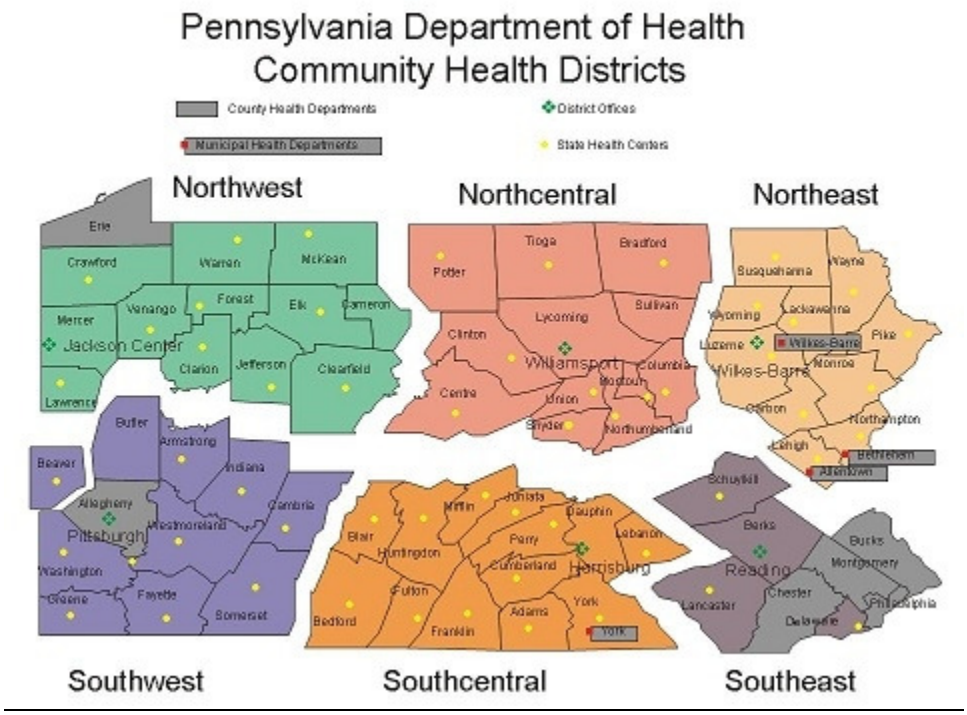
Pennsylvania Community HIV Prevention Plan Update 2011

pennsylvania
DEPARTMENT OF HEALTH

Edward G. Rendell, Governor
Everette James, 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, University of Pittsburgh Graduate School of Public Health September 1, 2010

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7. CONCLUSIONS AND RECOMMENDATIONS

Tables and Figures

Note: Section 6 Evaluation has a number of imported various evaluation reports. Hence, the sequences of the numbers on the many tables and/or figures contained therein are not included here as well they will not be related to the previous format numbering in the Plan Update.

1. EXECUTIVE SUMMARY

The Pennsylvania HIV Prevention Community Planning Committee, the Community Planning Group (CPG) for the Commonwealth of Pennsylvania (not including Philadelphia), has been at work since January 2010 developing a Plan Update for 2011. The Epidemiology, Evaluation, Interventions and Needs Assessment Subcommittees along with the Rural Work Group have met on a regular basis to insure that the nine steps of community planning are met to produce the key products of a comprehensive HIV Prevention Plan.

The 2011 HIV Prevention Plan is a contract extension of the Five-Year Plan submitted to the Centers for Disease Control and Prevention (CDC) in October 2003, which addressed HIV prevention from 2004 through 2008. As such this Plan focuses on the CDC key products of a comprehensive HIV Prevention Plan and refers to the 2004 HIV Prevention Plan. The 2004 Plan, excluding the appendices, can be accessed at the http://www.stophiv.com or by contacting the Division of HIV/AIDS, Bureau of Communicable Diseases, PA Department of Health (717-783-0572) or the Pennsylvania Prevention Project, University of Pittsburgh Graduate School of Public Health (412-383-3000).

1.1. HIV Epidemiology Support for Prevention Planning

Over the past three years of planning cycles, the Epidemiology subcommittee has implemented an integrated roundtable review. The roundtable review is intended to facilitate increased comprehension of the data-driven linkages between epidemiology of HIV and the work of the respective subcommittees and how this contributes to the prevention plan and application. The review is conducted annually by the Epidemiology Subcommittee in collaboration with other subcommittees, namely needs assessment, interventions, and evaluation. Following the orientation meeting in November of the preceding year, the annual integrated roundtable review is conducted early in each year's planning cycle during the first three consecutive full Community Planning Group (CPG) meetings (January, March and May). The integrated roundtable review is frontloaded into an early stage of the planning cycle to ensure that CPG participants can gain an understanding and knowledge of the linkages in each subcommittee's response plans [including gaps which need to be addressed during subsequent plan development/update meetings (May, July & August) in an integrated process involving all subcommittees]. This process facilitates cross-committee understanding of linkages across subcommittees, integrated plan development and informed CPG member participation in the planning process up to and including the culminating point of the concurrence discussion. Further details of the roundtable review are presented in the planning cycle/timeline, and in subsection 3 of the Section on the Integrated Epidemiologic Profile.

The HIV Epidemiology Section also presents a statement of "problems, goals and objectives" identified by Young Adult Roundtable (YART) participants. (Please see section titled **YART-Identified Problems, Goals, Objective and Epidemiology Clarification and/or Response Plans for Each Objective**). This statement relates to

data needed to facilitate planning for HIV prevention among adolescents and young adults. These problems, goals and objectives are quoted from the YART Consensus Statement. The Epidemiology Subcommittee offers general clarifications and response plans to address the data needs identified by the YART participants, and refers relevant aspects for follow-up by the other subcommittees where applicable.

1.1.1. Current Model for Prioritization of Target/Risk Populations for HIV Prevention

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 HIV risk-related behaviors. The CPG acknowledges the Centers for Disease Control and Prevention (CDC) requirement to prioritize HIV-infected persons as the highest priority population. Since the introduction of this requirement during the 2003-planning year, the CPG completed a new process for refinement and update of the model for prioritization of target populations for prevention in collaboration with an ad hoc prioritization workgroup of the CPG to work with the Health Department (and its consultant team). A report including the objectives, methods, results and recommendations of the prioritization process are presented in more details are in the prioritization section of this plan, have been reviewed with the CPG during the 2010 planning year, and are also incorporated into the Integrated Epidemiologic Profile of HIV/AIDS in Pennsylvania, which is provided through the internet at http://www.health.state.pa.us/hivepi-profile, subsections **8.1. and 8.2.** Revision of Prioritization Model

1.2. Community Service Assessment

This section describes the prevention needs of populations at risk for HIV infection, prevention activities/interventions that currently exist to address needs, and service gaps or where needs are not being met. The Community Services Assessment (CSA) is a combination of three products: Needs Assessment completed by the Needs Assessment Subcommittee and Resource Inventory and Gap Analysis completed by the Interventions Subcommittee.

1.2.1. Needs Assessment

The primary purpose of the needs assessment activities is to provide data for the DOH and CPG 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.

In 2009-2010, at the direction of the CPG, Pennsylvania Prevention Project staff worked on the following projects:

Reprioritization of target populations is still in process, the needs assessment process will not change until the reprioritization plan is finalized. The committee will be working with the Integrated Planning Council and Ryan White funded coalitions to conduct a study on the unmet needs of HIV positive men and women. The Registry project is an ongoing collaboration between the Pennsylvania Department of Health and the Pennsylvania Prevention Project (PPP) with the goal of establishing a statewide registry of HIV service providers. It is a long-term collaborative effort by the Integrated Planning Council and Ryan White funded coalitions to conduct a study on the unmet needs of HIV positive men and women.

The Needs Assessment Committee is examining the HIV prevention needs of MSM in greater detail in the coming year. The process will include conducting focus groups on specific groups of MSM. The goals are to examine the kinds of issues that these specific groups of MSM report concerning HIV and toward prevention. We are also investigating the HIV prevention resources for HIV positive men and women found within mental health and substance abuse treatment facilities.

1.2.2. Gap Analysis

In 2009-2010 the Subcommittee is continuing to update Diffusion of Effective Behavioral Interventions (DEBI) grids to incorporate new DEBIs, specifically CLEAR: Choosing Life: Empowerment! Action! Results! d-up: Defend Yourself! and SIHLE: Sisters Informing, Healing, Living and Empowering. The Interventions Subcommittee continues to review the utilization of available prevention services. In accomplishing this goal, the 2007 HIV/AIDS Surveillance Annual Summary from the Pennsylvania Department of Health was used to establish current living population of AIDS cases within Ryan White HIV/AIDS Regional Planning Coalitions. Pennsylvania Universal Data Systems (PaUDS) data was reviewed for the utilization data (Total Count of Intervention Contacts including Interventions Delivered to Individuals (IDI), Interventions Delivered to Groups (IDG), Comprehensive Risk Counseling Services (CRCS) and Health Communications/Public Information (HC/PI) excluding General Public category.

In the 2010-2011 year the Subcommittee is planning on exploring the utilization by specific priority populations within each Regional HIV Planning Coalition as well as continuing to update the Resources Inventory and the DEBI grids. The Intervention Subcommittee is exploring new technology to conduct gap analysis. The use of *Geo Mapping* will provide geographical information on populations receiving HIV prevention interventions in Pennsylvania. The data generated will demonstrate HIV cases by county to be compared to interventions by county implemented for the target populations of HIV positive individuals, Men who have Sex with Men (MSM), high-risk heterosexual and Injection Drug Use (IDU).

1.3. Appropriate Science-Based Prevention Activities/Interventions

Although CDC Grant funds cannot be used for the provision of viral Hepatitis C prevention services, the Department's Division of HIV/AIDS shall coordinate and

collaborate with other Department programs to integrate and facilitate the provision of HCV prevention services. The Department will continue to update the CPG on its collaborative activities with HCV and related programs. The Intervention Subcommittee recommends exploration of needle exchange programs as a means of reducing HIV as well HCV infection.

There is a current study with five selected drug and alcohol treatment facilities (Pittsburgh, Philadelphia, Clearfield/Jefferson, Northampton, and Lehigh) testing for Hepatitis C infection. This pilot test only screens for Hepatitis C, but is attempting to answer the question of whether clients in drug treatment return for follow-up, among those who test positive for Hepatitis C will they return for confirmatory tests, will they follow through for medical evaluation, will they get vaccinated for viral Hepatitis A and B and essentially going into Hepatitis C treatment. No users of other drugs are included nor are homeless persons in this analysis.

What emerges from the study is the importance of case management that links clients to substance use treatment and vaccination. Certain factors influence client outcomes in Hepatitis management. Having health insurance certainly helps and women are more responsive than males in seeking Hepatitis C testing and following through. There is also a higher probability in this at-risk population of having received a Hepatitis B vaccination than in the general population. It is critical to help those who are hepatitis infected to reduce their alcohol consumption. The number going into substance abuse treatment was comparable to that of the general population. One in ten goes into treatment with this program. There is also a need to increase vaccinations for viral Hepatitis A and B in men who have sex with men.

Limitations of these data are that it is a cross-sectional study of a relatively short time period of two years. Another limitation is the self-reporting of risk factors. This cohort will be followed and assessed at six, nine and twelve months.

1.4. Rural Work Group

According to the Centers for Disease Control (CDC) and Prevention, Health Status: HIV/AIDS summer 2005 publication, “AIDS rates have increased outside of metropolitan statistical areas (MSAs), and the demographic characteristics of people with HIV disease in rural populations may differ from those in urban populations. Compared with their urban counterparts, residents of rural areas may face additional barriers to accessing HIV testing and care, drug treatment, and mental health counseling. Such barriers include geographic isolation, poverty, unemployment, lack of education, lack of childcare services, and attitudinal and cultural factors. The Appalachian areas have long been medically underserved and economically disadvantaged. However, little information is available on the burden of HIV disease, including HIV infection without AIDS, in these rural communities.”

In response, the Pennsylvania CPG has established a rural work group, consisting of volunteer committee members, who are applying their efforts outside of regular

committee meeting time address the unique and often not well-understood concerns of rural areas within our state.

The express purpose of the rural work group is to present the special demographic, geographic and social/cultural conditions that impact the HIV prevention needs of non-metropolitan populations in Pennsylvania. These needs must be included in the Pennsylvania HIV prevention plan. "Although rural areas are significant sources of the state's natural resources, and are of primary importance to the economy of Pennsylvania, the needs of rural people are often overlooked because of population dispersion and inadequate political infrastructures" (Willits & Luloff, & Higdon 2004). As information related to rural needs, and interventions of proven effectiveness are located and researched, they will be included in our plan as a means of assisting the non-metropolitan populations.

"The Rural Work Group also realizes that there are few rural voices taking part in the policy discussions, and decision-making processes that shape the public health infrastructure. This is often true at both the state and Federal level. There are several factors at work that are responsible for this situation. One is the changing demographics of our communities. As rural areas continue to lose population relative to the urban and suburban areas, there is also a corresponding loss of political power in state legislatures. Many state governing bodies used to be dominated by their rural members. These rural voting blocks held great sway in many states, and ensured that rural communities had a place at the decision-making table. As the voting power has shifted toward urban and suburban-areas, rural communities have lost political power and, at the same time, there has been no effective lobbying organization devoted solely to rural public health." (The National Advisory Committee on Rural Health, February, 2000)

According to Saltmarsh; "since 1981, when New York, San Francisco, Chicago and, of course, Philadelphia started to see the birth of the HIV pandemic, big cities have had decades to create, establish, and expand medical and support service infrastructures for their residents living with HIV. Most small town and rural areas, however, have not, despite statistics that show infection rates increasing proportionally in such places. College towns may have a bit of an advantage, as their student health systems must address both prevention and treatment in the student population, but what if you live in a town where the main industry is farming and 'townies' work at the grain elevator or the box factory or the strip mall on the edge of town? Chances are Doc Smith, who's delivered all the babies born since the '60s, is not going to be an HIV specialist. The county hospital may not even have an infectious disease specialist since most of their business comes from bar brawls, harvesting accidents, and car crashes, with a smattering of cancer, diabetes, and heart disease. HIV and STI prevention is probably not a high priority. So if you find yourself suddenly in the hospital with pneumonia and an HIV diagnosis, where do you go for help?

"Most people find the nearest big city and, though it may be arduous and expensive to get there, that's where they go for treatment. Not only are they more likely to find a doctor there who specializes in HIV, but it's also a way to escape the risk of your next door

neighbor seeing you going into 'that place' where people go to get tested or see the doctor when they've 'done something they shouldn't have.' As high as the levels of ignorance, stigma, discrimination, and plain old religious condemnation may be in the neighborhoods of the big city, it's a whole 'nother country if you're one of the three people living with HIV in a town of 1,200." (Positively Aware, January/February 2010, *Is Anybody Out There? Life with HIV down on the farm or in small town, U.S.A., Sue Saltmarsh, p.24)*

1.5. Evaluation

The Evaluation Subcommittee has completed the 2010 CPG process evaluation and the seventh annual poster presentation. This year's poster presentation focused on HIV prevention services for rural populations.

The Health Department requires all CDC funded prevention programs—including local health departments—to use the PA Uniform Data System (PaUDS) to collect data about their activities. These data include the demographic and risk-behaviors of people reached by the program and other variables. This system collects much of the same data that Program Evaluation Monitoring System (PEMS) intends to collect. Once the data are cleaned and summarized, they are sent back to the agencies and to the Health Department where they are used to identify strengths and weaknesses, and to revise programs so that they better conform to the Committee's Plan.

The CPG addressed planning process concerns by having trained non-CPG members gather data through open-ended questions posed to small groups of CPG members. It was felt that this method provides greater objectivity and a lack of conflict of interest. The results of the November 2009 review of the calendar year 2009 planning process were presented at a subsequent CPG meeting. Most findings of this evaluation were immediately implemented by the CPG.

The evaluation of the impact of the Plan on interventions is a relatively new activity using poster presentations by statewide agencies. Agencies are asked to create posters describing their work. The Evaluation Subcommittee members develop a grid to identify all of the issues that Committee members want evaluated and collect the data at the presentations. The data are then analyzed and recommendations developed. This innovative program also promotes communication and networking between the Committee and providers.

The purpose of the Poster Presentations is to elicit an initial dialogue between funded agencies/organizations and the CPG. Any first step in designing a framework for an evaluation needs to establish dialogue and capacity. This process provides great insight to the local challenges of providing targeted HIV prevention. It informs the CPG in its development of a community-based HIV prevention Plan.

A comparison of the 2004-2010 poster sessions reveals several themes that are universal to all sessions. It should be remembered that each group of presenters differed from the

other, as did the prescribed content of their presentations. The representatives of community based organizations involved in HIV prevention activities in 2004 were uncomfortable with the process because they thought that they were being evaluated. They became much more comfortable once they understood that the purpose was not to evaluate them but to increase communication between providers and the Department of Health and the Committee and to have the DOH and Committee better understand the work of the providers. Nevertheless, the concerns of the providers may have had an effect on what information they were willing to provide. PA Department of Health regional staff presented in 2005 on their prevention activities. In 2006 Community-based providers of prevention services presented. However, they focused on their experiences in conducting the Diffusion of Effective Behavioral Interventions (DEBI). In 2007, local county and municipal health departments presented evidence-based HIV prevention programs. In 2008, a combination of local, county and municipal health departments along with community based providers presented posters describing evidence-based HIV prevention programs being delivered in correctional facilities. In 2009, a mix of HIV prevention agencies and immigration services agencies described their HIV prevention programs.

In 2010, the poster presentation focused on HIV prevention services for at-risk rural populations. The session included six poster presentations of HIV evidence-based interventions (EBIs). As a result, this year's summary is a clear picture of the programming available to rural populations. Five of the six organizations listed prior knowledge of the State HIV prevention plan prior to the invitation from the CPG. The presentation process has evolved in such a way that the efficiency of the session has allowed for an increased level of comfort for presenters and CPG members.

