs of *young people*.

Objective #1: Condoms should be made available where *young people* work and/or hang out, such as shopping malls, sporting events, bars, and clubs. Devise creative, free, and accessible condom distribution methods (such as condom mobiles) and promote their locations.

Objective #2: HIV primary and secondary prevention materials (brochures, local resource list, bleach kits, clean syringes, etc.) should be made available where *young people* work and/or hang out, such as shopping malls, sporting events, bars, and clubs. Devise creative, free, and accessible HIV prevention material distribution methods (outreach) and promote their locations.

Objective #3: Programs should be created to teach parents the facts about HIV/AIDS as well as how to approach the subject with their children. Parents need to be educated about HIV/AIDS. Classes can be offered and information can be mass mailed.

Objective #4: Programs that provide needle exchange and clean injection equipment distribution should be established in all communities that have a high rate of injection drug use among *young people.* These programs can also be utilized to educate *young people* about HIV prevention and proper needle hygiene. Research indicates needle exchange programs reduce the incidence of HIV without promoting injection drug use (Des Jarlais et al, 1994).

Objective #5: HIV prevention services should be provided for *young people* who are sex workers. Services should include latex and polyurethane condom (both male and female) distribution, HIV counseling and testing, and HIV education.

Objective #6: *Young people*, community and political leaders need to lobby and/or advocate for effective HIV prevention programs for *young people* at the local, state, and national levels.

Objective #7: *Young people*, community, and political leaders need to lobby school boards and advocate for effective HIV prevention programs for *young people* in all schools.

Objective #8: Eliminate legislative and bureaucratic (PA DOE and PA DOH) barriers that discourage effective HIV prevention programs targeting high-risk *young people* (such as state-mandated abstinence-based education and prohibitions of needle exchange programs).

Goal #6: Increase the number and quality of HIV prevention peer education programs for *young people*.

Objective #1: Trained *young people* (peers) should be available in clinic settings to offer HIV counseling and testing and other HIV prevention services.

Objective #2: Increase support (incentives, training, class credits, recognition, supervision, etc.) to young peer educators.

Objective #3: Peer education programs should also teach young people how to lobby and advocate for political and legislative change.

Problem #2: Because many *young people* in PA are still becoming infected/re-infected with HIV, they are at increased risk of other sexually transmitted infections and unintentional pregnancy.

Goal #1: Integrate HIV prevention programs for young people with STI and unintentional pregnancy prevention programs.

Objective D: Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.

- **Attribute 19 (Epidemiological Profile):** The Epidemiological (epi) profile provides information about defined populations at high risk for HIV infection for the CPG to consider in the prioritization process.

  In consultation with the CDC Federal Project Officer it was agreed that an Epidemiological Profile developed in 1999 with updates would be sufficient with for the 2004 Plan. A timeline has been established for the development of an Integrated Epidemiological Profile with the next two-year submission for 2005-2006. The 2004 Epidemiological Profile does contain thirteen defined populations at high risk for HIV infection across the Commonwealth of Pennsylvania not including Philadelphia.

- **Attribute 20 (Epidemiological Profile):** Strengths and limitations of data sources used in the epidemiological profile are described (general issues and jurisdiction-specific issues).

  At the May and July meetings the Epidemiology Subcommittee reviewed known national and local data sources provided by the CDC. In addition, they devised a written process for members to submit data requests to the Bureau of Epidemiology (*Appendix R*).

- **Attribute 21 (Epidemiological Profile):** Data gaps are explicitly identified in the epidemiological profile.

  Pennsylvania just became an HIV names-reporting jurisdiction in 2002. Hence, it will be a considerable time until such data is usable for HIV prevention planning. The profile will continue to use surrogate data as well as sexually transmissible infection data and other indicators of HIV risk-related behaviors where data is available. The Young Adult Consensus Statement identifies several data needs relative to youth and young adults such as a more finite age breakout. The Bureau of Epidemiology will be employing additional help that will assist in gathering additional data.

- **Attribute 22 (Epidemiological Profile):** The epi profile contains a narrative interpretation of data presented.

The epidemiological profile utilized in the 2004 Plan has a narrative interpretation, however, the CPG is working toward a more basic summary and narrative interpretation.

- **Attribute 23 (Epidemiological Profile):** Evidence that the epidemiological profile was presented to the CPG members prior to the prioritization process.

  This epidemiological profile was presented to the full CPG prior to the priority population process when developing the 2000 Plan in the summer of 1999. Data from this profile was directly used in the priority population process.

- **Attribute 24 (Community Services Assessment :** The Community Services Assessment (CSA) focuses on one or more high priority populations (i.e., substantially contributing to new HIV infections in a jurisdiction) identified in the epidemiological profile.

The CSA focuses upon all of the priority populations identified by the CPG; however as recently instituted HIV-reporting data becomes more usable the rates of new infections will become more identifiable.

- **Attribute 25 (Community Services Assessment):** Data are gathered that define populations' needs in terms of knowledge, skills, attitudes, and norms.

  When focus groups are developed and conducted by the Pennsylvania Prevention Project the process commences with a current literature search to determine what might already be known about specific populations. The next step in the process is to assemble a number of individuals who are part of those communities or have some expertise with the populations, which frequently involves Committee members. This group will formulate the questions that examine knowledge, attitudes, skills, norms, and barriers to be posed to focus group participants.