The Young Adult Roundtable Process Evaluation is administrated annually (November) to Planning Committee members. This survey provides Planning Committee members the opportunity (both qualitatively and quantitatively) to comment on the progress of the Roundtables during the past year. The evaluative tool assesses young people's parity, inclusion, and representation in the planning process. Roundtable members use the Committee's feedback to strengthen the project and Roundtable member involvement in the community planning process.

1.6. HIV Prevention Community Planning

In a 2009 communication from the National Alliance of State and Territorial AIDS Directors (NASTAD) the Centers for Disease Control and Prevention (CDC) Prevention Program Branch (PPB) has requested NASTAD to provide an update on several program announcements affecting HIV Prevention Community Planning. PCB will be replacing two announcements this year with two-year "bridge" programs that will begin January 2010. It is expected that funding levels under these Funding Opportunity Announcements (FOA) will be comparable to FY 2009 levels. During this two year period, PPB will be developing a plan for a new five-year prevention program for health departments that can begin in January 2012. In the interim, CDC recommends jurisdictions make no significant or major revision relative to their current HIV prevention planning efforts.

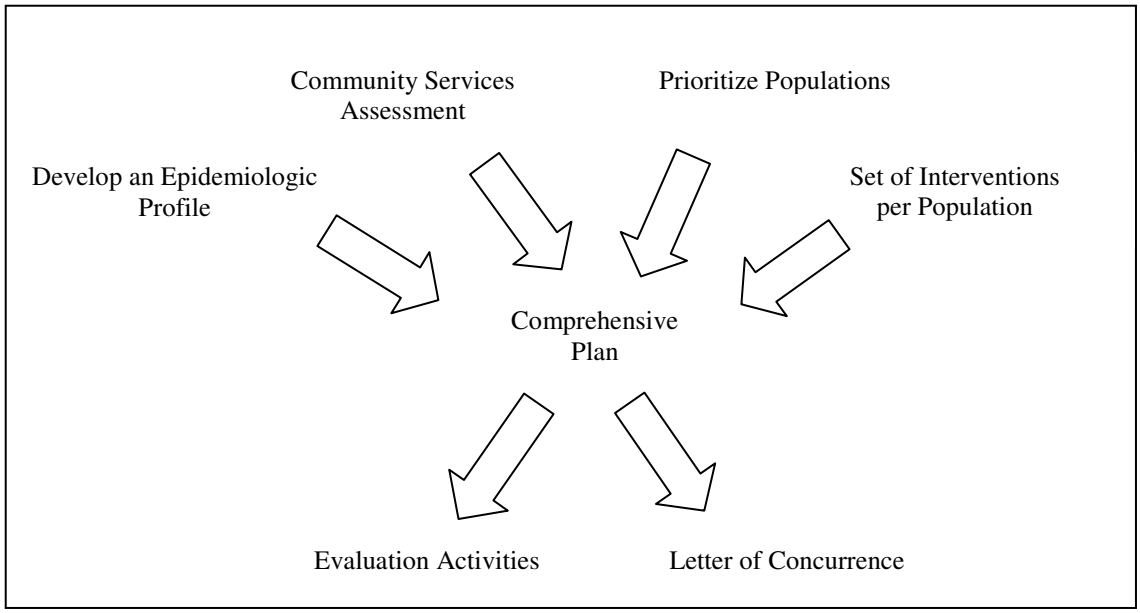

Figure 1.1 Components of HIV Prevention Community Planning

1.7. CPG Planning Cycle –Summary

During the final CPG meeting of the year in November and at the first meeting in January of each year the CPG members develop the CPG Planning Cycle for the upcoming year. This is the opportunity for each of the Subcommittees and Work Group(s) to effectively plan their direction and subsequent needs to complete the nine steps of community HIV prevention planning. The CG Planning Cycle is maintained by the Health Department and provided to each CPG member prior to the next meeting. The Steering Committee (Co-Chair, Community Co-Chair and each Subcommittee Co-Chair(s) & Work group representative) meet following each CPG meeting to update the cycle for the following meeting.

CPG Planning Cycle -Summary
(Based on 2-year CDC cycle: 2010 - 2011)

PA CPG Planning Cycle	Products to be developed:	Due Dates
2-year bridge program		
2010 **2011**	• **Plan Update for 2011** • **Plan Update for 2012**	• **August 20, 2010 - submitted** • **Unknown**

New 5-year planning cycle		
2012 **2013** **2014** **2015** **2016**	• **Comprehensive HIV Prevention Plan for 2013** • **Plan Update for 2014** • **Plan Update for 2015** • **Plan Update for 2016** • **Plan Update for 2017**	

Revised August 2010

2009-2010 CPG Meeting Schedule & Work Plan for 2011 Plan Update
November 2009 – September 2010

November 18, 2009 (1 day)

	Objective	**Subcommittee**	**Comments**
	Welcome new members.		Completed
	Brief Announcements	DOH	Completed
	Icebreaker	PPP	Completed
	Special presentations for current members (scheduled to occur during orientation): 1. Update on MSM Strategic Plan 2. Update on Expanded HIV Testing Project 3. Update on Reprioritization Process 4. PSU HIV+ Project		Completed
	Orientation of new members (full day) 1. CPG Guidance 2. Comprehensive Plan & Key Planning Products 3. Description of subcommittees 4. Basic Epidemiology 5. CDC Program Announcement - What is a comprehensive HIV prevention program? 6. Advancing HIV Prevention Initiative 7. Roles & responsibilities 8. Group process 9. Evaluation	DOH, PPP & CPG	1. Completed 2. Completed 3. Completed 4. Completed 5. Completed 6. Completed 7. reschedule for future meeting 8. Completed 9. Completed
	CPG Process Monitoring (focus groups) 1:00- 3:00 (2-hours)	All "old" members By-The-Numbers	3 break- out rooms
	Subcommittees Meet to:		

	Subcommittees will not meet during this meeting.	Epidemiology	
		Needs Assessment	
		Interventions	
		Evaluation	
	Steering Committee Meets to:		
	Review member attendance and termination of members not meeting By Law requirements for attendance.		Reschedule for Steering Committee
	Set agenda for next meeting.		Completed
	Presentations requested for January: • Travel, Lodging & Subsistence • Roles & responsibilities group activity • Review of member attendance (Steering Committee)		Travel, Lodging & Subsistence scheduled for January

January, 20 & 21, 2010 (2-days)

	Objective	**Subcommittee(s)**	**Comments**
	(Day 1)		
	Welcome new members.		Completed
	YART Report		Completed
	Presentation of 2009 CPG Process Monitoring findings	Evaluation	Completed
	Presentation of 2009 CPG Survey Part II findings.	Evaluation	Completed
	Completion of CPG Survey Part I	All members	Completed
	Introduction to HIV Epidemiology for Prevention & Care Planning (80 minutes)	Epidemiology Dr. Muthambi	Completed
	Update on Reprioritization of Target Populations	Epidemiology Dr. Muthambi	Completed in November
	Overview of Travel, Lodging & Subsistence Guidelines	DOH	Completed
	Presentation: Planning Process Overview	Ken	Completed during orientation in November
	Review of CDC Technical Review of IPR/Cost Extension and DOH Technical Review response	DOH	Schedule for March
	Subcommittees meet to:		**Need breakout rooms.**
	Elect chair & co-chair of each subcommittee	All subcommittees	Completed
	Review and finalize the work plan for 2010	All subcommittees	Completed
	Orient new members to Comprehensive Plan key products specific to each subcommittee: • Epidemiologic Profile (Epi Subcommittee)	All subcommittees	Completed

	• Community Services Assessment
	  ○ Resource Inventory (Interventions Subcommittee)
	  ○ Needs Assessment (Needs Assessment Subcommittee)
	  ○ Gap Analysis (Interventions Subcommittee)
	• Prioritize Target Populations (Epidemiology Subcommittee)
	• Identify Appropriate Science-based Prevention Interventions (Interventions Subcommittee)
	• Concurrence (ALL)		

	Prepare for Integrated Roundtable Review	Epidemiology	Completed
	• Discuss needs assessment activities conducted by PPP. • Start thinking about priority populations in relation to integrated Roundtable Review.	Needs Assessment	Completed
	Review of conference materials	Interventions	Completed
	Begin discussion for May Poster Presentation: • Floor plan and arrangements – reserve room. • Materials and equipment • Process • Select presenters	Evaluation	
	Rural Work Group meets from 6pm – 7:30pm.	All welcome!	Completed
	Special evening event: Get Acquainted Reception. 7:30pm – 9pm	***Everyone welcome!***	***Location to be announced.*** Completed
	1/22 (Day 2)		***Need breakout rooms.***
	Overview of Integrated Roundtable exercise.	Epidemiology	Completed
	Epidemiology Subcommittee (Dr. Muthambi) provides Epidemiologic Overview of 1 transmission group (Heterosexual & Perinatal)**.**	Epidemiology	Completed
	Subcommittees meet to prepare presentations for Round table Review	All	Completed
	<u>Part I- January Meeting</u>: <u>Integrated Round-Table Review and Discussion of Plans on Each Transmission Group with Other Subcommittees</u> (Epi Subcomm; Unmet Needs Assessments; Interventions Subcommittees; (Outcome) Evaluation): The integrated approach **<u>adds</u>** an integrated review mechanism to the current disjointed planning done in separate subcommittees and to conduct	CPG	**Format and time for integrated review for each transmission group:** 2 hours integrated review is proposed for each of the four transmission groups: *-Roundtable*

	the integrated review in phases as the planning year progressed as opposed to waiting until the end of the planning cycle. The proposed format of input to the integrated review is as follows: a) Summary of Epidemiology of HIV in each of the 4 main transmission groups (and constituent target populations); identification of data gaps and plans for obtaining data needed; b) Summary of unmet needs assessments conducted/planned for each of the 4 main transmission groups (and constituent target populations); identification of data gaps and plans for obtaining data needed; c) Interventions for each transmission group (and constituent target populations) and gaps in needed interventions; d) Outcome Evaluation Minimum Standards and Guidance for Each Category of Interventions; **Expected Outcome**: The integrated review approach will enable the full committee to: a) be more engaged and more informed on the development of plans by each subcommittee for each transmission group and its constituent target populations; and b) establish linkage and continuity of plans across subcommittee work. This approach is expected to increase understanding of the underlying Epidemiology of HIV in each transmission group and the prevention response plan alleviate the current disjointed nature of the planning as done in completely separate subcommittee tracks and only hurriedly reconciled at the end of the planning cycle.		*presentations to full committee*: 90 min (30 mins Epi overview on transmission group; 30 mins on Interventions, and 15 mins each for Unmet Needs Assessment and Outcome Evaluation); *-Integrated roundtable discussion with full committee*: 30 min **Timeline**: ***Part I-January meeting*: cover 1 transmission group (incl. their constituent target populations) (4 hrs needed). Hetero, and Perinatal** *Part II-March meeting*: cover 1 transmission group (incl. their constituent target populations) (4 hrs needed). **IDU** *Part III-May meeting*: cover 1 transmission group (incl. their constituent target populations) (4 hours needed). **MSM** Completed
	Steering Committee Meets to:		
	Set agenda for next meeting.		Completed
	Review of member attendance (Steering Committee)		Completed
	Requested presentations: • Review of post-test results of 1st Roundtable review • Roles & responsibilities group activity • DEBI overview training for CPG • Sexual minority sensitivity training • Human sexuality training • Domestic Violence & HIV (Susan		

	Spencer) • Update on MSM Strategic Plan (PPP & PSU) • Discussion of Prevention support for Epidemiologist position. • Planning Process overview. • Jurisdictions • Reprioritization status report. • Department of Education		

March 17 & 18, 2010 (2-days)

	Objective	**Subcommittee**	**Comments**
	Day 1		
	Remind CPG members to complete CPG survey part I	Ken (on behalf of Evaluation)	Completed
	YART Report		Completed
	Presentations: • Overview of Pharmacy Outreach project • Plan to Rollout Prevention for Positives Recommendations	PPP	Completed
	Review of CDC Project Officer's Summary Statement (review of 2010 application)	Ken	Time permitting – copies distributed to CPG members Completed
	Project Update: Refined Prioritization Model for target Populations in PA	Benjamin	Completed
	Discussion/report on status of preparation of for May Poster Presentations	Evaluation	Completed
	Presentation: review of Post-test results from January's Integrated Roundtable Review	Epidemiology	Completed
	Subcommittees meet:		
		Epidemiology	
	• Discuss current needs assessment activities. • Start brainstorming for the new plan update.	Needs assessment	Completed
	• Hepatitis C layout	Interventions	
	• Final review in preparation for Poster Presentation • Select presenters • Revise letters, methods of data collection, directions for presenters	Evaluation	Completed

	• Anything else to be done?		
	Open issues (may be an opportunity to meet with other subcommittees on potential joint collaborative matters, especially Needs Assessment).	All	
	Rural Work Group meets from 6pm – 8pm.	All welcome!	Completed
	Day 2		
	Overview of Integrated Roundtable exercise. Complete pre-test	Epidemiology	Completed
	Epidemiology Subcommittee (Dr. Muthambi) provides Epidemiologic Overview of 1 transmission group (MSM).	Epidemiology	
	Subcommittees meet to prepare presentations for Round table Review	All	
	Part II-March Meeting: Integrated Round-Table Review and Discussion of Plans on Each Transmission Group with Other Subcommittees (Epi Subcomm; Unmet Needs Assessments; Interventions Subcommittees; (Outcome) Evaluation): The integrated approach **adds** an integrated review mechanism to the current disjointed planning done in separate subcommittees and to conduct the integrated review in phases as the planning year progressed as opposed to waiting until the end of the planning cycle. The proposed format of input to the integrated review is as follows: a) Summary of Epidemiology of HIV in each of the 4 main transmission groups (and constituent target populations); identification of data gaps and plans for obtaining data needed; b) Summary of unmet needs assessments conducted/planned for each of the 4 main transmission groups (and constituent target populations); identification of data gaps and plans for obtaining data needed; c) Interventions for each transmission group (and constituent target populations) and gaps in needed interventions; d) Outcome Evaluation Minimum Standards and Guidance for Each Category of	CPG	**Format and time for integrated review for each transmission group:** 2 hours integrated review is proposed for each of the four transmission groups: *-Roundtable presentations to full committee*: 90 min (30 mins Epi overview on transmission group; 30 mins on Interventions, and 15 mins each for Unmet Needs

	Interventions; **Expected Outcome**: The integrated review approach will enable the full committee to: a) be more engaged and more informed on the development of plans by each subcommittee for each transmission group and its constituent target populations; and b) establish linkage and continuity of plans across subcommittee work. This approach is expected to increase understanding of the underlying Epidemiology of HIV in each transmission group and the prevention response plan alleviate the current disjointed nature of the planning as done in completely separate subcommittee tracks and only hurriedly reconciled at the end of the planning cycle. Note: Department of Health staff will present prevention activities process monitoring data in conjunction with Evaluation Subcommittee.		Assessment and Outcome Evaluation); *-Integrated roundtable discussion with full committee*: 30 min **Timeline**: ***Part II-March meeting*: cover 1 transmission group (incl. their constituent target populations) (4 hrs needed). IDU** Completed *Part III-May meeting*: cover 1 transmission group (incl. their constituent target populations) (4 hours needed). MSM
	Conduct post-test	Epidemiology	Completed
	Steering Committee Meets to:		
	Set agenda for next meeting.		Completed
	Future presentations requested: 1. Department of Education review of CDC grant and update on YRBS 2. Review of post-test results from March Integrated Roundtable Review **3. MSM Strategic Planning results (PPP and PSU/Benjamin)** 4. Review of post-test results of March Roundtable review 5. Roles & responsibilities group activity 6. DEBI overview training for CPG 7. Sexual minority sensitivity training 8. Human sexuality training		

	9. Domestic Violence & HIV (Susan Spencer) 10. Discussion of Prevention support for Epidemiologist position. 11. Planning Process overview. 12. Jurisdictions		

May 19 & 20, 2010 (2 days)

	Objective	**Subcommittee**	**Comments**
			YART Executive Committee Members to attend this meeting.
	Day 1		
	Young Adult Roundtables (YART) status report to CPG. YART Executive Committee attends this meeting.	YART	Completed
	MSM Strategic Planning results: 1. Epi Profile 2. Community Services Assessment (CSA)	PSU/Benjamin PPP	Completed
	CPG preparation for Poster Presentations: • Distribute Questions to CPG members • Count into groups	Evaluation	Completed
	CPG reconvenes downstairs after lunch for Poster Presentations:		
	CPG Poster Presentations: • **Review posters of Department-funded HIV Prevention contractors/grantees.** • Networking with contractors and CPG	CPG/Evaluation	Completed
	Rural Work Group meets from 6pm – 8pm.	All welcome!	Completed
	Special showing of the film: "Out in the Silence" @ 7:00 PM	**All welcome!**	Completed
	Day 2		
	CPG provides feedback on Poster Presentations.	CPG	Deferred until July
	Epidemiology Subcommittee provides direction to CPG on Integrated Roundtable Review.	Epidemiology	Completed

	Epidemiology Subcommittee (Dr. Muthambi) provides Epidemiologic Overview of 1 transmission groups (MSM).		Completed
	Subcommittees meet to prepare presentations for Round table Review	All	Completed
	<u>Part II-May Meeting</u>: <u>Integrated Round-Table Review and Discussion of Plans on Each Transmission Group with Other Subcommittees</u> (Epi Subcomm; Unmet Needs Assessments; Interventions Subcommittees; (Outcome) Evaluation): The integrated approach **<u>adds</u>** an integrated review mechanism to the current disjointed planning done in separate subcommittees and to conduct the integrated review in phases as the planning year progressed as opposed to waiting until the end of the planning cycle. The proposed format of input to the integrated review is as follows: a) Summary of Epidemiology of HIV in each of the 4 main transmission groups (and constituent target populations); identification of data gaps and plans for obtaining data needed; b) Summary of unmet needs assessments conducted/planned for each of the 4 main transmission groups (and constituent target populations); identification of data gaps and plans for obtaining data needed; c) Interventions for each transmission group (and constituent target populations) and gaps in needed interventions; d) Outcome Evaluation Minimum Standards and Guidance for Each Category of Interventions; **Expected Outcome**: The integrated review approach will enable the full committee to: a) be more engaged and more informed on the development of plans by each subcommittee for each transmission group and its constituent target populations; and b) establish linkage and continuity of plans across subcommittee work. This approach is expected to increase understanding of the underlying Epidemiology of HIV in each transmission group and the prevention response plan alleviate the current disjointed nature of the planning as done in completely separate subcommittee tracks and only hurriedly reconciled at the end of the planning cycle. Note: Department of Health staff will present prevention activities process monitoring data in conjunction with Evaluation Subcommittee.	CPG/Epidemiology	**Format and time for integrated review for each transmission group:** 2 hours integrated review is proposed for each of the four transmission groups: *-Roundtable presentations to full committee*: 90 min (30 mins Epi overview on transmission group; 30 mins on Interventions, and 15 mins each for Unmet Needs Assessment and Outcome Evaluation); *-Integrated roundtable discussion with full committee*: 30 min ***Part II-May meeting*:**

			cover 3 transmission groups (incl. their constituent target) (4 hours needed). MSM
	Steering Committee Meets to:		
	Provide feedback on poster presentations and Roundtable Review		Completed
	Set agenda for next meeting.		Completed
	Future presentations requested: 1. Department of Education review of CDC grant and update on YRBS 2. Review of post-test results from March & May Integrated Roundtable Review 3. Review of APR , CDC Technical Review & DOH response. 13. Roles & responsibilities group activity 14. DEBI overview training for CPG 15. Sexual minority sensitivity training 16. Human sexuality training 17. Domestic Violence & HIV (Susan Spencer) 18. Discussion of Prevention support for Epidemiologist position. 19. Planning Process overview. 4. Jurisdictions overview.		

July 21 & 22, 2010 (2 day)

	Objective	Subcommittee	Comments
	Day 1		
	CPG feedback on Poster Presentations	CPG	Completed
	Report on Highlights of Roundtable Reviews	Epidemiology	Completed
	Report on CPG feedback from Poster Presentations	Evaluation	Completed
	Presentation: Results of CPG Survey Part I, and CPG membership comparison to Epidemic in Jurisdiction	Evaluation	Completed
	Discussion & Recruitment for CPG Nominations & Recruitment Process	Ken & N&R Work Group	Completed
	Subcommittees meet to:		
	Subcommittees to prepare draft Plan Update.	All	In progress
	Open issues (may be an opportunity to meet with other subcommittees on potential joint collaborative matters, especially Needs Assessment).	Epidemiology & All	
	Continue to draft Plan for review at next meeting.	Needs Assessment	In progress

	• Continue to draft Plan for review at next meeting. • Needle exchange formatting • NPEP	Interventions	
	Continue to draft Plan for review at next meeting.	Evaluation	In progress
	Rural Work Group meets from 6pm – 8pm.	All welcome!	Completed
	Day 2		
	Discussion & Motion to Approve CPG Process Monitoring for November	Eval.	Completed
	Project Update: HIV & STD Integration (Co-infection) Activities	STD Program Staff	Completed
	Project Update: MSM Internet Interventions	PPP (Ray)	Completed
	Subcommittees meet to:		
	Subcommittees to prepare draft Plan Update.	All	In process
		Epidemiology	
		Needs Assessment	
	Geo Mapping	Interventions	
		Evaluation	
	Open issues (may be an opportunity to meet with other subcommittees on potential joint collaborative matters, especially Needs Assessment).	All	
	Steering Committee Meets to:		
	Set agenda for next meeting.		Completed
	Future presentations requested:		

August 18 & 19, 2010 (2 days)

	Objective	**Subcommittee**	**Comments**
	Day 1: Draft Plan Review		
	YART Report		Completed
	Presentation of draft 2011 Plan Update	PPP(Rodger)/CPG	Completed
	Subcommittees meet to review & discuss draft Plan	All	Completed
	Subcommittee co-chairs present to CPG comments on draft Plan	Subcommittee co-chairs	Time will be provided for subcommittees to meet to revise/complete the Plan Update, as necessary. Completed
	Open issues (may be an opportunity to meet with other subcommittees on potential joint collaborative matters, especially Needs Assessment).	All	
	Agenda can be revised to allow subcommittee to meet the remainder of the afternoon to work on revisions to the Plan Update as necessary.		
	Report on results of CPG Survey Part I & CPG membership Comparison to Epidemic in Jurisdiction	Evaluation	Completed in July
	Update on Nominations & Recruitment	N & R Work	Completed

		Group	
	Update on Changes to PPAs	Bob	Completed at a previous meeting
	Subcommittees meet to begin to develop work plan for 2011.		In progress
	Rural Work Group meets from 6pm – 8pm.	All welcome!	Completed
	Day 2: Presentations		
	Presentation: Department of Education –YRBS update	Department of Education (Shirley)	Completed
	Review of 2009 CDC APR Technical Review & DOH response.	Ken	Completed
	Presentation: Human Sexuality	Emilia & Dennie	Completed
	Project Update: Unmet Needs	Benjamin	Completed
	Project update: stophiv.con & provider registry	PPP	Completed
	If necessary - Subcommittees meet to:		
	Subcommittees meet to review & discuss draft Plan Update	All	Completed
	Open issues (may be an opportunity to meet with other subcommittees on potential joint collaborative matters, especially Needs Assessment).	All	
	Steering Committee meets to:		
	Finalize Plan Update		Completed
	Set agenda for September meeting.		Completed
	Discuss concurrence process in September		Completed
	Future presentations requested:		N/A

***Application due to the CDC on August 20 – Plan will be submitted ASAP following September 15th meeting (October 15th)**

September 15, 2010 (1 day)

	Objective	**Subcommittee**	**Comments**
	YART Executive Committee report meeting.	YART	YART Executive Committee Members to attend this meeting.
	Review of draft CDC budget and application	DOH/Ken	
	Review of CDC-funded services	DOH/Ken	
	"Linkages" presentation to CPG	DOH/Ken	
	Subcommittees meet to discuss concurrence	All subcommittees	
	Subcommittee co-chairs present comments/concerns regarding concurrence to CPG.	CPG	
	Vote on concurrenc/nonconcurrence/concurrence	CPG	

	with reservations.		
	Conduct CPG Survey Part II	CPG	
	Plan & Application due to CDC by October 15th.	DOH	
	Status report on CPG Process Monitoring for November	Evaluation	Contract in place.
	Update on nomination and recruitment – distribute Nomination Applications	DOH/Ken	Applications distributed.
	Discussion of State HIV Prevention Budget	DOH/Ken	
	Remind subcommittees to submit data requests for 2011 – no later that November 2010.	Epi	
	Subcommittees meet to:		
	Review Plan and CDC Application and discuss concurrence. Provide comments/concerns to Subcommittee Chairs for presentation to full CPG.	All	
	Develop work plan for 2011 planning year.	All	
		Epidemiology	
		Needs Assessment	
		Interventions	
		Evaluation	
	Open issues (may be an opportunity to meet with other subcommittees on potential joint collaborative matters, especially Needs Assessment).	All	Ongoing
	Steering Committee meets to:		
	Finalize Plan Update		
	Set agenda for November meeting.		
	Future presentations requested:		

November 17, 2010 (1 day)

	Objective	**Subcommittee**	**Comments**
	Welcome new members.		
	Report on CPG Concurrence Votes	DOH	
	Orientation of new members (full day) 1. CPG Guidance 2. Comprehensive Plan & Key Planning Products 3. Description of subcommittees 4. Basic Epidemiology 5. CDC Program Announcement 6. What is a comprehensive HIV prevention program?	DOH, PPP & CPG	PPP to distribute Orientation Guide prior to meeting.

	7. AHP initiative 8. Roles & responsibilities 9. Group process 10. Evaluation		
	CPG Process Monitoring (focus groups) 10- 12 (2-hours)	All "old" members By-The-Numbers	Need 3 break-out rooms
	Remind subcommittees to submit data requests for 2010 – due this month.		
	Subcommittees Meet to:		
		Epidemiology	
		Needs Assessment	
		Interventions	
		Evaluation	
	Open issues (may be an opportunity to meet with other subcommittees on potential joint collaborative matters, especially Needs Assessment).	All	Ongoing
	Steering Committee Meets to:		
	Review member attendance and termination of members not meeting By Law requirements for attendance.		
	Set agenda for next meeting.		
	Presentations requested:		

2. INTEGRATED EPIDEMIOLOGIC PROFILE OF HIV/AIDS IN PENNSYLVANIA

The Integrated Epidemiologic Profile of HIV/AIDS in Pennsylvania (Profile) describes the impact of the HIV epidemic in the jurisdiction. This profile provides the epidemiologic/scientific basis for prioritization of target populations for HIV prevention and pin-pointing target populations to whom prevention interventions need to be focused, for identification of gaps in data needed for prevention planning which may be supplemented through needs assessments, and for describing population-level outcomes of interventions through describing changes in the epidemic.

2.1. Current Integrated Epidemiologic Profile of HIV/AIDS in Pennsylvania

The current Epidemiologic Profile (for prevention and care) is attached in *Epidemiology Appendix 1* of this Plan Update application. Various aspects of the Epidemiologic Profile are presented to the Committee each year during part 2 of the Epidemiology orientation for new CPG members in January and in greater details during 3 roundtable reviews in January, March and May of each year's planning cycle; i.e. roundtable reviews of the linkages between a) the epidemiology/distribution of heterosexual (incl. Perinatal), IDU, and MSM reservoirs of persons living with HIV infection (i.e. CDC-mandated top priority population for prevention services), and b) needs assessments, interventions and outcome evaluation/process monitoring indicators.

2.2. Epidemiologic Profile Update

As part of the process of updating the Epidemiologic Profile, gaps in the data are identified annually (see below). The CPG continues to update the prioritization process to refocus attention specifically towards reservoirs of persons who are living with HIV and at risk of transmitting HIV to others, in addition to persons at high risk of acquiring HIV. 2009/10 updates to the prioritization revision of 2007 were presented to the full CPG in May 2010.

The Community Planning Group acknowledges that AIDS incidence and prevalence data as currently reported no longer accurately reflect the true impact of the HIV epidemic in Pennsylvania. The Commonwealth began HIV reporting in October 2002 and began HIV incidence and resistance surveillance in 2005-06 (HIV incidence and resistance studies were suspended due to CDC surveillance funding reductions in 2007).

The current 2009/10 Integrated Epidemiologic Profile was based on HIV/AIDS cases diagnosed through December 31, 2008, reported through June 30, 2009 (to accommodate reporting delays), and was presented to the CPG during the 2010 planning year. Several supplements (including detailed regional and county mini-profiles and detailed analyses for strategic planning of HIV prevention programs for MSM) have been provided with the Epidemiological Profile during each successive planning year while the Department awaited HIV reporting data. In-between the major updates, interim abridged updates that are produced based on AIDS cases consist of the following supplements to the Integrated

Epidemiologic Profile of HIV/AIDS in Pennsylvania (both of which have been posted online at http://www.health.state.pa.us/hivepi-profile): a) twice yearly publications of the HIV/AIDS Surveillance Annual Summary along with the featured abstract series of incisive special analyses on key target populations; b) detailed regional and county-level AIDS prevalence and incidence mini-profiles published once every two years; and c) other special supplementary analyses that may be needed to support prioritization or other planning-related purposes..

2.3. Integrated Roundtable Review of Linkages between the Epidemiology of HIV and Other Aspects of the Prevention Plan (i.e. Needs Assessments, Interventions and Evaluation)

Over the past three planning year cycles, the Epidemiology Subcommittee has implemented an integrated roundtable review. This roundtable review is intended to facilitate increased comprehension of the data-driven linkages between epidemiology of HIV and the work of the respective sub committees and how this contributes to the prevention plan and application. The review is conducted annually by the Epidemiology Subcommittee in collaboration with other subcommittees, i.e. needs assessment, interventions, and evaluation. Following the orientation meeting November of the preceding year, the annual integrated roundtable review is conducted early in each year's planning cycle during the first three consecutive full CPG meetings (January, March and May). The integrated roundtable review is frontloaded into an early stage of the planning cycle to ensure that CPG participants can gain an understanding and knowledge of the linkages in each subcommittee's response plans including gaps in linkages which need to be addressed during subsequent plan development meetings (May, July and August). This process facilitates cross-committee understanding of linkages across subcommittees, integrated plan development and informed CPG member participation in the planning process up to and including the culmination point of the concurrence discussion.

The review begins with detailed input on the epidemiology of HIV highlighting each of the main transmission risk groups (i.e. injection drug use (IDU), heterosexual contact, men who have sex with men (MSM), MSM-IDU, and Perinatal transmission) followed by input and discussion of each subcommittee's presentation of its response plans (and potential gaps in response plans) addressing the issues raised by epidemiology input on each of the main risk groups, and finally closing with a full CPG roundtable review of each of the subcommittee's inputs. Gaps in response plans are noted as items to be addressed by each subcommittee in updates of its component of the prevention plan. A pre- and post-roundtable evaluation is conducted to examine the impact of the roundtable review on knowledge of response plans or gaps in response plans, and attitudes and perceptions of committee members regarding the prevention plan. Feedback on the results of the evaluation is discussed with the subcommittee and translated into action plans for the next roundtable review and for each subcommittee to follow-up, and discussions of recommended updates to the plan that are flowing from the roundtables are incorporated into the relevant parts of the Prevention Plan. Further details of the roundtable review are presented in the planning cycle/timeline.

2.4. Written Process for CPG Subcommittees to Submit Data Requests/ Recommendations for New Data Sources/Analyses to the DOH Bureau of Epidemiology

A written process has been in place by which CPG Subcommittees may request/contribute/suggest additional data (guidance for recommending additional local, regional or statewide data sources/analyses for use in the planning process and the development of the Profile) by the submission of a form that is available online at http://www.health.state.pa.us/hivepi-profile (subsection 1.2. Planning Committees Input Mechanism)

Outline of Guidance for Requesting/Recommending Additional Local, Regional or Statewide Data Sources/Analyses for Use in the Planning Process and the Development of the Integrated Epidemiologic Profile of HIV/AIDS (for Prevention and Care)

(Note: Proposed data source/analyses abstract/summary should be no more than one page in length and typed in >=10 pt font)

1. Outline the main statewide or specialized planning questions/objectives that you propose to answer with the proposed data source/study data/analyses.
2. Clarify how the proposed data source/study data/analyses addresses the main planning objectives/questions outlined in #1 above.
   a. Describe the study/objectives/purpose of the study/data collection/source/analyses proposed.
   b. Describe the study population/setting, sample size, representativeness of study and generalizability/applicability of findings of study/data source from which the data to be analyzed is derived.
   c. Describe the study methods and procedures (attach data collection forms used to collect the data to be analyzed where applicable).
   d. Describe the public health applicability/recommendations possible/anticipated or already established from study findings.
3. Summarize the public health inference for planning that is possible/anticipated from the use of findings/data from the proposed data source/study data.

[**Recommendation to CPG members submitting requests**: To ensure that data requests truly reflect the data needs and are relevant to the CPG planning process, the HIV Epidemiology Subcommittee recommends that CPG members request the above details in an abstract formatted according to the above guidelines from the researchers and investigators of all data sources/analyses that are recommended for use in the planning process. Most scientific studies and many formal data collection processes that are likely to be useful for this purpose already have abstracts/summaries of project descriptions formatted in the standardized Health & Human Services (HHS)/National Institutes of Health (NIH) format described above under items 1 & 2 above].

2.5. Update on Implementation of Guidance

Members of the Epidemiology Subcommittee are available to assist other CPG sub-committees and provide training to reiterate the process of requesting data from the Bureau of Epidemiology. Each year, the Epidemiology Subcommittee reminds the CPG membership (ideally in September) that data requests must be submitted by November to be included in the following year's planning process. In addition, the Epidemiology Subcommittee continues to work with other subcommittees on coordinating data needs with the care planning process and to ensure that epidemiology methods used in data collection processes assure representativeness, generalizability and standardization of studies commissioned by the planning committee. Several data requests that have been received have been reformatted in accordance with the guidance and are currently being followed up.

2.6. Young Adult Roundtable (YART) Input on Epidemiology Data Needs and the Epidemiology Subcommittee Clarification(s) and Response Plan(s)

This section presents the Young Adult Roundtable (YART) consensus statement on Epidemiology data that they consider necessary to facilitate planning for prevention of HIV among young adults. The subsection subtitled "Young Adult Roundtable Consensus Statement on Epidemiology Data Needs and Epidemiology Clarification(s) and/or Response Plan(s)" presents the statements of problems, goals and objectives identified by the YART. These statements are quoted verbatim from the YART consensus statement. Epidemiology Clarifications and/or Response Plans appear next to each objective. A new YART consensus statement was released to the CPG in June 2010 and the Epidemiology subcommittee provides preliminary responses below. Final responses to the 2010 YART Consensus statement will be included in the next major plan update

2.6.1. Consensus Statement Introduction

This Consensus Statement describes which statistics should be looked at when developing a view of HIV/AIDS infection among young people in Pennsylvania. Some 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 epidemiologic data are available to support the targeting of these programs?" Effective HIV prevention programs for young people in Pennsylvania cannot be developed and targeted without accurate and sufficient epidemiologic 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, we do not know HIV incidence and prevalence data for young people in Pennsylvania.

- What information (data) should be used to help paint the most accurate picture that reflects the HIV epidemic among *youth* (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 youth?

2.6.2. Epidemiology Clarifications and/or Response Plans

*Introduction and Clarifications***:** The Consensus Statement on Epidemiology Data Needs from the YART is a well-done and detailed effort with an outline of specific data needs for planning of HIV prevention for adolescents and young adults. A new YART consensus statement was released to the CPG in June 2010 and reviewed by the Epidemiology subcommittee at the July 2010 CPG meeting. The HIV Epidemiology subcommittee offers the following preliminary clarifications and response plans to address the data needs identified. Further responses will be provided as the new Epidemiologic profile is reviewed by the subcommittee during the next planning cycle and final responses to the 2010 YART Consensus statement will be included in the next major plan update.