- **Attribute 26 (Community Services Assessment):** Data are gathered that define populations' needs in terms of access to services.

As stated under Attribute 25, barriers to HIV prevention services are sought in focus group endeavors. In addition, to focus groups with more difficult to reach communities and/or subpopulations key informant interviews are utilized. The same rigorous format is used to insure that questions are relevant.

- **Attribute 27 (Community Services Assessment):** The CSA details the target populations being served. (Resource Inventory)

  The Resource Inventory is the culmination of work since March 2000 in developing, implementing and refining uniform data reporting. The ten local county and municipal health departments and seven Ryan White HIV/AIDS Regional HIV Planning Coalitions as well as all of their subcontractors now report specific data detailing HIV prevention service data by target populations and with CDC defined individual, group and community level interventions.

- **Attribute 28 (Community Services Assessment):** The CSA details the interventions provided to each target population. (Resource Inventory)

  An extensive list of all funded HIV prevention interventions by target population was developed and provided to the CPG at their August meeting. See Pages 307-335 of this Plan.

- **Attribute 29 (Community Services Assessment):** The CSA describes the geographic coverage of interventions or programs. (Resource Inventory)

  The Resource Inventory is completed reflecting services within each of the 66 counties of Pennsylvania not including Philadelphia. (*Appendix P*).

- **Attribute 30 (Community Services Assessment):** The CSA was utilized in demonstrating linkages between the application and funded interventions. (Resource Inventory)

The CSA has provided the linkage between what the epidemiological profile and needs assessment inform relative to HIV prevention service needs and barriers with targeted populations and what HIV prevention is being provided irrespective of funding source.

The fourteen counties with the highest incidence have been identified and what services are needed are identified.

- **Attribute 31 (Community Services Assessment):** Evidence that prior to the prioritization (recommendation of interventions) process, the CPG was provided with a summary of the CSA.

  The full Community Assessment was provided to the CPG at their July and August meeting. That information was then used in August to examine the gaps in service by specific target population and determine what interventions might be developed to meet those identified needs.

- **Attribute 32 (Gap Analysis):** The gap analysis includes data from the epidemiological profile and the CSA.

  The gap analysis reviewed HIV prevention services being provided regardless of funding sources. Unmet needs of the priority populations identified through the Epidemiological Profile of emerging HIV infections in 14 high-risk counties were examined.

- **Attribute 33 (Gap Analysis):** A gap analysis specifically identifies both met and unmet needs.

  A method utilizing grids were used to track the process and that clearly identified both met and unmet needs (Page 263).

- **Attribute 34 (Gap Analysis):** The gap analysis identifies the portion of needs being *met* with CDC funds.

  A column on the gap analysis grid identifies the portion of needs being met with CDC funds (Page 307).

- **Attribute 35 (Gap Analysis):** Evidence that prior to the prioritization process (recommendation of interventions), the CPG was provided with a summary of the gap analysis findings.

Gap analysis information was in part provided at the July CPG meeting as well as prior to recommended interventions at the August CPG meeting.

- **Attribute 36 (Gap Analysis):** The gap analysis was utilized by the CPG in demonstrating linkages between the application and funded interventions.

The Gap analysis informs the CPG on what is needed in specific geographic locations and the Plan is addressing those needs within the bounds of resources available.

Objective E: Ensure that prioritized target populations are based on an epidemiological profile and a community service assessment.

- **Attribute 37 (Target Population):** Evidence that the size of at-risk populations was considered in setting priorities for target populations.

  Size of target populations is something that will have to be developed in the next funding cycle, in other words, during 2004 for the 2005 & 2006 HIV prevention Plan.

- **Attribute 38 (Target Population):** Evidence that a measurement of the percentage of HIV morbidity (i.e., HIV/AIDS incidence or prevalence), if available, was considered in setting priorities for target populations.

  Factors used in the priority population process included (1) predominant mode/risk factor (blood-to-blood, unprotected anal sex, vaginal sex and/or oral sex), (2) estimated live HIV cases in transmission category as a proportion of total living with HIV in PA, (3) estimated unadjusted relative risk or likelihood of death equal to or greater than relative survival time for transmission category equal to or greater than likelihood of increase/decrease in prevalent pool of infected persons, (4) Prevalence of predominant risk behavior during most recent behavioral survey, (5) Average annual rate of increase in AIDS incidence in most recent 4-5 year period, (6) rate of change of HIV prevalence and direction, (7) sexually transmitted infections of gonorrhea and syphilis, (8) relative size of transmission category population, (9) services allocated to transmission category relative to category as percentage of total,, (10) number of factors in transmission category that are barriers to prevention and (11) race/ethnicity as a proportion of AIDS incidence (Page 235 and *Appendix M*).

- **Attribute 39 (Target Population):** Evidence that the prevalence of risky behaviors

in the population was considered in setting priorities for target populations.

See Factors One and Four identified in Attribute 38.

- **Attribute 40 (Target Population):** Target populations are defined by transmission risk, gender, age, race/ethnicity, HIV status, and geographic location.

  See Factor 11 in Attribute 38 as well as the Prioritization Table on Page 237.

- **Attribute 41 (Target Population):** Target populations are rank ordered by priority, in terms of their contribution to new HIV infections.

  Pennsylvania only became an HIV names-reporting jurisdiction in 2002 and as such reliable data is not yet available. See also Factors Two, Three and Six in Attribute 38.