Preliminary clarifications and response plans to address the data needs identified by the 2010 YART Consensus Statement

HIV Incidence and Prevalence Surveillance: HIV incidence and prevalence data constitute the key epidemiologic data needed to support HIV prevention planning, including prioritization and targeting of prevention services for adolescents and young adults. . The Pennsylvania (PA) Department of Health (DOH) recognized the increasing limitations on the usefulness of AIDS incidence data to estimate HIV incidence and prevalence trends since the introduction of highly active antiretroviral therapy (HAART) in 1996/1997. In response, the Department began a process to make HIV reportable in PA. HIV case reporting began in October 2002 and HIV reporting data is now available in the 2010 Epidemiologic profile.

Interim Bridging Solution & Data Sources: A variety of data sources are currently being analyzed to provide indicators of HIV risk in the general population including adolescents and young adults, and these data have been available in the Epidemiologic Profiles published since 2005. Relevant findings from additional updates and supplemental analyses are presented during the roundtable reviews. The data sources being utilized for these analyses include surrogate data on Sexually Transmitted Infections (STI), teenage pregnancy rates, abortions, etc. The 2010 Integrated HIV Epidemiologic Profile addresses some of the data needs raised by the YART and will be the basis for an update of the model for prioritization of target populations.
Behavioral Surveillance: The YRBS (Youth Risk Behavioral Survey) has been resumed in selected regions of PA. As data becomes available from this survey it will be made available to the CPG and YART.

Providing Guidance on Recommending Additional Data Sources to the CPG, including Representatives of the YART: The Epidemiology Subcommittee provides the planning committee with a list of a variety of data sources that are currently being analyzed (summarized in the Epidemiologic profile), provides guidance on how to recommend additional data sources, and also solicits input for analyses to support various aspects of prevention planning. The Planning Committee (including YART and other subcommittees) continues to work closely with the Epidemiology Subcommittee to

enable them to follow the data request guidelines for additional analyses as per established process.

*Bridging the gap of knowledge at the planning level regarding HIV Epidemiology work in progress***:** The Prevention Planning Committee is provided annually with an orientation which includes an update of ongoing HIV Epidemiology work during the planning year.

Coordination of consultations on HIV Epidemiology and other studies in progress or planned: This activity has been in progress within the Department and at the Planning Committee level since 2007 with the goal of eliciting further input on specific issues that need to be taken into account or modified in the data collection processes for HIV Epidemiology studies in progress or planned.

2.6.3. YART-Identified Goals, Objectives and Epidemiology Clarifications and/or Response Plans for Each Objective

This subsection presents the Young Adult Roundtable (YART) consensus statements of problems, goals, and objectives identified by the YART quoted verbatim from the YART Consensus Statement along with preliminary Epidemiology Clarifications and/or Response Plans that appear next to each objective. It is meant to address the lack of data regarding the prevalence of HIV among young people in Pennsylvania. Final responses will be included in the next major plan update.

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.
>
> *Epidemiology Clarification(s) and/or Response Plan(s):* The breakdown of age groups is adjusted where statistically feasible, taking into account sample sizes available for analyses of meaningful trends, and national standardization used for comparisons with other reference data and census data.
>
> **Objective #2:** HIV data should be used to establish target populations (and interventions) in Pennsylvania. Data have proven that young African American, young Latinos/Latinas, young men who have sex with men (YMSM), and young women are at a particularly high risk of HIV infection in the United States. *Epidemiology Clarification(s) and/or Response Plan(s):* HIV reporting data is available in the 2010 Epidemiologic Profile and will be used to inform the next planning cycle.

Objective #3: HIV reporting has only recently been implemented and has not yet been made available. Sufficient data are urgently needed in order to reevaluate target populations of youth.
Epidemiology Clarification(s) and/or Response Plan(s): HIV reporting data is available in the 2010 Epidemiologic Profile and will be used to inform the next planning cycle.

Objective #3b: It is imperative to determine the number of youth who are accessing HIV testing services, and in addition those who return for test results. Data currently being collected at testing sites is not specific to youth.
Epidemiology Clarification(s) and/or Response Plan(s): Data currently collected by the Counseling and Testing program include age of service recipients and can be analyzed by age group to show the number of young people who are accessing HIV testing services and those who return for test results. Requests for data analyses are to be submitted (using the "Guidance" and form referenced in Section 4 above) to the Epidemiology Subcommittee by November each year indicating what data each subcommittee needs for planning work during the following year. The Epidemiology Subcommittee can assist the Young Adult Roundtable in submitting this data request.

Objective #4: Initiate a data collection process targeting needle exchange programs to estimate demographic and specific drug-behavior data about young users in Pennsylvania.
Epidemiology Clarification(s) and/or Response Plan(s): The Department of Health is not currently involved in needle exchange intervention or research programs since Pennsylvania law does not permit public funding of needle exchange activities. However, it is possible for the Department to collect data on/among needle exchange users through commissioning supplemental observational studies such as needs assessments and surveys in this risk group or service users. This request has been referred to the Needs Assessment Subcommittee for collaborative/joint review and possible follow-up with the Epidemiology Subcommittee. We also suggest that this request be taken to the Steering Committee to discuss facilitation of this data collection.

Objective #5: Collect statistics regarding income, household size, geographic location, religion and sexual orientation among youth receiving HIV testing.
Epidemiology Clarification(s) and/or Response Plan(s): The Department of Health collects some of the recommended information from the general population including subpopulations at risk for HIV through the population census. Analyses of such data are reported in the 2010 Integrated HIV Epidemiologic Profile. Surrogate data elements, such as insurance status at time of testing and census tract of residence (which may reflect income level), is collected from individuals receiving HIV testing at Counseling and Testing sites and can be requested using the Data request process outlined above. In addition, supplemental data not currently being collected (such as precise income, household size and religion) can also be collected through commissioning

supplemental observational studies such as needs assessments and surveys in samples of at risk populations. This request has been referred to the Needs Assessment Subcommittee for collaborative/joint review and possible follow-up with the Epidemiology Subcommittee.

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

Objective #1: Share data on the number of youth who are living with AIDS, in relation to the total number of people living with AIDS in Pennsylvania with the Interventions subcommittee to better target youth for prevention with positives.
Epidemiology Clarification(s) and/or Response Plan(s): Demographic data on AIDS cases is available in the Epidemiologic profile and can be shared with the Interventions Subcommittee to facilitate targeting of youth for prevention with positives.

Objective #2: Collect statistics regarding income, household size, geographic location, religion, and sexual orientation among youth receiving AIDS diagnoses.
Epidemiology Clarification(s) and/or Response Plan(s):
Surrogate data elements, such as insurance status and census tract data is collected and reported at time of AIDS diagnosis and can be requested using the data request process outlined above. Supplemental data not currently being collected (such as precise income, household size and religion) could be collected through commissioning supplemental observational studies such as needs assessments. This request has been referred to the Needs Assessment Subcommittee for collaborative/joint review and possible follow-up with the Epidemiology Subcommittee.
In addition, the intake assessment of the new generation Unmet Needs Project will be collecting some of this data and is scheduled to commence in late 2010.

Goal #3: Data needs to be collected to identify the specific HIV risk (sexual and drug using) behaviors of youth in Pennsylvania, in order to aid intervention planning.

Objective #1: The Young Adult Roundtables support the continued expansion of the Youth Risk Behavior Survey (YRSB) to survey HIV risk (sexual and drug using) behaviors. Questions should include what substances are being used, including crystal meth, fentanyl patches, and heroin. Previously, the Commonwealth of Pennsylvania participated in the nationwide, CDC-sponsored YRBS. This survey collected information from high school students on a variety of risk behaviors including drug use and sexual practices. When these data are available it will allow for effective preventative measures.

Epidemiology Clarification(s) and/or Response Plan(s): Departments of Education are the State partner agencies that CDC's Division of Adolescent and School Health (DASH) has designated to collaborate with on projects such as the Youth Risk Behavior Surveillance System as these surveys are aimed at a

population best reached through the school systems. The YRBS (Youth Risk Behavioral Survey) has been resumed in selected regions of PA. As data becomes available from this survey it will be made available to the CPG and YART. Recommendations of data analyses or studies are to be submitted (using the "Guidance" and form referenced in Section 4 above) to the Epidemiology Subcommittee by November each year indicating what data each subcommittee needs for planning work during the following year. Upon receipt of the relevant data needs and study recommendations, the HIV Epidemiology Section has referred this request to the Department of Education through the Division of Community Epidemiology in the Department of Health. The YART is thus invited to submit any other relevant recommendations with the relevant information indicated on the recommendation form for review and follow-up with the Epidemiology Subcommittee and CPG.

Objective #1a: Determine other risk behaviors of youth not covered by the YRBS, such as STIs, pregnancies, abortions, IDU, dating websites, and emergency contraceptive use. Statistics that have yet to be collected include: frequency of protected and unprotected anal and oral sex; the age of first sexual encounter; and the number of partners per year.

Epidemiology Clarification(s) and/or Response Plan(s): This data could be collected through commissioning supplemental observational studies such as needs assessments and surveys in samples of at risk populations. This request should be referred to the Needs Assessment Subcommittee for collaborative/joint review and possible follow-up with the Epidemiology Subcommittee.

Objective #1b: Youth risk behavior data should be specific to demographics: race, gender, income, household size, religion, geographic location, and sexual orientation.

Epidemiology Clarification(s) and/or Response Plan(s): Data currently collected by the Department's HIV/AIDS Case reporting system (for HIV-positive individuals) include demographics, sex, geographic location and probable mode of transmission. The current Epidemiologic Profile already analyzes data on adolescents and young adults by demographics (age and race/ethnicity, sex, geographic location, and probable mode of transmission). This approach is continued in the analyses for the new Integrated HIV Epidemiologic Profile. The recommended supplemental data on sexual orientation and gender (Note: gender is used in this context to denote part of an individual's self-perception of sexual identity, which is not necessarily biological sex at birth) may not be currently feasible to collect through the HIV/AIDS case reporting system. However, the Department of Health can collect the recommended supplemental data through commissioning supplemental observational studies such as needs assessments and surveys in representative samples of the target populations of interest. This request has been referred to the Needs Assessment Subcommittee for

collaborative/joint review and possible follow-up with the Epidemiology Subcommittee.

Data on youth risk behavior for HIV negative individuals or those unaware of their *status* could be collected through commissioning supplemental observational studies such as needs assessments and surveys in samples of at risk populations. This request should be referred to the Needs Assessment Subcommittee for collaborative/joint review and possible follow-up with the Epidemiology Subcommittee.

2.7. Tentative Integrated Timeline of Updates of Epidemiologic and Data Support Work -Products for CDC- and HRSA-Funded Activities to be done jointly by the Prevention Community Planning Group and the Integrated Care Planning Council

2.7.1. Updates of Comprehensive Needs Assessment (Including the Integrated Epidemiologic Profile of HIV/AIDS and various other data products)

The Comprehensive Needs Assessment should be updated regularly. Certain aspects need to be updated annually while other aspects need to be updated every two years. The Prevention Committee and Care Planning Council will develop the Integrated Timeline jointly.

2.7.2. Timing of Updates of Each Component of the Comprehensive Needs Assessment

The updates of each component will be done based on Academy of Educational Development (AED)/Health Resources & Services Agency (HRSA) guidance for unmet needs assessments. Updates will be performed based on the following timeline:

- Integrated Epidemiologic Profile of HIV/AIDS in Pennsylvania
    - Major updates will occur every second year
    - Interim updates/supplements include the 'Biannual Summary,' and the 'Featured Abstracts Series' twice-yearly
- The Resource Inventory will be updated every one to two years
- The Profile of Provider Capacity and Capability will be updated every two years
- The estimation and assessment of Unmet Needs - A Comprehensive update will occur every two years (reconciling unmet needs and service gaps). Estimation of unmet needs will be updated every second year
- The assessment of service needs among affected populations (including service gap analyses and surveys of needs and barriers) will also be updated every second year

List of Epidemiology & Prioritization Appendices
(Attached to Plan/Application Submission)

Epidemiology & Prioritization Appendix 1: 2009/2010 Integrated Epidemiologic Profile of HIV/AIDS in Pennsylvania; http://www.health.state.pa.us/hivepi-profile (including updates and supplements through 2010)

Epidemiology & Prioritization Appendix 2(Attached PDF): Step 1 Abstract/Summary of Steps 1 - 4 of the Refined Model's Interim Methods & Results for Statewide Prioritization of Regional HIV Prevention Service Areas in Pennsylvania.

3. EPIDEMIOLOGY & PRIORITIZATION OF TARGET POPULATIONS (SECTION UPDATED IN 2009)

This section focuses on 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 current model (under revision) to rank-prioritize target populations/ transmission groups at the statewide level to ensure that priority setting is fair. In pursuit of this goal, the CPG and the state Department of Health HIV/AIDS Epidemiologist developed an empirical/evidence-based objective process to set priorities as opposed to a method that relies on subjective perceptions. This model continues to undergo peer review and refinement.

This section also focuses on the process of identifying and ranking those target populations with high infection rates and high incidence of risky behavior. The CPG acknowledges the CDC requirement to prioritize HIV-infected persons as the highest priority population. This requirement was introduced late in the 2003 plan year and is reflected in the 2009/10 updated report on prioritization which was completed and presented to the CPG in 2010. The inception of this refinement and update of priority target populations was done by the CPG's ad hoc prioritization workgroup in collaboration with the Department of Health's HIV Epidemiologist and a consultant team. The objectives, methods, results and conclusions/recommendations for prioritization are presented in the next sections.

3.1. Current Model for Prioritization of Target/Risk Populations for HIV Prevention in Pennsylvania

-
- 3.1.1. Review of CDC Mandate and Recommendations
-
- The CDC has mandated that the HIV-positive population in each state be given first priority in the prioritization process. Since the current state model for prioritizing risk populations was designed with HIV-negative high-risk populations in mind, the current model will need to be adjusted/refined to consider the particular prevention needs of those who are HIV-positive. It would be too resource- and time-consuming to fully integrate this model to consider HIV-positive and HIV-negative populations together in exactly the same process. Therefore, we recommend that two separate processes be conducted for the HIV-positive and HIV-negative populations. The same model will be used for each process, but with adjustments to the weight given to different types of data based on differing circumstances and quality of data per each of these two populations.
- (See Appendix 2)
-
- The CDC's mandate to include the HIV-positive population in prioritization raises a further issue: It begs the question of whether the HIV-population should be considered as one large priority population, or whether sub-populations among those who are HIV positive should be considered in prioritization. The team

agreed to recommend that sub-populations among HIV-positive be prioritized, as this is a more valid approach since sub-populations among HIV-positive also do not have a uniform likelihood of HIV transmission, barriers, and so forth.

- 3.1.2 Review of Literature and Other States' Practices

- Through a contract with the University of Pittsburgh's Pennsylvania Prevention
- Project (PPP), the Department of Health commissioned a review of the state's process for prioritizing HIV Risk Populations. Investigators reviewed the literature on prevention needs of populations at high risk of HIV to learn whether updated needs assessment was needed in Pennsylvania. Also, the same investigators reviewed other state's processes for prioritizing risk populations. The results of both of these processes were discussed with members of the State Department of Health and PPP (the group reviewing needs assessment and prioritization processes will hereinafter be referred to as "the prioritization team"). Based on these discussions and consultations, the recommendations in the next section were developed.

- 3.1.3 Summary of Recommendations

- Literature Review for Current Information of Relevance to Needs Assessments and Interventions. Three areas arose from the literature review as possible areas with need for further attention. Two of these areas appear to be currently addressed by the Needs Assessment Subcommittee of the PA HIV Prevention Community Planning Committee. Namely, this subcommittee is addressing the primary and secondary prevention needs of HIV-positive MSM on antiretroviral treatment and needs of minority women at heterosexual risk. A third area concerned the Internet as a context for prevention interventions among MSM. More details on each of these areas appear in the full report (see Appendix 2). Therefore, the only recommendations stemming from the review of prevention needs literature are:

- The Needs Assessment Subcommittee read and incorporated into their current needs assessments, the attached report's discussions on (a) HIV-positive men who have sex with men (MSM) taking antiretroviral drugs; and, (b) minority women.
- The Interventions Subcommittee read and incorporated into their recommendations on interventions this report's discussion on the use of the Internet as a context.

- The implications of this process are:
- The focus of prioritization is shifted to the regional/service area level where the actual prioritized target populations assume more meaning and have application. In each region, this method will generate two lists of priority populations in Pennsylvania: one for prevention among HIV-positives and one for HIV-negative populations.

- The statewide lists of target populations are recognized to be of no practical application, given the diversity of the epidemic in PA, hence the statewide composite lists will only be produced to give an indication of the statewide distribution. Other recommendations for possible attention are also addressed in the full report attached and are not included in this summary because the issues addressed are beyond the scope of this project. These additional recommendations are provided (see Appendix 2) for whatever benefit they might be to the Committee and its work.
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3.2 2009/10 Update on Refined Objectives, Background/Rationale, Methods, Results, and Recommendations for Prioritization of Target Populations for Prevention:

Pursuant to the Community Planning Group's adoption of a regional prioritization framework along HIV prevention regions/service areas funded by the Department (ten County/municipal Health Departments and six Health District areas), the refinement project was completed and is presented in the next section.

3.2.1 Technical Abstract:

Overall Objectives:
The overall objectives are to establish an empirical process for prioritization of target populations for HIV prevention in Pennsylvania. The specific objectives of the state-commissioned refinement of the model for prioritization of target populations for HIV prevention were to:

i) Introduce a mechanism within the revised plan/model for refocusing the main target population within each population-transmission group to firstly identify HIV infected persons most likely to transmit HIV to others and secondly uninfected populations most at risk of acquiring HIV infection;
ii) Introduce a mechanism within the revised plan/model for changing the current statewide paradigm of one set of statewide priority target populations to include regional priority target populations that are more relevant to the epidemic in each region;
iii) In addition to the above-outlined primary/"macro prioritization", further consultations with the CPG Ad-hoc Prioritization Workgroup and consultants will develop a mechanism and guidelines to be used for secondary/"micro prioritization" within each prioritized regional population-transmission group;

Background and Significance:
The CPG in PA has commissioned the prioritization of target populations in order to ensure that priority setting is fair. In pursuit of this goal the CPG has committed itself to an empirically determined objective process as opposed to the previous method that relied on subjective perceptions of committee members to set priorities. The field of prioritization of target populations for HIV prevention is still in relative infancy and is yet to be rigorously peer-reviewed, hence the difficulty in finding relevant literature.