Objective F: Ensure that prevention activities/interventions for identified populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended consumers for cultural appropriateness, relevance, and acceptability.

- **Attribute 42 (Prevention Activities/Interventions):** Demonstrated application of existing behavioral and social science, and pre- and post-test outcome evidence (Including evaluation date, when available) to show effectiveness in averting or reducing high-risk behavior within the target population.

  The CPG's process of identifying a set of prevention interventions necessary to reduce transmission in prioritized target populations is outlined in the "Appropriate Science-based Prevention Interventions and Gap Analysis" section of this Plan starting on page 262 . This process narrative provides evidence of compliance with this attribute. Specifically, in "Step 3" on page 265, the Interventions Subcommittee utilized the CDC "Compendium of HIV Prevention Interventions with Evidence of Effectiveness", (*Appendix Q*), to identify prevention interventions that demonstrate evidence of effectiveness for reducing sex and/or drug-related risks, for each of the prioritized target populations. The Interventions Subcommittee inferred that the inclusion of an intervention in the "Compendium of HIV Prevention Interventions with Evidence of Effectiveness" indicated that the intervention demonstrated application of existing behavioral and social science, and pre- and post-test outcome

evidence to show effectiveness in averting or reducing high-risk behavior within the target population.

In addition, each CDC-funded provider of prevention interventions completed the "Prevention Intervention/Other Supporting Activity Summary Worksheets" (CDC Monitoring and Evaluation Tools). Documentation of supporting evidence for the choice of the prevention intervention activity is indicated in box 18 on each worksheet (*Appendix S*).

Attribute 43 (Prevention Activities/Interventions): Evidence that the prevention activity/intervention is acceptable to the target population (e.g., testing, focus groups, etc.).

The CPG's process of identifying a set of prevention interventions necessary to reduce transmission in prioritized target populations is outlined in the "Appropriate Science-based Prevention Interventions and Gap Analysis" section of this Plan (starting on page 262). This process narrative provides evidence of compliance with this attribute. Specifically, in "Step 2" on page 264 the Interventions Subcommittee utilized the needs assessment data collected in the CSA process (*Appendix N*), to develop a set of prevention interventions for each target population, that were identified by the target population as being appropriate/acceptable.

- **Attribute 44 (Prevention Activities/Interventions):** Evidence that the prevention activity/intervention is feasible to implement for the intended population in the intended setting.

The CPG's process of identifying a set of prevention interventions necessary to reduce transmission in prioritized target populations is outlined in the "Appropriate Science-based Prevention Interventions and Gap Analysis" section of this Plan starting on page 262 . This process narrative provides evidence of compliance with this attribute. Specifically, in "Step 3" on Page 265, the Interventions Subcommittee utilized the CDC "Compendium of HIV Prevention Interventions with Evidence of Effectiveness", *(Appendix Q*), to identify prevention interventions that demonstrate evidence of effectiveness for reducing sex and/or drug-related risks, for each of the prioritized target populations. The Interventions Subcommittee inferred that the inclusion of an intervention in the "Compendium of HIV Prevention Interventions with Evidence of Effectiveness" indicated that the intervention was feasible to implement for the intended population in the intended setting.

In addition, each CDC-funded provider of prevention interventions completed the "Prevention Intervention/Other Supporting Activity Summary Worksheets" (CDC Monitoring and Evaluation Tools). Documentation of supporting evidence for the

choice of the prevention intervention activity is indicated in box 18 on each worksheet. (*Appendix S*)

- **Attribute 45 (Prevention Activities/Interventions):** Evidence that the prevention activity/intervention was developed by or with input from the target population.

  The CPG's process of identifying a set of prevention interventions necessary to reduce transmission in prioritized target populations is outlined in the "Appropriate Science-based Prevention Interventions and Gap Analysis" section of this Plan starting on page 262. This process narrative provides evidence of compliance with this attribute. Specifically, in "Step 4" on page 267, the Interventions Subcommittee utilized the CDC "Compendium of HIV Prevention Interventions with Evidence of Effectiveness", (*Appendix Q*) and the needs assessment data collected in the CSA process (*Appendix N*), to identify prevention interventions that demonstrate evidence that the prevention intervention was developed by or with input from the target population.

- **Attribute 46 (Prevention Activities/Interventions):** Prevention activities/interventions are characterized by focus, level, factors expected to affect risk, setting, and frequency/duration.

  The CPG's process of identifying a set of prevention interventions necessary to reduce transmission in prioritized target populations is outlined in the "Appropriate Science-based Prevention Interventions and Gap Analysis" section of this Plan starting on page 262 . This process narrative provides evidence of compliance with this attribute. Specifically, in "Step 3" on page 265, the Interventions Subcommittee utilized the CDC "Compendium of HIV Prevention Interventions with Evidence of Effectiveness", (*Appendix Q*), to identify prevention interventions that demonstrate evidence of effectiveness for reducing sex and/or drug-related risks, for each of the prioritized target populations. The Interventions Subcommittee inferred that the inclusion of an intervention in the "Compendium of HIV Prevention Interventions with Evidence of Effectiveness" indicated that the intervention was characterized by focus, level, factors expected to affect risk, setting, and frequency/duration.

  In addition, each CDC-funded provider of prevention interventions completed the "Prevention Intervention/Other Supporting Activity Summary Worksheets" (CDC Monitoring and Evaluation Tools). The worksheets document the intervention content, frequency, and duration of each of the prevention intervention activities. (*Appendix S*)

- **Attribute 47 (Prevention Activities/Interventions):** Each prevention

activity/intervention is also characterized by scale and significance.

The understanding of this CPG is that at this time, the CDC has designated this Attribute as "optional". Insufficient data exists to address this Attribute until reliable estimates of at risk population have been established. (Per discussion with Lisa Manley and Ted Duncan regarding the Monitoring and Evaluation worksheets.)

The section in the "Prevention Intervention/Other Supporting Activity Summary Worksheets" that addresses "scale and significance" is marked "optional". (*Appendix S*)

- **Attribute 48 (Prevention Activities/Interventions):** Prevention activities/interventions are prioritized by risk population and their ability to have the greatest impact on decreasing new infections.

  The CPG's process of identifying a set of prevention interventions necessary to reduce transmission in prioritized target populations is outlined in the "Appropriate Science-based Prevention Interventions and Gap Analysis" section of this Plan starting on page 262. Each step of the process was structured to prioritize interventions for each risk population. This process narrative provides evidence of compliance with this attribute. Additionally, in "Step 6" on page 271, the process narrative explains that the Interventions Subcommittee utilized epi profile data to prioritize geographic locations within the jurisdiction where prevention interventions would have the greatest impact in reducing HIV transmission.

GOAL Three—Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

A draft Plan and Application were available to the CPG and discussed at the July meeting. Each Subcommittee was provided a laptop computer with the Plan to make direct changes to their sections. A draft with changes to the Plan and Application was sent to the CPG on 8 August for review at the 20 August meeting. A draft of the Plan and Application were overnight mailed to CPG members on 9 September for review at the 17 September CPG meeting. In addition, the Community Planning Linkage Table Worksheet was completed at the August meeting.

Objective G: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding.

- **Attribute 49 (Comprehensive Plan):** Explicit demonstration of linkages between the comprehensive HIV prevention plan and the health department application to CDC for federal funding.

  The Department provided presentations of the CSA process and the process used to identify a set of appropriate science-based prevention interventions to the CPG at the July and August meetings. The Department also provided a presentation at the August meeting on the prevention intervention services supported in the application for CDC funding. During these presentations, a comparison was made between the CPG's set of appropriate science-based prevention interventions necessary to reduce transmission for each target population and the lists of the Department's CDC-supported providers of CTR, PCRS and prevention interventions. This was an explicit verbal demonstration of the linkage between the HIV plan and the Department's CDC application. The CPG was also provided with drafts of the Department's application and the CPG's HIV prevention plan prior to the CPG meetings in July, August and September.

  In this Plan, the list of CDC-supported providers of CTR, PCRS and prevention interventions starting on page 306 can be compared to the CPG's set of appropriate science-based prevention interventions necessary to reduce transmission for each target population (Pages 283 to 293). The list of CDC-supported providers of CTR, PCRS and prevention interventions is taken from the Department's CDC application. This is an explicit written demonstration of the linkage between the HIV plan and the Department's CDC application.

- **Attribute 50 (Comprehensive Plan):** Letter of Concurrence.

  Letter of Concurrence is attached to the Application.

Objective H: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.

- **Attribute 51 (Comprehensive Plan):** Explicit demonstration of linkages between the comprehensive HIV prevention plan and funded interventions.

  During the July and August CPG meetings, the Department provided both written and verbal presentations to the CPG on the set of appropriate science-based prevention interventions necessary to reduce transmission for each prioritized population, as

identified by the Interventions Subcommittee. During the August CPG meeting, the Department provided both a written and verbal presentation on the prevention intervention services supported in the application for CDC funding. During these presentations, a comparison was made between the CPG's set of appropriate science-based prevention interventions necessary to reduce transmission for each target population and the lists of the Department's CDC-supported providers of CTR, PCRS and prevention interventions. This was an explicit verbal demonstration of the linkage between the HIV plan and the Department's CDC-funded interventions.

The CPG was also provided with drafts of the Department's application, including the budget, prior to the CPG meetings in July, August and September. The budget and lists of intervention services funded were discussed. The Department also provided the CPG with lists of prevention intervention services supported by the Department through State and other funding.

In this Plan, the list of CDC-supported providers of CTR, PCRS and prevention interventions starting on (Page 306) can be compared to the CPG's set of appropriate science-based prevention interventions necessary to reduce transmission for each target population (Page 267). The list of CDC-supported providers of CTR, PCRS and prevention interventions is taken from the Department's CDC application. This list is also reflected in the application's budget. This is an explicit written demonstration of the linkage between the HIV plan and the interventions funded through the Department's CDC application.

- **Attribute 52 (Community Services Assessment):** Explicit demonstration that the CPG has used the CSA to determine whether interventions were funded according to the comprehensive HIV prevention plan.

The HIV prevention plan demonstrates the step-by-step process the CPG utilized to develop the CPG's set of appropriate science-based prevention interventions, and the process used to conduct the CSA (needs assessment, resource inventory and gap analysis). These processes were interconnected. The needs assessment data was used to develop the CPG's list of prevention interventions, and this list of prevention interventions, when compared to the resource inventory, resulted in the gap analysis. Although funding limitations do not enable the Department to fund all of the unmet needs (interventions) identified by the CSA (gap analysis), the CPG determined that interventions are funded according to the set of prevention interventions included in the comprehensive HIV prevention plan.