Methods: The Priority Setting Model to Identify Target Populations and Analyses:
To achieve the objectives for refinement of prioritization of target populations, the methods were organized into a 4-step process as illustrated in Methods Diagram 1.
Step 1: This step entailed developing a model/formula for regional distribution of HIV prevention resources to Pennsylvania's 15 HIV prevention service areas (excl. Philadelphia).

Step 2: Within each HIV prevention service area, this step entailed prioritization of resources into two main target populations of: a) persons living with HIV and b) HIV negative persons at risk of acquiring HIV infection within each service area/region.
Step 3: This step entailed prioritization within each of these two main target populations in each HIV prevention service area/region, so as to generate two (2) sets of target populations for HIV prevention (within each region) based on probable modes of transmission/behavioral risks (i.e., MSM, IDU, MSM/IDU, and heterosexual risks) stratified by race/ethnicity, sex/gender, and age within each of the two main populations. The prioritization process applied to each of the two main populations within this step entailed the following: a) Transmission categories and factors by which the target populations for prevention would be ranked were established based on the CPG's previous priority target groups that were based on the main modes of transmission and races/ethnicities across the state; b) Potential factors for prioritizing the target populations that were identified were mainly of three types: i) factors related to transmission potential of probable mode of transmission (Predominant mode/risk behavior); ii) factors indicative of incidence, with a likelihood of new infections, and prevalence of HIV (Estimated live HIV cases in transmission category as proportion of total living with HIV in Pennsylvania and 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 the prevalent pool of infected persons, assuming there is no decline in other contributing factors); and iii) factors that may impede or enhance access to prevention and care (Barriers to prevention and resources currently distributed to each target population)]; more specifically, the factors for prioritization of target populations used included the following: 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); c) Data needed for each factor and target population were gathered if it existed, new data collection and 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; d) 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; e) Categories within each factor were ranked and each factor assigned a relative weight compared to other factors in the model; f) The available data were inputted into the model (Table 1, Appendix I) 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; g) The product for each factor by transmission category was then entered into the respective cell in the transmission category column as shown in Table 1 (for example, Table1 for South East (SE) district is shown); h) The totals for each transmission category column were calculated; based on the sum of scores of the transmission category column, the percentage for each transmission category were calculated and entered on Table 1; i) Each transmission category was stratified by race/ethnicity to establish population-transmission categories; j) Each transmission category sum of scores was thus stratified by race/ethnicity according to the relative percentage of prevalent HIV cases (diagnosed in more recent year, 2007) in each transmission category by race/ethnicity; k) 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 as shown in Table 2 [as an example, Table 2 for South East (SE) district is shown in the body of this report]. The model is designed to permit each region to further extend the prioritization process to take into account local prioritization "micro" factors within each target population in each region/service area (i.e. factors such as the local variations in occurrence of homelessness and other socioeconomic factors, gay identified vs. non-gay identified MSM, transmission mode-

related risk factors such as MSM or IDU through sharing of injection paraphernalia for transgender, sex work, etc). As part of the supplement for strategic planning on MSM, the model described above was extended to generate priority target populations among MSM population-transmission groups.

Step 4: Develop a composite list of statewide target populations for HIV prevention based on the sums of the scores of the same target population across regions, i.e. to show a statewide picture of the rank of each target population within each of the two main populations of a) persons living with HIV and b) HIV negative persons at risk of acquiring HIV infection at the statewide level. For example, the average of the sum of scores of white MSM target populations within the main population living with HIV in each region is calculated and used as the statewide composite measure for the white MSM target population within the statewide main population living with HIV. These results of the population-transmission groups in each region were summarized and the statewide composite results were calculated and entered in Table 3 in the full report in Appendix 2.

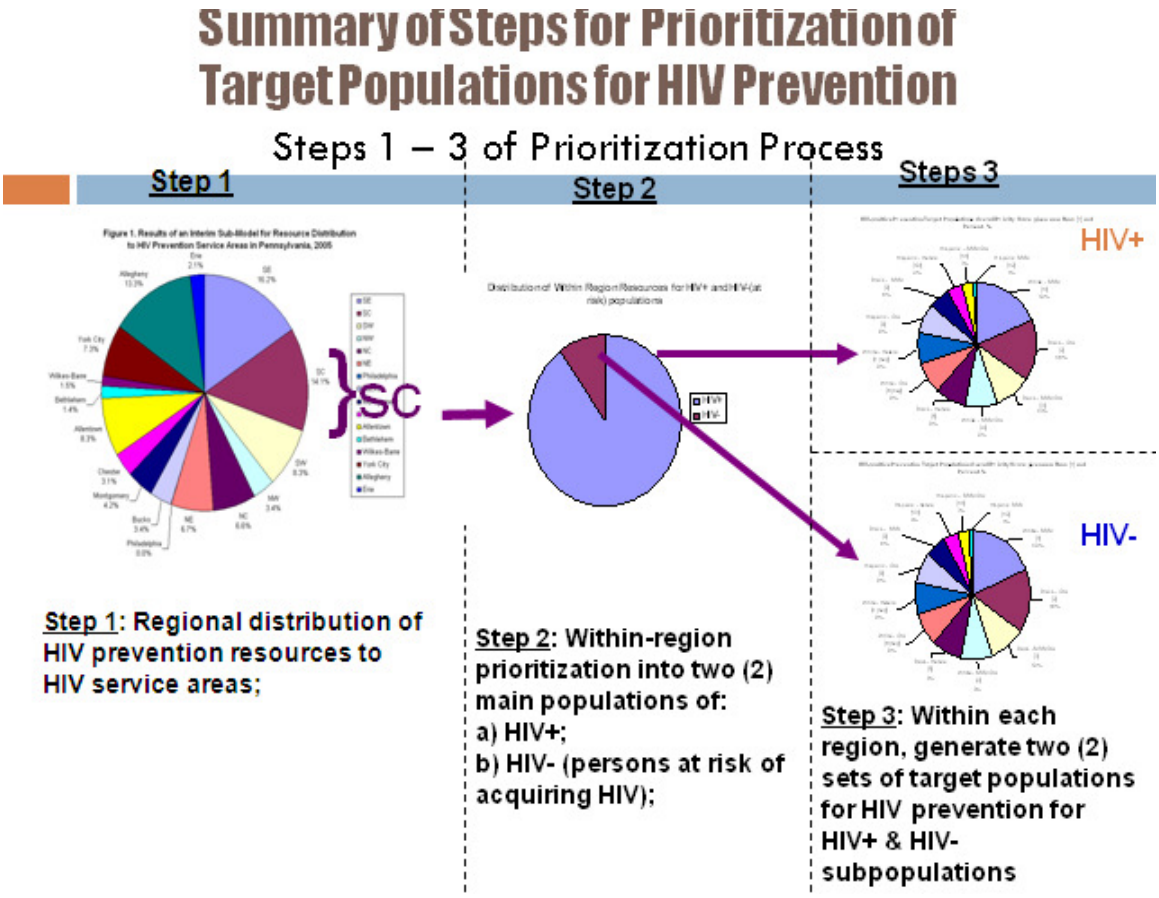

Figure 3.1 Methods Diagram: Overall Steps for Refinement of Prioritization

Interim Results:

The interim results of the implementation of the prioritization model at this point in the progression of the prioritization process shows the following major results: A) statewide priority ranking of 15 CDC-funded HIV prevention service areas (excl. Philadelphia) for resource

allocations (as shown in Figure 1): 1) Southeast (17.48%); 2) South-central (15.1%); 3) Allegheny. (13.27%); 4) Northeast (8.42%); 5) Southwest (7.89%); 6) North-central (6.36%); 7) York City (5.89%); 8) Montgomery (5%); 9) Allentown (4.41%); 10) Northwest (4.12%); 11) Bucks (3.63%); 12) Chester (1.5%); 13) Erie (1.99%); 14) Bethlehem (1.99%); 15) Wilkes-Barre (1.31%); and B) a set of priority target populations-transmission groups among the main target populations of a. HIV positive and b. at risk persons in each service area (Please see Figure 2 showing an example of the priority target populations in the Southeast region); the regional priority target populations were also summed up into a composite statewide set of target populations (as shown in Table 1 and Figure 3): 1) white MSM (30.0%); 2) black IDU (11.0%); 3) white IDU (11.0%); 4) white hetero (10.0%); 5) black hetero (9.0%); 6) Hispanic IDU (9.0%); 7) black MSM (7.0%); 8) Hispanic hetero (5.0%); 9) white MSM/IDU (3.0%); 10) Hispanic MSM (2.04%); 11) black MSM/IDU (2.0%); 12) Hispanic MSM/IDU (1.0%)..

The above results, for the state (excluding Philadelphia) and for each HIV prevention service area/region by population-transmission category (including a composite of MSM population-transmission categories) are presented by means of pie-charts (see additional figures in Appendix 2 of the prevention plan).

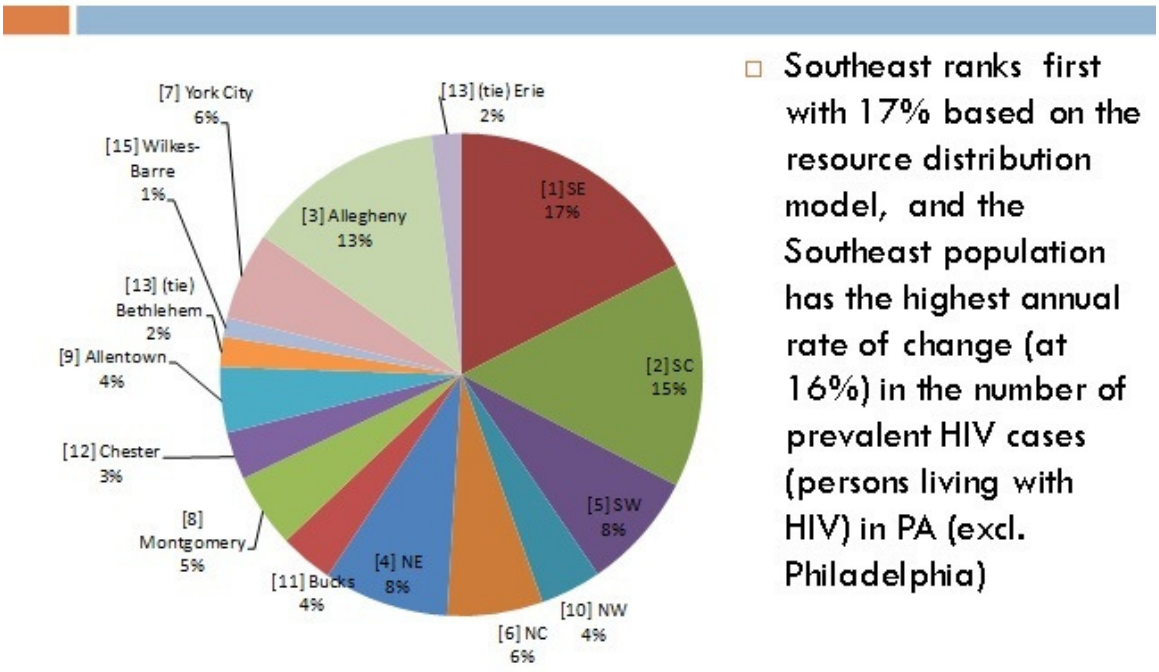

Figure 3.2 [step 1]: Results of Interim Sub-Model for Resource Distribution to HIV Prevention Service Areas in Pennsylvania

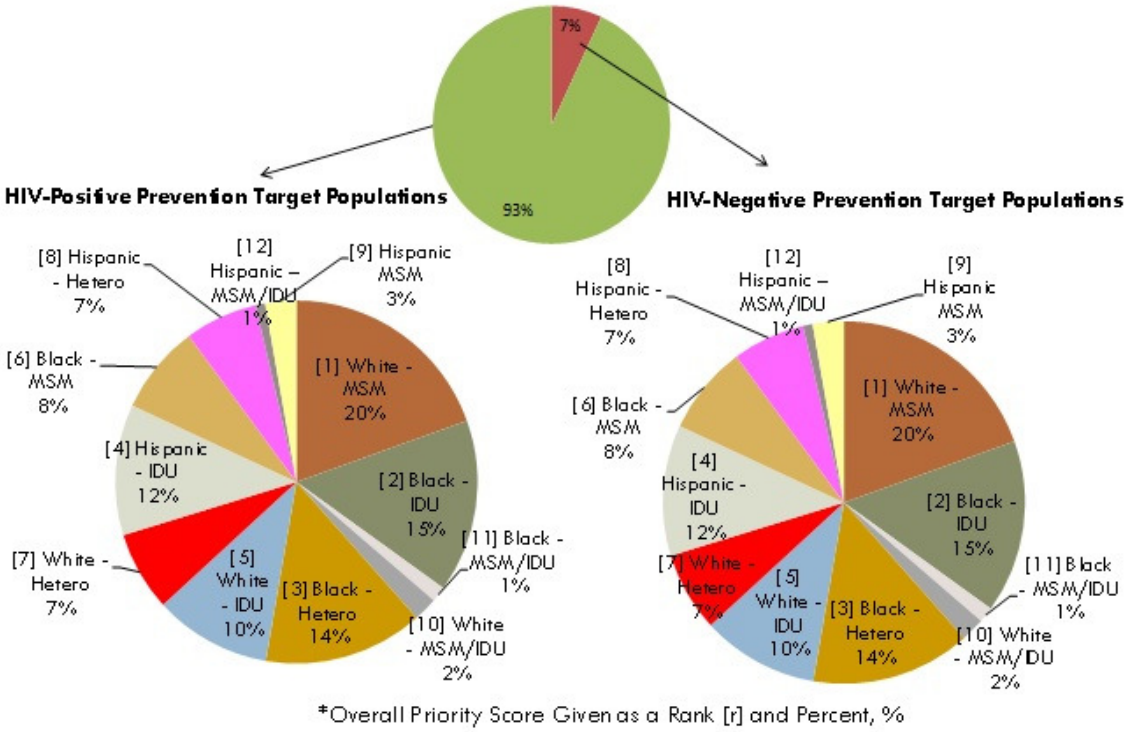

Figure 3.3 [Steps 2 & 3] Southeast Health District—Example of Distribution of Within—Region Resources for HIV+ [infected] and HIV [at risk] Populations

Table 3.1: Statewide Composite/Summation of Products of % Allocated to Risk Group within Region AND % of Statewide Total Allocated to Region/Service Area

Population/ Transmission Group	SUMMATION: PA(Excl Phila)(HIV+)		SUMMATION: PA(Excl Phila)(HIV-)	
	% Allocated to risk group within region (calculate average of regional proportions)	**Sum** of products of % allocated to risk group within region AND % of statewide total allocated to region/service area	% Allocated to risk group within region (calculate average of regional proportions)	**Sum** of products of % allocated to risk group within region AND % of statewide total allocated to region/ service area
	HIV+ persons		HIV- persons	
White - MSM	0.30	0.290	0.30	0.501
Black - IDU	0.11	0.112	0.11	0.195
Black - MSM/IDU	0.02	0.016	0.02	0.027
White - MSM/IDU	0.03	0.020	0.03	0.043
Black - Hetero	0.09	0.088	0.09	0.175
White - IDU	0.11	0.097	0.11	0.170
White - Hetero	0.10	0.099	0.10	0.171
Hispanic - IDU	0.09	0.072	0.09	0.126
Black - MSM	0.07	0.077	0.07	0.133
Hispanic - Hetero	0.05	0.049	0.05	0.086
Hispanic – MSM/IDU	0.01	0.005	0.01	0.009
Hispanic MSM	0.02	0.024	0.02	0.041
Perinatal Transmission				
Emerging Risk Group Needs Assessments				
	0.99		0.99	
% STATEWIDE TOTAL ALLOCATED TO REGION/SERVICE AREA (ALL RISK GROUPS) - DATA FROM STEP 1	0.10		0.15	

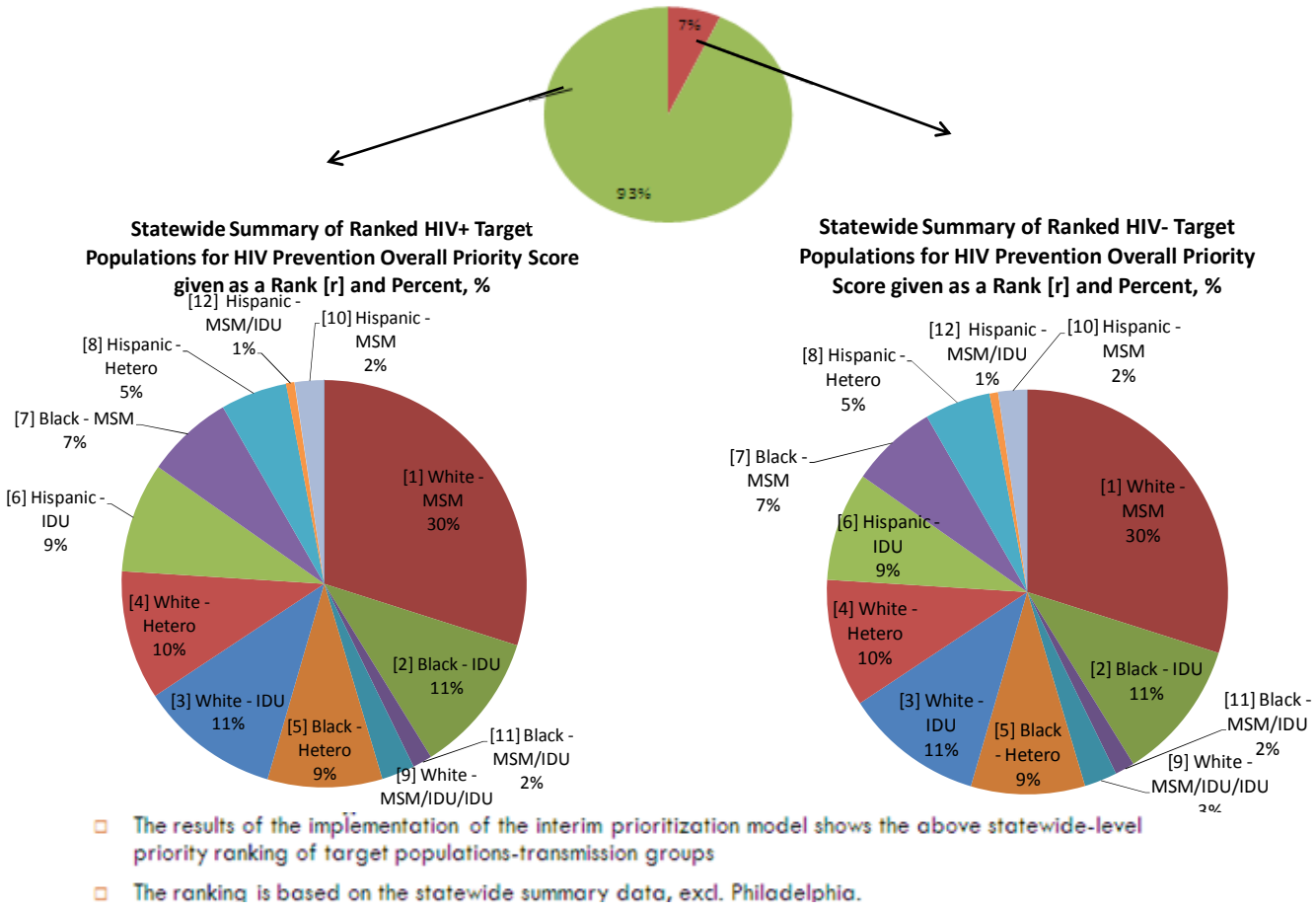

Figure 3.4 Statewide Summary of Ranked HIV+ & HIV- Target Populations for HIV Prevention Overall Priority Score given as a Rank [r] and Percent, %

Public Health Use of Findings of Prioritization Analyses:
The findings of the study are used by the CPG to target prevention services to HIV infected persons most likely to transmit HIV to others and populations most at risk of acquiring HIV infection. The results of the study are also disseminated by the CPG and the State to HIV prevention service delivery partners and are used by the State in allocating prevention resources and as a guide for services provided by the Department's HIV prevention service delivery partners.