The Department provided verbal and written presentations of the CSA process (needs assessment, resource inventory and gap analysis) to the CPG at the July and August meetings. The Department also provided a verbal and written presentation at the August meeting on the prevention intervention services supported in the application for CDC funding. During these presentations, a comparison was made between the

CPG's set of appropriate science-based prevention interventions and the lists of the Department's CDC-supported providers of prevention interventions. This was a demonstration of the connection between the CSA, the CPG's set of prevention interventions identified in the plan, and the CDC-funded interventions.

IV. ROLES AND RESPONSIBILITIES

Each member of the CPG has a specific role to play whether reflecting the perspective of a specific community, co-chairing, leading a committee or work group, or staffing the community planning process. There are specific roles and responsibilities that the **health department** and **CPG** are each expected to perform in implementing the community planning process. In addition, there are **shared responsibilities** between the health department and the CPG, and specific roles and responsibilities related to the CDC's support and monitoring of HIV prevention community planning.

Health Departments

Health Departments are responsible for supporting the HIV prevention community planning process (via funding, staff and/or consultant/contractor resources, and leadership.) The Health Department's role in HIV prevention community planning is to:

1. **Create and maintain at least one CPG that meets the goals and objectives and operating principles described in this *Guidance.***
   - If there is more than one CPG in the jurisdiction, the health department is responsible for deciding how best to integrate statewide, regional, and local community planning.
   - If there are multiple jurisdictions within a state (i.e., Los Angeles, San Francisco, and California; Chicago and Illinois; Philadelphia and Pennsylvania; New York City and New York; and Houston and Texas), the state and local jurisdictions are expected to have ready access to and review each other's comprehensive HIV prevention plans.

The Pennsylvania HIV Prevention Community Planning Committee (CPG) has representation from Philadelphia as well as from The Philadelphia AIDS Coalition (TPAC, the Ryan White HIV/AIDS Regional Planning Coalition). These jurisdictions have shared or collaborated with needs assessment, epidemiology, and uniform data collection.

In addition, it is the health department's responsibility to support community-planning activities, including:

- Supporting meeting logistics (CPG, public, and other input-focused meetings).
- Supporting CPG member involvement (such as transportation, expense reimbursement, etc.), especially for persons with or at risk for HIV infection.

- Supporting infrastructure for the HIV prevention community planning process (such as staff, consultants, contracts, etc.).

The Division of HIV/AIDS of the health department in concurrence with state travel regulations provides mileage reimbursement, airline flights where appropriate or necessary and hotel vouchers for members of the CPG. In addition, they contract with a hotel setting for the regular meetings of the CPG where a continental breakfast and lunch is provided as well as members have a per diem for meals not provided. Staff of the Division as well as the Pennsylvania Prevention Project are present to provide Committee support as well as consultation when requested.

2. **Appoint the Health Department Co-Chair.** If a state health department implements multiple CPGs, they may encourage local health departments to serve as the Health Department Co-Chair of such planning groups.

Joe Pease, Director of the Division of HIV/AIDS, Pennsylvania Department of Health has served as the Co-Chair through the current planning process. Commencing in November 2003 Ken McGarvey of the Division will serve as Co-Chair.

3. **Ensure collaboration between community planning and other relevant planning processes in the jurisdiction** such as Ryan White CARE Act planning (Titles I, II, III, and IV) and STD prevention.

The Division of HIV/AIDS is part of the Bureau of Communicable Diseases (whose Director was the former Division Chief and hence the original Health Department Co-Chair) and therefore the Division of Tuberculosis and Sexually Transmitted Infections is easily accessible and involved when needed. In addition, the Division of HIV/AIDS is also responsible for all titles of the Ryan White Care Act and staff regularly attend the CPG meetings.

4. **Develop the epidemiological profile and conduct the community services assessment.** Because the health department has a responsibility to inform the public about emerging public trends, including HIV/AIDS and other health related issues, such as syphilis among MSM, it is responsible for developing both of these products (which may be developed by the health department or via a consultant or contract). However, the health department should discuss each of the products with the CPG and agree on the approach that will be used to develop the epidemiological profile (e.g., types of data desired, format, etc.) and the

community services assessment (e.g., types of data to be collected, the methodologies to be used, format, etc.).

The Division of HIV/AIDS has produced the community services assessment in conjunction with the CPG (Page 239) as well as the Epidemiological Profile (Appendix I), and gap analysis (Page 263).

5. **Provide the CPG with information on other federal/state/local public health services for high-risk populations identified in the comprehensive HIV prevention plan.**
   - For example, STD prevention and treatment, TB, hepatitis services, etc.

An information table is provided at each CPG meeting with pertinent information provided by the Division, other CPG members and/or the Pennsylvania Prevention Project.

6. Assure that CPGs have access to current information (including relevant budget information) related to HIV prevention and analysis of the information, including potential implications for HIV prevention in the jurisdiction. Sources of information include evaluations of program activities, local program experience, programmatic research, the best available science, and other sources, especially as it relates to the at-risk population groups within a given community and the priority needs identified in the comprehensive plan.

The Pennsylvania Prevention Project has CPG members on their stophiv.com listserv for both funding as well as pertinent HIV prevention related information. In addition, as mentioned in point 4 information is regularly reproduced and provided at CPG meetings.

7. **Develop an application to the CDC for federal HIV prevention cooperative agreement funds based on the comprehensive HIV prevention plan(s) developed through the HIV prevention community planning process.**
   - Allocate resources based on the priorities presented in the comprehensive HIV prevention plan.
   - Present the funding application and budget to the CPG with adequate time for the CPG to review and issue a written response.
   - Demonstrate that the community planning process has met the Goals and Objectives of community planning.

In January 2003 the health department worked with the CPG to establish a planning timeline that insures that adequate information is provided in a timely fashion to assure that the CPG has sufficient time to review and comment on the Plan and grant application. Initial drafts of the health department application and the CPG Plan were presented at the 16-17 July CPG meeting as well as drafts dated 15 August and 9 September were provided. In September 2003 the timeline for the 2004 submission of the two year Plan was initiated. All allocations of funds are based upon the annual Plan or Plan Updates to which the CPG has concurred.

8. **Allocate, administer and coordinate public funds (including state, federal, and local) to prevent HIV transmission and reduce HIV associated morbidity and mortality.**
   - Award HIV prevention funds to implement the HIV prevention services stated in the comprehensive HIV prevention plan and health department application.
   - Monitor contractor (service provider) activities and document contractor compliance.

Major subcontractors of the Health Department for HIV prevention include the nine local and municipal health departments and the Pennsylvania Prevention Project at the Graduate School of Public Health, University of Pittsburgh. These programs are part of the recently created uniform data collection system and are monitored for program performance on a regular basis. State HIV prevention funds are awarded to the seven Ryan White HIV/AIDS Regional Planning Coalitions which are also part of the uniform data collection system and are monitored regularly.

9. **Provide regular updates to the CPG on successes and barriers encountered in implementing the HIV prevention services described in the comprehensive HIV prevention plan.**
   - Provide the CPG with local program evaluation data, where available.

Funded programs, local county and municipal health departments (represented on the CPG) and programs of the Pennsylvania Prevention Project regularly report as well as when requested to the CPG at their meetings.

10. **Report progress and accomplishments to CDC.**

HIV Prevention Community Planning Groups

CPGs are responsible for developing a comprehensive HIV prevention plan and reviewing the health department's application for federal HIV prevention funding for concurrence with the plan. CPGs do not allocate resources.

The CPG's role in HIV prevention community planning is to:

1. **Elect the Community Co-Chair(s), who will work with the health department designated co-chair(s).**

Community Co-Chairs are elected from the membership of the CPG for two-year terms and can serve two consecutive terms. Co-Chairs are elected at the final meeting of the year in November and commence their term with the January meeting. Current Co-Chair Angi PeaceTree was elected in November 2002 for the 2003-2004 calendar years.

2. **Review and use key data to establish prevention priorities.** The CPG should review all existing and new products (i.e., epidemiological profile, community services assessment, prioritized target populations, selected set of prevention activities/interventions, and the comprehensive HIV prevention plan) prior to all decision making.

The CPG has utilized a wide variety of data to make priority population decisions. There have been over 160 focus groups and dozens of key informant interviews conducted since 1994. The annual Epidemiological Profile and updates guide decisions as well as the inclusion of quality data such as socioeconomic status and other life factors in determining priority populations.

3. **Develop a Comprehensive HIV Prevention Plan.**
   - The CPG's emphasis should be on developing a comprehensive HIV prevention plan that includes priority target populations and prevention activities/interventions. Target populations should be prioritized and prevention activities/interventions chosen based on their ability to prevent as many as new infections as possible.
   - The health department and CPG, together, determine if the CPG will take on responsibility for more than planning- related activities.

The CPG's priority population process is outlined on page 235 as well as in *Appendix M*.

4. **Collaborate with the health department in reviewing and finalizing key community planning activities: the** epidemiological profile, the community services assessment, prioritized target populations, set of

prevention activities/interventions, and the comprehensive plan for HIV prevention community planning.

At the November CPG meeting the planning cycle for the following year is developed and finalized in January following the annual orientation of new Committee members. Each of the Subcommittees therefore informs the health department on requests for epidemiology, interventions, and evaluation and community service assessment information.

5. **Review the health department application to CDC for federal HIV prevention funds, including the proposed budget, and develop a written response that describes whether the health department application does or does not, and to what degree, agree with the priorities set forth in the comprehensive HIV prevention plan.**
   - This is often called the concurrence/non-concurrence process.

The CPG created timeline for completion of the Plan or Plan Update establishes August when the final form of the Plan and Application must be reviewed and discussed for concurrence, concurrence with reservations or nonconcurrence. The Plan and Application must be submitted to the Health Department internal review process for approval at least two weeks prior to the federal deadline for submission.

Shared Responsibilities

Together, the health department and CPG share in:

1. **Process Management: Develop** procedures/policies that address membership, roles, and decision-making, specifically:
   - Composition of the CPG; selection, appointment, and duration of terms to ensure that the CPG membership reflects, as much as possible, the epidemic in the jurisdiction (i.e., age, race/ethnicity, gender, sexual orientation, geographic distribution, and risk for HIV infection);
   - Roles and responsibilities of the CPG, its members, and its various components (i.e., committees, work groups, regional groups, etc.).
   - Process to prospectively identify potential conflict(s) of interest and methods for resolution of conflict(s) of interest for CPG members.
   - A method of reaching decisions; attendance at meetings; and resolution of disputes identified in planning deliberations.