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- Additional details and the full report on prioritization are online at http://www.health.state.pa.us/hivepi-profile, subsections 8.1 & 8.2. Refined Prioritization Model.

3. 3 Epidemiology & Prioritization Responses to Objectives and Attributes from 2003 HIV Prevention Plan Guidance

Specific objectives to be addressed and attributes to measure the attainment of those objectives were provided within the 2003 CDC Plan Guidance. The Epidemiology Subcommittee has reviewed and updated those objectives and attributes specific to their work beginning with Objective D so labeled in the original announcement along with Attributes 19-23 that specifically relate to Epidemiology:

Objective D: Carry Out A Logical, Evidence-Based Process to Determine the Highest Priority, and Population-Specific Prevention Needs in the Jurisdiction.

Attribute 19 (Epidemiologic Profile): The Epidemiologic (Epi) profile provides information about defined populations at high risk for HIV infection for the CPG to consider in the prioritization process. The 2009/10 Integrated Epidemiologic Profile of HIV/AIDS in Pennsylvania has been developed, presented and reviewed with the CPG (including updates and supplements in each successive year). The Integrated Epidemiologic Profile of HIV/AIDS in Pennsylvania identifies the thirteen-ranked/prioritized populations at high risk for HIV infection across the Commonwealth of Pennsylvania not including Philadelphia. These data will be utilized as input for the new prioritization model that is under development to target those individuals who are living with HIV and HIV negatives at risk of acquiring HIV infection.

Attribute 20 (Epidemiologic Profile): Strengths and limitations of data sources used in the Epidemiologic profile are described (general issues and jurisdiction-specific issues). The Integrated Epidemiologic Profile of HIV/AIDS in Pennsylvania contains the strengths and limitations of data sources used in the Epidemiologic Profile. (http://www.health.state.pa.us/hivepi-profile, subsection 1.1. Data Sources and Methods)

Attribute 21 (Epidemiologic Profile): Data gaps are explicitly identified in the Epidemiologic Profile. Data gaps are identified where relevant in the profile. Pennsylvania became an HIV names-reporting jurisdiction in October 2002. The profile clearly addresses the limitations resulting from the recent inception of HIV reporting in the Commonwealth. The current profile now uses HIV reporting, surrogate data, as well as sexually transmissible infection data and other indicators of HIV risk-related behaviors where data are available. The Young Adult Roundtable Consensus Statement identifies several data needs that will be addressed as outlined in the response plan. The profile will be updated with HIV and other relevant data as they become available.

Attribute 22 (Epidemiologic Profile): The Epidemiologic Profile contains narrative interpretations of data presented. The Integrated Epidemiologic Profile of HIV/AIDS in Pennsylvania includes relevant narrative in each section and an overall basic summary overview of the Epidemic.

- Attribute 23 (Epidemiologic Profile): Evidence that the Epidemiologic profile was presented to the CPG members prior to the prioritization process. This Epidemiologic profile was presented to the full CPG in January, March and May 2010 during the orientation, and subsequent 3 roundtable reviews during the 2010 planning year. CPG members will receive a CD containing the profile *prior* to the next revision of the prevention plan. Data from this profile (including refined regional and statewide target populations) will be used in the priority setting process. In addition, as part of the Community HIV Prevention Planning process, new members receive an Epidemiology presentation as a component of the new member orientation provided in January (at the beginning of each annual planning cycle).

4. COMMUNITY SERVICE ASSESSMENT

This section describes the prevention needs of populations at risk for HIV infection, prevention activities/interventions that currently exist to address needs, and service gaps or where needs are not being met. The Community Services Assessment (CSA) is a combination of three products: Needs Assessment, Resource Inventory, and Gap Analysis.

4.1. Needs Assessment

4.1.1. Needs Assessment Summary Report

Complete Needs Assessment Reports can be found in *Appendix N* (2003 Five-Year Plan)

4.1.2. History

When the Committee began in 1994 HIV prevention programs were generally providing information to groups upon request. Since that time major strides have been made. The providers, the consumers, and the community now understand the need for targeting specific populations, culturally appropriate prevention, and evidence-based interventions. These changes have been nurtured by the Health Department's directive that the Pennsylvania Community HIV Prevention Plan (Plan) be used in designing all HIV prevention projects that they fund. This has had a major impact on who is reached by interventions and the quality of the programs that reach them. A second major change occurred in 1997 when the HIV Prevention Community Planning Committee (CPG) 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 Committee have focused considerable attention on the most widely used HIV prevention intervention, namely, HIV antibody testing and counseling; and that Partner Counseling and Referral Services (PCRS) has been found to be an effective intervention for HIV positive men and women. 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.

Focus groups, surveys and interviews were used to gather data related to barriers in at-risk populations. The needs assessment indentified barriers to intervention strategies as confidentiality concerns, stigma, the invisibility of many at-risk to the greater community, and distrust of those at-risk to the Medical establishment. The research allowed staff to strengthen community connections and to work with participant recruiters, facilitators, and interviewers known and trusted by those at-risk**.** Some of the major barriers in needs assessment are confidentiality concerns, stigma, the invisibility of many at-risk, and distrust of those at-risk. Focus groups surveys and interviews were used to gather the data. These methods allowed staff to work with participant recruiters, facilitators, and interviewers known and trusted by those at risk**.**

4.1.3. Designing Several Large Needs Assessments

In the past the Committee designed several large needs assessments. These assessments involved over 160 groups and dozens of interviews with those at risk of infection, including Men who have Sex with Men (MSM), Injection Drug User (IDU), heterosexual partners, and African-American women over age 50. The groups were chosen to represent the epidemic and reflected the racial, ethnic, age, sex, sexual orientation, and geographic location of people with AIDS in Pennsylvania. 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.

The context in which these problems occur has, however, 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.

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

Based upon the Epidemiologic 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.

In the 2001 work plan, the CPG 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 individuals in care. A recent literature review described seven factors that may be positively or negatively 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. 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 Communicable Diseases, Division of HIV/AIDS applied for supplemental funds to identify the needs and barriers to prevention among positives in Pennsylvania.

Also, 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, and the CPG agreed, to add objectives exploring the status and needs of adolescents with regard to HIV education within Pennsylvania's public schools.

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 CPG 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 available and have been reported to the CPG.

4. 2. Overall Purpose of Needs Assessments and Goals of Specific Projects

The primary purpose of the needs assessment activities is to provide data for the DOH and CPG 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.

As stated above, the CPG 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 Epidemiologic profile contained in the Plan
- the relative amount that was known about a particular population (populations for whom little is known may be prioritized)

- feedback from CPG members concerning their experiences and perceptions indicate that 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 Men who have Sex with Men (MSM,) studies have found increasing rates of HIV and other sexually transmitted infections (STIs) among this population
  - In most areas, transmission rates among injection drug users (IDU) 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, IDU, and subgroups of heterosexuals in PA report that little HIV prevention exists that specifically targets these individuals

The DOH, CPG, and PPP are continuing work in regards to the CDC's priority of prevention for those who are HIV positive

In 2009-2010, at the direction of the CPG, Pennsylvania Prevention Project staff worked on the following four projects:

1. Mental health and substance abuse provider study
2. MSM literature reviews
   a. Sex workers
   b. IDU
3. Access to services report
4. MSM internet study

4. 3. Methods

- Literature Review: Databases, web sites, past needs assessments, and other data are searched to identify relevant themes, gaps in literature, and qualitative methods. Important issues and questions that need to be assessed and are identified.
- Identification of Sample: A steering committee of PPP staff, committee members and other PA experts make preliminary recommendations of subgroups for study based on relevant Epidemiological data, feedback from the CPG, and the literature review.
- Questions are developed and based on: 1) needs of the CPG; 2) topics identified through the literature review; 3) past needs assessments; 4) discussions by the CPG; and 6) outside expert input.
- Identification of Methods: A panel consisting of the needs assessment subcommittee identifies the most appropriate methods (e.g., key-informant interviews for more marginalized and harder to reach populations).
- Development of Budget: A detailed budget for the project is developed.

- Institutional Review Board: Applications are submitted to the University of Pittsburgh's and PA State Dept. of Health's Institutional Review Boards for approval.
- Staffing and training: Individuals are identified based on their relationships with target populations and relevant skills to recruit participants, lead groups, or implement interviews. Training includes purpose of the study, dynamics of each population, confidentiality, facilitation or interviewing skills, and, other issues.
- Data Collection: Focus groups and interviews are tape-recorded. Pilot groups and interviews are implemented. PPP staff review tape recordings of pilot groups and interviews and provide feedback to the facilitators and interviewers.
- Analysis of Data: In order to analyze qualitative data Individuals listen to a cross-section of tapes and identify themes based on frequency, intensity, reliability, and level of consensus findings are checked for validity in sessions with CPG members who are also representatives of the targeted populations. Quantitative data is sometimes gathered within needs assessments, but is only utilized in univariate and bivariate analyses to help describe the data.
- Evaluation: Participants, facilitators and interviewers complete written evaluations. Facilitators and PPP staff meet to evaluate project. Data is presented to the CPG to have them provide feedback.

4.4. Summaries

Access to Services Report

Some HIV positive men and women may require services in addition to medical care in order to properly manage their infection. Understanding the usage and need for HIV services among HIV positive community members is an important part of identifying the needs of HIV positive people. Assessments that indicate unmet needs in the region may not fairly represent the region's service capacity if services are not marketed effectively. In light of service agency budgetary changes and restructuring of service delivery, it is important to understand what needs are not currently being met and how these needs were impacted by recent federal funding changes within the Ryan White Care Act

This study was facilitated to determine HIV positive men and women's knowledge of existing services and how they come by this knowledge. By doing so, we can then determine how to better meet the needs of the community. This information will be used by the Pennsylvania Department of Health and the Pennsylvania HIV Prevention Committee to develop recommendations for future HIV prevention activities to be made available for these populations. The goals of the study are to examine the service needs of HIV positive men and women and whether they have problems finding information on how to access the services they need. The issue is that many HIV positive men and women may not know how to access services that may be widely available. Lack of knowledge is a significant barrier in accessing services.

This study indicates that many people reported needing services, particularly African-Americans. Examination of the qualitative data has found the issue of knowledge to be

more complicated than merely knowing how to access services. Knowledge can be divided into two categories: knowing where to access services and knowing how to access services. One can know where services are offered, but may not know how to access that particular service. In some cases people may receive incomplete information regarding services. They may be told where services are offered, but not told how to access that particular service. The barriers represent a need for improved information dissemination. Participants indicated a need for step by step instruction in how to access and maintain services. Additionally, participants who accessed services at one agency seemed unfamiliar with the opportunities for other services. This could indicate a need for more collaboration among agencies.

Lack of knowledge can have implications for HIV prevention in that unmet needs may create barriers. Two examples of unmet needs uncovered by this study were transportation and access to food. Although some community resources for transportation and meal delivery are available, several participants discussed problems with transportation. These issues also became linked to access to food as food pantries are accessible for some participants only through several bus transfers. If the services seem inaccessible it could be construed as if they did not exist. A review of prevention programs for HIV positive men and women concluded that prevention services need to be included with other services like transportation and housing (Fisher & Smith, 2009). When a population experiences an unmet need in one service category this may compromise the efficacy of prevention services. For future studies, the perceived accessibility of services along with its actual accessibility must be examined.

This study consisted of a small sample of people recruited from two clinics in the Pittsburgh region. The population recruited was well-educated and the clinic provided case management and distributed information about services via newsletters and their website. The information gathered is not representative of other HIV positive men and women. The purpose of this study was to examine people's access to services, namely their knowledge on how to access such services. Additional research is needed in order to examine the multiple ways people experience barriers in accessing care and in how people work with the information given to them by service providers about such care.

The finding that African-American men and women reported needing more services than Caucasian men and women is a finding needing greater examination. One potential issue not included in this study is that many African-American men and women are found to be HIV positive much later in the course of the disease than Caucasian men and women. It may be that the African-American men and women in this sample have been living with the knowledge of being HIV positive for a shorter period of time compared to Caucasian men and women. This is another reason why additional research is needed.

Service providers must be aware of how information about services is communicated to people. Service providers will likely face clients with a wide range of abilities in regards to how they process information. There will be those who need more guidance in how to find and interpret information in regards to services. The difference in abilities requires additional research and greater attention by service providers.

MSM Internet Study

The objective of the HIV Prevention needs assessment is to provide the Pennsylvania Department of Health's Bureau of HIV/AIDS with information regarding the needs of and services encountered by men at risk of HIV transmission. The specific aim of this study was to pilot an internet needs assessment instrument (n=100) of men who have sex with men who are 16 years of age or older. Participants were to be asked to complete a self-administered internet questionnaire. The PA DOH Institutional Review Board responded with requests that would not have made the study feasible and therefore it was canceled in December 2009.

Active Needs Assessments

Mental Health and Substance Abuse Provider Study

The overall purpose of the study is to examine the extent prevention activities are being conducted for people who are HIV positive within mental health and substance use treatment facilities. The CDC has also identified prevention activities for HIV positive people to be a high priority.
Previous needs assessments consisting of people with HIV indicate that:

- Attitudes of denial and apathy toward prevention increase people's chances of infection, particularly among the newly diagnosed.
- Newer treatments may have led to increased risk taking because of improved health.
- Doctors, nurses, and other providers in general, do not talk about prevention. Some participants also noted that their providers do not provide condoms.
- Active addiction is a major barrier to prevention.
- Many participants perceived that HIV+ patients in rural areas received poor quality of care.

Research Questions:

1. What HIV prevention services are provided to HIV positive men and women?
2. How much time and resources are they able to provide HIV positive people?

A listing of agencies is being generated from a PA Dept. of Health database. Mental health and substance use treatment agencies will be placed into separate lists, and 125 agencies from each list will be selected (250 total). Those selected will be sent a packet to their executive director (or similar official) to ask them to post study advertisement within areas easily accessed by staff and to inform the staff to the existence of the study. Those interested will be told to contact our study office to be screened. They will be asked if they provide services for patients/clients within a mental health or substance use treatment facility, or if they have patients/clients who are HIV positive if they are in private practice. If they are eligible, they will be given the internet link to the survey. The survey should only take 15-20 minutes to complete. Once completed, participants

will be asked to provide a mailing address for us to send them $10 to reimburse them for their time (that information will not be included with the study information and only study personnel will have access to it). Their address will not be attached to the data. Survey responses will be anonymous. The study will seek to recruit 200 subjects. The number will have sufficient power for bivariate statistical techniques. The goal of the study is to describe the availability of HIV prevention service within mental health and substance use treatment facilities for inclusion within the state's HIV prevention plan.

Literature reviews.

Men Who Have Sex with Men and Also Engage In Sex Work

Male sex workers (MSW) have been described as a vector of transmission of HIV into the heterosexual population.[1] However, other more recent studies have questioned the importance of this vector and have suggested that MSW use condoms more consistently with clients than they do with casual (non-paying) male partners, putting their partners at a high risk.[2] In western countries, MSW operate generally via three types of venues: direct contact between client and customer on the streets or in bars, mediated via an escort agency, and passive contact through the use of advertisements.[2]

A study of men who have sex with men (MSM) and also inject drugs found sex work to be associated with HIV infection, with the number of paying sex partners associated with risk of HIV infection.[3] Another study of MSW in London showed HIV prevalence to be related to the amount of time spent in sex work.[4] A recent study of MSW in Houston, Texas found that 26% of participants who had been tested for HIV were positive, while the overall prevalence of HIV infection in the general Houston population is around 0.01%.[5] Another study of gay and bisexual men in Vancouver, Canada found that those involved in the sex trade had a significantly higher prevalence of HIV infection than those not involved (7.3% vs. 1.1%).[6] Finally, another Canadian study found that MSW who also injected drugs had a higher prevalence of HIV than male IDU who weren't sex workers (27% vs. 17%).[7] These studies indicate that MSM who engage in sex work have a much higher prevalence of HIV infection compared to not only the general population but also other high risk populations such as MSM and IDU.