Committee members volunteer at the September meeting for an ad hoc nominations committee to nominate new members to the Committee. In late September or early October the department of health, following input from the Committee, widely distributes

nominating forms to the seven Ryan White HIV/AIDS Regional Planning Coalitions for distribution to their subcontractors and community representatives, the ten local county and municipal health departments, Committee members, posts at the stophiv.com web site in a downloadable fashion, and special mailings to other pertinent groups particularly those representing target and sub-populations. The Pennsylvania Prevention Project analyzes the current composition of the Committee to determine representation within several categories. These include racial/ethnic categories in relation to both the epidemic and Epidemiological profile in Pennsylvania not including Philadelphia, gender, geographic representation, and HIV-infected persons by transmission categories in accordance with the most recent surveillance data. Committee member attendance for the current year is reviewed to determine any vacancies. Nominations are reviewed and scored by the Nominations Committee. Ad hoc Committee members contact potential new Committee members for a brief interview emphasizing the commitment of time necessary for the community planning process. Once the potential members have completed the interview process the Nominations Committee has a final vote. New Members are notified in writing that they have been selected and are invited to attend a one-day orientation and reception the day preceding their first meeting in January. In addition, they are assigned a Committee member who will mentor them through the community planning process.

2. **Membership Selection: Develop** and apply criteria for selecting CPG members:
    - Special emphasis should be placed on procedures for identifying representatives of at-risk, affected, and socioeconomically marginalized groups that are under-served by existing HIV prevention programs.

The Committee has an ad hoc membership work group that meets in the fall to review the current membership representation and needs. They also review the current application and distribution process and recommend necessary adjustments to better insure securing the needed representational membership.

3. **Input Mechanisms: Determine** the most effective input mechanisms for the community planning process.
    - The process must be structured to best incorporate and address needs and priorities identified at the community level.
    - The process should include strategies for obtaining input from key populations (e.g., IDUs, MSM, youth, undocumented immigrants, etc.) that may not be CPG members.

If particular groups are not at the table as members, representatives of those sub-populations or communities can be invited to either full Committee or Subcommittee meetings to provide input. In addition, special populations and sub-populations HIV

prevention needs and barriers are accessed through needs assessment focus groups and key informant interviews (Page 239). The CPG established Young Adult Roundtables throughout the Commonwealth in 1996 to access the "voice" of youth and young adults needs and barriers to HIV prevention. Currently there are 159 representatives in ten communities. Their Executive Committee elects four members who are full voting members of the CPG. They have organized themselves so that one representative relates to each of the four Subcommittees thereby insuring that the youth and young voices permeate the planning process.

4. **Planning Funds: Provide** input on the use of planning funds:
   - Support CPG meetings, public meetings, and other means for obtaining community input;
   - Facilitate involvement of all participants in the planning process, particularly those persons with and at risk for HIV infection;
   - Support capacity development for inclusion, representation, and parity of community representatives and for other CPG members to participate effectively in the process;
   - Provide technical assistance to health departments and community planning groups by outside experts;
   - Assure representation of the CPG (governmental and non-governmental) at necessary regional or national planning meetings.
   - Support planning infrastructure for the HIV prevention community planning process;
   - Collect, analyze, and disseminate relevant data; and
   - Monitor and evaluate the community planning process.

The health department provides meeting space through a subcontract with a local hotel for the CPG. Meeting notices are published as this meeting process is subject to the Pennsylvania Sunshine Act and not a closed session. The Pennsylvania Prevention Project at the Graduate School of Public Health is subcontracted to provide meeting facilitation, access to behavioral science, evaluation and needs assessment expertise. Consumer Advisory Boards of the Ryan White HIV/AIDS Community Planning Coalitions as well as HIV-related clinical sites and community-based AIDS service organizations are solicited for CPG membership representation from HIV infected communities. During the new member Committee selection process current CPG members talk with prospective members concerning their potential role on the Committee particularly as it relates to participation and commitment to the process. As well new members are assigned mentors (current more experienced CPG members) to help them understand representation, inclusion, and parity within the HIV prevention community planning process. Requests for technical assistance from Committee members and subcommittees have been honored. The health department funds the Co-Chair to attend the annual National HIV Prevention Community Planning Summit but is under state constraints to provide additional participation at national or local events. Options are currently being reviewed to insure others have the ability to participate.

5. **Provide a thorough orientation for all members, as soon as possible after appointment.** New members should understand the:
   - Goals and Core Objectives, roles, responsibilities, and principles outlined in this *Guidance;*
   - Procedures and ground rules used in all deliberations and decision making; and
   - Specific policies and procedures for resolving disputes and avoiding conflicts of interest that are consistent with the principles of this *Guidance.*

All new CPG members receive a three-ring binder with pertinent information to the HIV prevention planning process. The following day they attend their first full Committee meeting.

The CPG meets seven times each year and the Steering Committee meets following each of these times. The 2004 CPG Orientation will take place on Tuesday 20 January and the full CPG will meet on Wednesday 21 January. CPG meetings for the remainder of 2004: 17 & 18 March, 19 & 20 May, 21 & 22 July, 18 August, 15 September, and 17 November. The Committee meets at the Best Western Inn and Suites of Middletown/Harrisburg.

The CPG operates on a consensus basis. In 2000 a CPG member skilled in negotiation provided technical assistance to the CPG relative to developing group consensus.

Rules for respectful Engagement (developed in 2000)
(1) Those who wish to speak must be recognized by the Co-Chair or Facilitator
(2) No cross-talking or sidebar conversations
(3) Respect time—no long oratories
(4) Verbal attacks are not acceptable
(5) Agree to disagree with respect
(6) Respect the other speaker and do not interrupt
(7) Members are encouraged to ask questions and seek clarification
(8) Create a "parking lot" during meetings to rest ideas or discussion items and decisions on each parking lot issue should be made before the end of discussion
(9) Recognize and respect others' physical limitations and capacities
(10) Do not simply reiterate, just agree
(11) Do not speak for others (in other words, use "I" statements).

Conflict of Interest
The CPG created a conflict of interest statement in 1998. A disclosure statement form is completed by each CPG member and kept on file. On issues where a CPG members' affiliate is the potential recipient of funds, that member may not vote or participate in the

discussion. The minutes of the meeting shall reflect that a disclosure was made as well as the abstention from voting.

6. **Evaluate the community planning process to assure that it is meeting the core objectives of community planning.**

Centers of Disease Control and Prevention – The role of the CDC in the community-planning process is to:

1. **Provide leadership in the national design, implementation, and evaluation of HIV prevention community planning.**

2. **Collaborate with health departments, CPGs, national organizations, federal agencies, and academic institutions to ensure the provision of technical/program assistance and training for the community planning process.**
   - Work with the health department and the community co-chairs to provide technical/program assistance for the community planning process, including discussing roles and responsibilities of community planning participants, disseminating CDC documents, and responding to direct inquires to ensure consistent interpretation of the guidance.

3. **Provide technical/program assistance through a variety of mechanisms** to help recipients understand how to:
   - Analyze epidemiological, behavioral and other relevant data to assess the impact and extent of the HIV/AIDS epidemic in defined populations;
   - Analyze community services assessments and compile analyses of prevention program gaps;
   - Prioritize target populations, and interventions based on their ability to result in the greatest decrease in new HIV infections;
   - Identify and evaluate effective and cost-effective HIV prevention activities for these priority populations;
   - Provide access to needed behavioral and social science expertise;
   - Ensure PIR in the community planning process;
   - Identify and manage dispute and conflict of interest issues; and
   - Evaluate the community planning process.

4. **Alert health departments and CPGs about emerging trends or changes in the HIV/AIDS epidemic.**

5. **Provide leadership in the coordination between health departments, CPGs, directly funded community-based organizations (CBOs).** CDC

will provide leadership for internal collaboration that may impact HIV prevention programs and funding.

6. **Monitor the HIV prevention community planning process for implementation of the three goals and eight objectives.**

7. **Collaborate with health departments in evaluating HIV prevention programs.**

8. **Collaborate with other federal agencies and offices** (particularly the Health Resources and Services Administration, National Institutes of Health, Office of Health Services Administration) in promoting the transfer of new information and emerging prevention technologies or approaches (i.e., epidemiological, biomedical, operational, behavioral, or evaluative) to health departments and other prevention partners, including non-governmental organizations.

VI ACCOUNTABILITY

A. Program Performance Indicators

Program Performance Indicators—The following **required** indicators provide a gauge for HIV prevention community planning implementation specifically in processes, activities, and/or products that must be developed or implemented to achieve the goals and objectives of HIV prevention community planning. The data sources detail what data will be reported to CDC. Furthermore, CDC will provide specific guidance on how performance indicators will be operationalized and reported and also how to set baselines and targets for each indicator.

Indicator E.1: Proportion of populations most at risk, as documented in the epidemiological profile, that have at least one CPG member that reflects the perspective of each population.

- Data source: Community Planning Membership Survey, Epidemiological Profile.

70-Percent based upon a comparison of the CPG Membership Survey Report and the top ten priority populations found in the comprehensive Plan.

Indicator E2: Proportion of key attributes of an HIV prevention community planning process that CPG membership agreed have occurred.

- Data source: Community Planning Membership Survey

The five objectives relating to the HIV prevention community planning process had an average 93% agreement.

Indicator E3: Percent of prevention interventions/supporting activities in the health department CDC funding application specified as a priority in the comprehensive HIV prevention plan.

- Data source: Community Planning Linkage Table Worksheet

81-Percent based upon the 2003 process monitoring data for the first ten priority populations and corresponding interventions.

Indicator E4: Percent of health department-funded prevention interventions/supporting activities that correspond to priorities specified in the comprehensive HIV prevention plan.

- Data source: Community Planning Linkage Table Worksheet & Process Monitoring system.

83-Percent based upon the 2004 intervention plans for the first ten priority populations and corresponding priority populations.

B. Concurrence, Concurrence with Reservations and Nonoccurrence

As part of its application to the CDC for federal HIV prevention funds, every health department must include letter of concurrence or nonoccurrence from each CPG officially convened and recognized in the jurisdiction. CPG members should carefully review the comprehensive HIV prevention plan and the health department's entire applications (including the proposed budget) to CDC for federal funds. It is critical the CPG review the proposed allocation of resources in the health department's application using the "Community Planning Linkage Table Worksheet (*Appendix T*).

V. APPENDICIES