Several studies have shown MSM sex workers to be engaged in high risk sexual activities. Due to the nature of their trade, MSW have been shown to have multiple and high numbers of sex partners, especially one-time encounters.[5] However, another study reported that although MSW were at high risk for HIV and STIs, this does not appear to be directly linked to sex work.[4] In this study, HIV infection was associated with history of IDU and unprotected sex with a casual partner. Several studies have shown a high prevalence of drug use among MSM sex workers.[5-7] Apart from drug use, MSM sex workers also have been shown to have a high prevalence of needle sharing.[7] In addition to drug related to risky behavior, studies have also shown MSM to have a high prevalence of risky sexual behavior. In one study, only 32% of MSW reported using a condom when having sex with a contact person.[5] Another study found MSW to not only have higher rates of unprotected sex with casual partners, but also to have a

significantly lower age of first sexual encounter, which has been associated with higher levels of sexual risky behavior.[6]

It is also important to understand the population of MSM who seek out the services of MSM sex workers to fully understand the risks faced by sex workers. One study in Los Angeles found that MSM who frequented commercial sex environments (bath houses, sex clubs etc.) had a higher prevalence of HIV and STIs and also had more sexual partners, engaged in riskier sexual behaviors, and were more likely to have used drugs/alcohol the last time they had sex.[8] It has also been shown that HIV positive MSM are more likely to use commercial and public sex environments than HIV negative MSM.[9] A study of HIV positive MSM found that men frequenting commercial sex environments were more likely to use stimulating drugs such as amphetamines and ecstasy which may encourage risky sexual behavior.[10] These studies highlight the risks involved for MSM sex workers who use commercial sex environments to meet their clientele.

There have been few evaluations of interventions targeted towards MSM sex workers or their clients. One such evaluation was of a peer-led intervention conducted in three "hustler" bars in New York City based on social influence techniques.[11] The goal of the intervention was to reduce reported rates of unprotected sexual behavior and needle-sharing among MSW and their patrons by altering peer norms by having opinion leaders endorse safer behaviors to their peers. The evaluation reported a small but significant reduction in unprotected anal sex during paid encounters. However, this was not associated with a change in peer norms and the results were not consistent across the different bars where the intervention was conducted. Another more recent evaluation was of a brief intervention targeting street-based MSW in Houston, TX.[12] The intervention were informational and were based on elements of the Centers for Disease Control and Prevention's HIV risk reduction intervention and the National Institute on Drug Abuse's standard risk reduction intervention and consisted of two one-hour sessions.[13, 14] The evaluation revealed the intervention to have high acceptability (i.e. rate of completion by the intervention population) with almost 2/3 of those enrolled completing it. There was also a significant decrease in risky behaviors such as drug use, IDU, number of sex partners and an increase in condom use.

In the past decade, there have been perhaps no studies looking exclusively at minority MSM sex workers. Most studies have found no difference between Black MSM and MSM of other races in the rate of commercial sex work.[15] Even less is known about Latino/Hispanic MSM sex workers. Another area of interest is of Men who have sex with women (MSW) who work in multiple cities. One study of MSW in Houston, TX examined spatial bridging by drug-using MSW between Houston and other cities. [16] In this study, slightly less than half of the participants were identified as spatially bridging one city to another. In addition, a significantly higher proportion of MSWs who spatially bridged cities were HIV positive, self-identified as gay and had significantly more male sex partners than MSWs who did not bridge cities. Apart from risky behaviors, trading sex may also be associated with other factors. A study of drug using MSM, found trading sex for money, drugs, and shelter, or food was correlated with not only use of crack

cocaine and IDU, but also homelessness, childhood maltreatment and self-identified sexual orientation.[17]

Men Who Have Sex With Men And Are Injection Drug Users

Within the United States the lifetime prevalence of injection drug use has been estimated to be around 1.5%.(1) Around 19% of AIDS cases in the US are among the IDU population in 2006.(2) Of the 31,518 cases of HIV/AIDS diagnosed among adult or adolescent males in 2007 in 34 US States and 5 US dependent areas, around 4% were attributed to MSM-IDU.(3) Between 2002 and 2007, around 3% of AIDS cases diagnosed in Pennsylvania were attributed to MSM-IDU.(4) Among IDU-related AIDS cases in the US in 2006, the proportions of AIDS diagnoses attributed to MSM & IDU were generally of the same magnitude across different age groups among adults and adolescents.(2) Among MSM-IDU, 6,300 received a diagnosis of AIDS in 1992. After 1992, a decreasing trend occurred in this group; in 2006, an estimated 1,844 MSM-IDU received a diagnosis of AIDS.(2) In 2006, 50 jurisdictions (45 states, 5 dependent areas, including PA) reported 8,638 cases of HIV infection (not AIDS) related to injection drug use among adults and adolescents. Of these 23% were attributed to MSM-IDU.(2) MSM-IDU have the highest rate of HIV infection of any risk group in the US. MSM-IDU have higher HIV prevalence, incidence, and risk behaviors compared to other male IDUs and non-IDU MSM.(5) MSM-IDUs also provide an important source of HIV transmission between high prevalence and low prevalence groups through drug-use and sexual relationships with gay men and heterosexual women.(6) HIV surveillance and behavioral research involving drug users and MSM are considered , both IDU and MSM are considered hidden populations and thus are difficult to study.

One study of MSM-IDU from San Francisco noted that HIV-positive MSM-IDU were more likely than HIV-negative MSM-IDU to be older, African American, less likely to be homeless, more likely to have engaged in anal intercourse with men over the past 6 months, less likely to have had vaginal sex with women in the past 6 months, and more likely to have used an Amphetamine injection.(5) There was a high prevalence of high risk behavior such as unprotected anal sex and needle sharing with over a third of the study population reported syringe sharing. The study also showed that MSM-IDUs comprise a heterogeneous population with gay and bisexual self-identified MSM-IDUs had significantly higher rates of positive HIV status than heterosexual self-identified MSM-IDUs. Additionally three quarters of heterosexual MSM-IDUs engaged in sex trading (for drugs or money). Although antiretroviral treatment (ART) among HIV positive MSM in San Francisco is common, only 15% of HIV+ MSM-IDUs in this study reported ART use. Additionally, though most studies have focused on stimulant use among MSM-IDU this study also revealed a high level of heroin use (62% for all participants) along with high use of syringe exchange programs suggesting that future interventions may incorporate methadone treatment and syringe exchange programs.

The MSM-IDU population can be stratified not only on self-identified sexual orientation but also on drug use, and the risk of HIV infection therefore differs with type of drug use. Studies of IDU have shown that injection of “speedballs” (combination of heroine and cocaine) compared to cocaine or heroine alone is associated with a higher risk of HIV infection.(7) Similarly, while the use of methamphetamines has been associated with HIV infection among MSM-IDU, the use of cocaine and heroin is much less studied.(5)

One recent study examined primarily cocaine and heroin using MSM (including non-IDU) in New York City.(8) In this study, HIV+ participants generally participated in fewer high risk behaviors such as sex with multiple partners and exchange for sex partnerships and also reported higher socioeconomic status than HIV- participants. The authors suggest that this may be because HIV+ individual may have known of their status for some time and subsequently reduced their high risk behaviors.

Black and Latino MSM populations generally have been under-recruited in studies of MSM individuals.(8) There are likely to be important differences among sexual risk behavior among MSM-IDU of different race/ethnicities. One study of drug using (non-IDU) MSM reported a sense of exclusion from the mainstream gay community by the participants of color including at HIV+ organization.(9) Studies have suggested that bisexual MSM of color are less likely to inform their female sex partner of their sexual identities thus increasing the risk of heterosexual transmission of HIV.(8, 10, 11) Studies of IDU in Black MSM have had mixed results with some studies revealing higher IDU than white MSMs while other studies showed equal or less prevalent IDU compared to white MSMs.(12) The Latino MSM-IDU community is perhaps even more understudied. One study found Latino ethnicity among MSM to be inversely associated with IDU.(13) Deiss et al. studied MSM-IDUs in two Mexican cities near the US border to explore risk behaviors among Latino MSM-IDUs whose study population is likely to have some similarities with US Latino MSM-IDU.(14) This study revealed very high levels of sexual relationships with females and needle-sharing among the study population.

MSM-IDU have been reported to engage in multiple high-risk behaviors that may have a synergistic effect on HIV transmission.(15) Needle-sharing may not be the primary contributor of risk for IDU, but rather the engagement in high risk activities such as unprotected sex by drug users.(16, 17) One study reported that MSM-IDU engaged in risky behaviors to satisfy a heightened need for immediate gratification.(15) Choice of drugs by MSM-IDU differed from non-MSM IDU (methamphetamines and cocaine vs. heroin) which contributed to an increased sex drive. Between 45-60% study participants reported being high during sex half the times or more which may allow for a greater risk of risky sexual behavior. This study strongly suggests that targeting just IDU or MSM related risky behavior may not be sufficient for interventions targeting MSM-IDU, especially as MSM-IDU may not identify with either the general gay community (due to heterosexual self-identification) or the IDU community (due to not using heroin). Another study of young MSM-IDU in San Francisco reported that HIV infection was associated primarily with sexual risk factors including commercial sex work.(18) The study authors' commented that commercial sex work among MSM-IDU provides additional challenges to any intervention as it provides powerful commercial disincentives for condom use and IDU how have sex with men primarily for money may not identify with the general gay community.

Apart from HIV, MSM-IDU are at risk for other health issues. One study found that HIV+ MSM with Hepatitis C infection (HCV), had a trend towards higher IDU than those without HCV.(19) Another reported HCV to be strongly associated with IDU in a cohort of MSM.(20). Another study reported a low prevalence of HCV in MSM who do

not use drugs pointing to a possible important difference between MSM and MSM-IDU groups.(21) Another study reported a higher rate of self-reported history of tuberculosis and sexually transmitted infections (STI) – most commonly syphilis or gonorrhea – among MSM-IDU compared to non-MSM IDU.(14) IDU has also been identified as a risk among HIV+ MSM for Community-Associated Methicillin-Resistant Staphylococcus aureus (CA-MRSA) skin Infections.(22)
Possible Future Investigation: There seemed to be few studies specifically looking at Latino/Hispanic MSM-IDU. Also as the MSM-IDU community may be stratified according to type of drug used, with very different risk associated with heroin vs. methamphetamine and cocaine use, it is important to study different drug using populations within the MSM-IDU community. Also the importance of poly-drug use was acknowledged by some studies and as such this needs to be further investigated

4.5. Activities related to the Registry Project

The Registry data storage system was named the HIV/AIDS Service Provider (HASP) system in spring 2010. Programming of the data collection system was completed in June 2010. We are presently developing the instructions and support documentation.

Piloting of the system with agencies is scheduled for August 2010. The system is to be fully operation for data collection by employees and agencies in October 2010, with all Pennsylvania agencies listed in the Pennsylvania Uniform Data System (PaUDS) and their employees having entered their data into HASP by the end of 2010. Enrollments and trainings to use HASP will be ongoing in 2011.

Programming and development for consumers will continue in 2011, with completion planned for September 2011. Updates and revisions to the employee/agency sections of HASP are scheduled in the second half of 2011.

Definition of HIV service provider

State, federal and international health organizations were queried to find a foundational definition for HIV service providers. Through this process it was determined that no standardized definition of such a provider exists. The definition of an HIV service provider as defined by the Registry Project is currently: An HIV service provider for the purpose of this registry is a provider who is serving the HIV related health needs of HIV infected, affected, and at-risk people using appropriate science-based and professionally recognized methods of treatment and/or service. Services include primary medical, psychological, support services, and health prevention activities/interventions. The services must be culturally competent. The registry reserves the right to list, not list, add or remove any service from the list.

Definition of service categories

A preliminary best practice in the scope of HIV care was created to serve as a template for data collection and data organization on the registry site. To gain a full range of data, existing servicing categories from the State of Ohio, New Jersey and California (Los

Angeles) were included as were the Coalition Planning Sheets, the HRSA Careware Core services from 2006 and 2007, the Medical Monitoring Project Provider Survey, the Facility Attributes Information Worksheet, and the Facility Contacts Lab Contact Access Database. Also, included was information collected from interviews facilitated with Allegheny County based HIV service agencies. Other sources that were queried but may not have been incorporated due to lack of relevant data or insufficient data were: PANO (the Pennsylvania Nonprofit Association), GUIDESTAR, and the Pennsylvania MidAtlantic AIDS Education and Training Center.

Definition of service employee profiles

A list of service categories is being designed to serve as a template for the registry data collection. Websites of existing service agencies have been queried for a framework of core skills. Additionally, guidelines from HRSA, the Ryan White Care Act, and Philadelphia department of Health have been incorporated into these categories.

Definition of agency profiles

The existing Pennsylvania Prevention Project Resource Directory, PaUDs and PEMS are serving as a template for a universal agency profile.

4.6. Pennsylvania Prevention Project/Pitt Men's Study Internet Activities

The Pennsylvania Prevention Project and the Pitt Men's Study joined efforts in January of 2008 to create a web-based intervention program for gay and bisexual men in Pennsylvania. This goal of this program is to:

1. maintain the "Health Alerts" email list service,
2. create and maintain an online partner notification application,
3. maintain a chat room "sexual health educator" presence on the gay.com, Manhunt, and Adam4adam websites,
4. create and maintain a website that would serve as a general source of STI information and community resources,
5. and research other possible methods for conducting effective online interventions.

Pitt Men's Study Health Alerts

After several months of research and testing, the Pitt Men's Study Health Alert list service was officially launched in early October of 2007, with advertisements in the local gay newspaper and a bulk mailing to Pitt Men's Study participants (1000 plus gay and bi men). The first message was sent on November 5th to 70-plus initial subscribers in the greater Pittsburgh area.

As of February of 2008, the list service became a state-wide program, with on-going advertisements in the local Out Magazine, The Philadelphia Gay News, The Erie Gay

News, and the Washington Blade. The list continues to grow, however slowly, with a current total of 146 subscribers.

In March of 2009, the list was upgraded to a new University of Pittsburgh service that will allow for graphics and manipulation of text.

Given the slow rate of subscription, Health Alerts will also continue to be sent to Yahoo gay and bisexual groups in the state. In this way, another 1,500+ gay and bi men will be reached with the important health information.

Health Alerts are also posted in Gay.com chat rooms across the state.

Additional marketing of the list service is on-going via advertisements on the Pitt Men's Study website, Pittsburgh's Out Magazine and in the Erie Gay News.

Partner Notification

The partner notification application was completed in December of 2008 and released to State Department of Health officials, along with instructions for testing. A meeting was held at the PPP offices with those officials, in early April of this year, and a list of changes and updates was compiled. These changes have been made and the application is ready for Beta testing by state officials.

Chat Room Intervention

The chat room outreach project has been thoroughly researched and a resulting literature review was compiled in late 2007. Based on the available information, a chat room "health educator" went on line in April 2008 for an average of five to ten hours per week on *Gay.com, Adam4adam,* and *Manhunt*. The purpose of which, like the list service, is to inform MSM in the state about sexual health risks and to provide links to STI-related resources.

The bulk of the general information provided to chat room participants comes from a standardized list of Q & A responses created by the PPP staff and edited by Health Department officials. Other resources include StopHIV.com and the Pitt Men's Study website. Difficult or unusual issues posed by chat room participants are forwarded to the Pitt Men's Study medical staff.

In March of 2009, an official relationship was created between PPP's online outreach efforts and the local Allegheny County Health Department testing facility in order to provide direct access to testing for localized MSM.

Over the last year, conversations were conducted with more than 250 individuals.

Creating a Website Resource – www.m4mHEALTHYsex.org

Creation of the STI information-based website was completed in February of 2009. Testing is on-going and updates are being made before its release to the public in May. Features of this website include:

- A "virtual online health educator" to answer questions posed by users with sexual health questions. Answers are given in the form of an animated avatar, using the same transcript of questions and answers used for chat room outreach. Questions not answerable by the existing database will be forwarded to the Pitt Men's Study medical staff. Once an answer is obtained, it will then be added to the website's database.
- Links to other noteworthy resources, including the Pitt Men's Study website, the National STD and HIV Testing Resource Directory, links to LGBT-friendly medical providers, and other pertinent organizations.
- A news-based page with articles and information regarding the health issues of MSM.

Research of Other Potential Online Interventions

In late February of 2009, PPP began research into other methods of conduction online interventions. The goal was to identify research-proven applications that might be deployed in Pennsylvania for the purpose of reducing the incidents of new HIV infections among MSM in the state. So far, the results of the research have turned up one potential project:

The Wyoming Rural AIDS Prevention Project (WRAPP)—Funded by the National Institutes of Health in 2004, WRAPP was designed to increase awareness and thereby reduce the incidents of HIV infection among rural MSM. Although results are still preliminary and research is on-going, the application showed some promise. Currently, PPP has acquired the code for the intervention and hopes to implement the application online for Pennsylvania MSM.

Research into additional methods of conducting online interventions is ongoing.

4.7 Pennsylvania Youth Risk Behavior Survey (YRBS)

The Young adult Roundtable had requested more data regarding the HIV risks of young people.

The 2009 Pennsylvania Youth Risk Behavior Survey (YRBS) indicates that among high school students:

Sexual Risk Behaviors

- 48% even had sexual intercourse
- 6% had sexual intercourse for the first time before 13 years
- 15% had sexual intercourse with four or more persons during their life

- 37% had sexual intercourse with at least one person during the 3 months before the survey
- 35% did not use a condom during last sexual intercourse (1)
- 73% did not use birth control pills or Depo-Provera before last sexual intercourse to prevent pregnancy (1)
- 10% were never taught in school about AIDS or HIV infection

Alcohol and Other Drug Use

- 15% drank alcohol or used drugs before last sexual intercourse (1)
- 2% used a needle to inject any illegal drug into their body one or more times during their life

(1) Among students who were currently sexually active

Additional information can be obtained at www.cdc.gov/yrbs

4.8. Future Needs Assessment Activities

Reprioritization of target populations are still in process, the needs assessment process will not change until the reprioritization plan is finalized.

The committee will be working with the Integrated Planning Council and Ryan White funded coalitions to conduct a study on the unmet needs of HIV positive men and women, which is ongoing from the previous year. The registry project is the direct result of this collaboration.

Two studies of service needs are almost complete. One examines whether HIV positive men's and women's lack of knowledge about services are affecting their access. The other examines MSM usage of HIV testing services and the barriers they face.

In the next year the needs assessment activities will focus upon the HIV prevention needs of men who have sex with men. The current epidemiological profile lists men who have sex with men as having the highest risks of HIV infection. Studies will be conducted via the internet and through focus groups on specific subgroups of MSM (Black, Hispanic, White, Rural, gay/bi and transmen, and MSM-IDU). The goal is to examine the risks and needs of these groups in comparison to previous needs assessments. The internet study will examine the feasibility of using such methods for needs assessments in comparison to the focus groups that have been conducted in the past and those to be conducted in the future. Focus groups of MSM to be conducted will be used in comparison to previous needs assessments conducted by the CPG. The goal is to examine differences in the findings found between the current focus groups and those conducted ten years earlier.

1. A study examining the service needs of HIV positive men and women. The study examines whether people's lack of knowledge is affecting their service usage.
2. A study examining "men who have sex with men" and their access and usage of services for HIV testing.
3. An internet based survey for men who have sex with men.

4. Focus Groups to examine the HIV prevention needs of various categories of MSM.
    a. African American
    b. Latino
    c. Youth
    d. Rural
    e. White Gay Men
    f. Internet Users
    g. Sex Workers (defined by those who have direct intimate contact with clients)
    h. Gay/Bi Trans Men
    i. IDU
    j. Men over 50 years of age.

Based upon the Epidemiologic profile and the prioritized target population and in consultation with the Department of Health, the CPG has identified the target populations to be assessed and the types of needs assessments to be implemented, which are to be carried out by University of Pittsburgh staff. This report covers needs assessments of at risk subgroups conducted within 2006:

1. Continued to work on a long-term collaborative effort with the Integrated Planning Council and Ryan White funded coalitions to conduct a study on the unmet needs of HIV positive men and women.
2. Utilized the Youth Empowerment Project data to provide needs assessment data.
3. Conducted literature reviews of MSM failure of prevention and Heterosexual women with partners in prison.
4. Developing focus groups with parents about the HIV prevention needs of their children.

Since reprioritization is still in progress, we will focus on the unmet needs collaboration with the Integrated Planning Council and Ryan White funded coalitions to provide ongoing assessment of the prevention needs of HIV positive individuals. Future needs assessments will include recommendations that will be:

- Presented and distributed to the CPG
- Utilized by various AIDS service organizations, coalitions, etc.

4.9. Pennsylvania Young Adult Roundtables

Overview and Philosophy

The Pennsylvania Young Adult Roundtable project is a needs assessment tool of the Pennsylvania HIV Prevention Community Planning Committee. The project is NOT an intervention. The Roundtables' primary purpose is to involve youth in Pennsylvania in the HIV Prevention Community Planning process. The project accomplishes this purpose by "giving youth a voice" in the statewide HIV Prevention planning process. During Roundtable meetings, youth evaluate HIV materials (videos, brochures, etc.), make

recommendations to improve HIV prevention for Pennsylvania youth, and develop the Roundtable HIV Prevention Consensus Statement. Secondary purposes of the YART include providing HIV/AIDS education/sensitivity and linking youth with local HIV prevention activities. University of Pittsburgh staff members facilitate the meetings, listen to Roundtable members, and do not make any judgments about them or their discussed behaviors. Roundtable members are considered the experts, as they have the opinions and recommendations needed in statewide HIV prevention planning.

Needs Assessment Data

Each of the current seven statewide Roundtables is composed of young adults at high risk of HIV infection/re-infection. Each Roundtable meets five times per year for three hours. Typical meetings consist of informal discussions about HIV, its transmission and prevention, and reactions to and evaluations of HIV prevention videos and magazines produced for young people. The groups meet in a location recommended by a local recruiter and acceptable to the group members. Refreshments, usually pizza and soda, are served at each meeting.

Priorities

We wish to determine:

- What HIV prevention programs exist for young people?
- What programs are needed for young people?
- The gaps that exist between their needs and existing programs.
- The barriers that exist for young people across the state.
- New ways to outreach with young people.

In January 2009, members convened a Consensus Revision conference to generate ideas in order to revise the Young Adult Roundtable Consensus Statement. Content was analyzed for goals and objectives achieved, and new goals and objectives were suggested. The document was further revised at the May 2010 Executive Committee meeting, and has now been finalized and is being disseminated. A full version will appear in a future Pennsylvania HIV Prevention Plan.

In addition, the Pennsylvania Young Adult Roundtables are continuing to work on the Video Prevention Assessment project initiated in 2009. This project entails producing videos of real-life and role-modeled narratives that reflect issues that young adults have when negotiating safer sex with their partners. This initiative comes out of a Young Adult Roundtable needs assessment that identified an important gap in teaching young people to have relevant, practical sexual conversations with potential sexual partners. The Video Prevention Assessment project suggests a potential structure, involving community-based scriptwriting and video-recording, that HIV prevention service agencies can follow in order to address this need at a programmatic level. Agencies that work with young people should not assume that they are capably speaking with their partners about sexual risk.

4.10. 2008—2009 Resource Inventory

This Resource Inventory is a compilation of multiple surveys conducted of the HIV Prevention Planning Group members, the Pennsylvania Department of Health, their contractors (nine county/municipal health departments, seven Ryan White HIV regional planning coalitions, University of Pittsburgh/Pennsylvania Prevention Project, Council of Spanish Speaking Organizations of the Lehigh Valley), their subcontractors, other state government agencies, and data collected from the Pennsylvania Prevention Project STOPHIV.COM resource directory database. It should be noted:

- This Resource Inventory is a list of HIV prevention service providers regardless of their funding source. The Pennsylvania Department of Health utilizes both CDC and State funding for HIV Prevention Interventions.
- Agencies may be listed more than once because they receive funding from multiple sources, for multiple projects that may target different populations and provide different interventions. Additionally, agencies may be providing services in multiple counties.
- When available, Pennsylvania's Uniform Data System (PaUDS) prevention intervention data were used to indicate the actual target populations served and interventions provided to each target population. This process monitoring data are available from only the Department's CDC-funded and state-funded contractors and subcontractors.
- Where process-monitoring data are not available, the Resource Inventory relies upon agency self-reporting of target populations and interventions
- Data on the number of individuals served by the interventions was not collected
- For some agencies, the target population is identified as "General Public" because either the agency has not been funded to target a specific population or the actual process monitoring data indicates that the agency reported serving the "General Public"
- For this Resource Inventory, the state-funded, confidential/anonymous counseling and testing sites (HIV clinics) were designated as serving the "General Public" because they are walk-in sites open to the general public. Services are not targeted to a specific population. A more accurate indication of services provided at these sites may be to look at the actual risk behaviors reported by individuals that utilized these services. This information is available through the data collected by Department's HIV Counseling, Testing and Referral (CTR) database
- Department-funded sexually transmitted infections (STI) and tuberculosis (TB) target populations were based on client demographics as reported by the STI and TB program management staff. Again the CTR data may give us a clearer picture of the self-reported risk behaviors, and thus the target populations reached. The Community Planning Group is aware of these limitations and will refine the process of data collection for the Resource Inventory
- The Interventions Subcommittee reviewed and updated the extensive resource inventory developed with the Department of Health in the 2006 Plan Update. Once HIV prevention services are recorded then the lack of service emerges and a gap analysis of needed services is developed for priority populations not receiving HIV prevention services

4.11. Resource Inventory Findings

The resource inventory is an important part of the Community Service Assessment (CSA). Each year, the Interventions Subcommittee reviews and updates this document. This year, the Resource Inventory was sent to the nine county, municipal health departments, seven Ryan White HIV/AIDS Regional Planning Coalitions, Planning Committee members as well as other stakeholders familiar with HIV prevention services in their communities for review and update. The Resource Inventory was also cross-referenced with data from the Pennsylvania Uniform Data System (PaUDS) to assure its' accuracy.

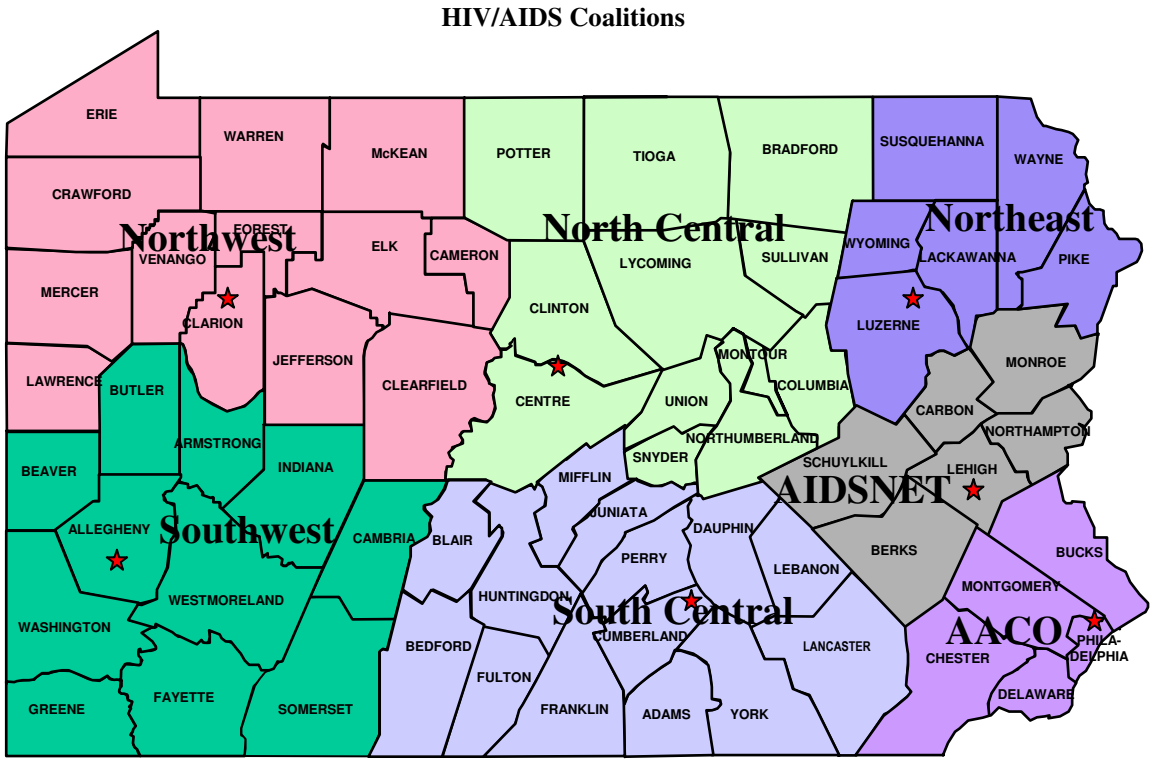

Figure 4.1 Pennsylvania Department of Health Ryan White HIV/AIDS Regional Planning Coalitions

The AIDS Activities Coordinating Office (AACO) Region
The AACO region consists of Bucks, Chester, Delaware, Montgomery and Philadelphia Counties. The total population of this region is 2,465,276 not including Philadelphia there is a +6% change since the 2000 Census. Including Philadelphia, the total population is 4,012,573 (32% of state population and a +4% change since the 2000 Census)

Key: IDU – Injection drug user; MSM – Men who have Sex with Men; MSM/IDU – Men who have Sex with Men who are Injection Drug Users

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
BUCKS COUNTY Population—626,015 (Doylestown)-county seat		
Aldie Counseling Center 3369 Progress Drive Bensalem, PA 19020 215.642.3230	Counseling, Testing and Referral Services (CTR)	HIV+ IDU MSM Heterosexual General Public
Bucks County Department of Health Neshaminy Manor Center Health Building, 2nd Floor 1282 Almshouse Road Doylestown, PA 18901 215.345.3318 www.buckscounty.org Government Service Center 7321 New Falls Road Levittown, PA 19055 215.949.5805	CD4 and Viral Load Testing Counseling, Testing and Referral Services (CTR), Partner Services (PS) Health Education/Risk Reduction (HE/RR) Outreach, Health Communication/Public Information (HC/PI), **HIV Clinic** **STD Clinic** **Tuberculosis Clinic**	General Public
Bucks County Community Corrections 1730 South Easton Road Doylestown, PA 18901 215.345.3700	CD4 and Viral Load Testing Counseling, Testing and Referral Services (CTR), Partner Services (PS) Health Education/Risk Reduction (HE/RR) Outreach, Health Communication/Public Information (HC/PI)	HIV+ IDU MSM Heterosexual General Public Emerging Risk Group – Women
Family Service Association of Bucks County HIV/AIDS Program Cornerstone Executive Suites 3 Cornerstone Drive	Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI) Case Management	IDU MSM Heterosexual General Public Emerging Risk Group –

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
Langhorne, PA 19047 215.757.6916 www.fsabc.com	Support Groups Healthy Relationships	Women Emerging Risk Groups Homeless, Immigrants
Good Friends Inc. 868 West Bridge Street Morrisville, PA 19067 215.736.2861	Counseling, Testing and Referral Services (CTR)	IDU MSM Heterosexual General Public
Libertae 5242 Bensalem Boulevard Bensalem, PA 19020	Counseling, Testing and Referral Services (CTR)	HIV+ IDU Heterosexual General Public Emerging Risk Group – Women
Livengrin 4833 Hulmeville Road Bensalem, PA 19020 215.638.5200	Counseling, Testing and Referral Services (CTR)	General Public
Penn Foundation 807 Lawn Avenue Sellersville, PA 18960 215.257.9999	Counseling, Testing and Referral Services (CTR)	IDU MSM Heterosexual General Public
Planned Parenthood The Atrium 301 Main Street Suite 2E Doylestown, PA 18901 215.348.0555 www.ppbucks.org	Counseling, Testing and Referral Services (CTR), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	General Public Emerging Risk Group – Youth
Planned Parenthood The Atrium, Suite 303 610 Louis Drive Warminster, PA 18974 215.957.7980 www.ppbucks.org	Counseling, Testing and Referral Services (CTR), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	General Public Emerging Risk Group – Youth
Pyramid Healthcare 2705 Old Bethlehem Pike Quakertown, PA 18951	Counseling, Testing and Referral Services (CTR)	IDU MSM Heterosexual General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
		Emerging Risk Group – Youth
Today Inc. 1990 Woodbourne Road Langhorne, PA 18940 215.968.4713	Counseling, Testing and Referral Services (CTR)	IDU MSM Heterosexual General Public Emerging Risk Group – Youth
CHESTER COUNTY Population—498,894 (West Chester)		
Addiction Recovery Center 1011 West Baltimore Park Suite 101 West Grove, PA 19390	Counseling, Testing and Referral Services (CTR)	IDU MSM Heterosexual General Public
Advanced Treatment Systems 1825 East Lincoln Highway Coatesville, PA 19320 610.466.9250	Counseling, Testing and Referral Services (CTR)	IDU MSM Heterosexual General Public
ChesPenn Family Health Center 1029 East Lincoln Highway Coatesville, PA 19320 610.344.5562	Counseling, Testing and Referral Services (CTR)	General Public
Chester County Department of Health 601 Westtown Road, Suite 190 West Chester, PA 19382 Atkinson Health Care 830 East Chestnut Street Coatesville, PA 19320 Oxford Health Care 35 North 3rd Street Oxford, PA 19363 610.344.5562	CD4 and Viral Load Testing Counseling, Testing and Referral Services (CTR), Partner Services (PS) Health Education/Risk Reduction (HE/RR) Outreach, Health Communication/Public Information (HC/PI) HIV/STD Clinics Tuberculosis Clinic	HIV+ IDU MSM Heterosexual General Public Emerging Risk Group – Homeless, Immigrants, Women, Youth
Chester County Infectious Disease Association – John Bartels, MD 213 Reeceville Road, Suite 13 Coatesville, PA 19320 610.383.7505	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	HIV+
Chester County Prison	Counseling, Testing and	IDU

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
501 South Wawaset Road West Chester, PA 19382 610.793.1510	Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	MSM Heterosexual
Family Services of Chester County, Project ONE 14 East Biddle St West Chester, PA 19380 610.466.0603	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	HIV+ IDU MSM Heterosexual General Public
First United Church of Christ 145 Chestnut Street Spring City, PA 19475 610.344.5562	Counseling, Testing and Referral Services (CTR)	General Public
Gaudenzia West Chester Outpatient 110 Westtown Road, Suite 115 West Chester, PA 19382 610.429.1414	Counseling, Testing and Referral Services (CTR)	General Public
HELP Counseling Counterpoint 503 North Walnut Road, Suite E Kennett Square, PA 19438 610.444.0555	Counseling, Testing and Referral Services (CTR)	General Public
La Comunidad Hispana 314-316 East State Street Kennett Square, PA 19348 610.444.4545 www.lacommunidadhispana.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	Hispanic Heterosexual Hispanic IDU Hispanic MSM
Northwestern Human Services of Phoenixville 21 Gay Street Phoenixville, PA 19460 610.933.0400	Counseling, Testing and Referral Services (CTR)	General Public
Paoli Center for Addictive Diseases	Counseling, Testing and Referral Services (CTR)	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
21 Industrial Boulevard, Suite 200 Paoli, PA 19301		
Planned Parenthood of Chester County 8 South Wayne Street West Chester, PA 19382 610.692.1770 1660 Baltimore Pike Avondale, PA 610.268.8848 1001 East Lincoln Highway Suite 101 Coatesville, PA 19320 610.383.5911 1041 West Bridge Street Suite 10A Phoenixville, PA 610.935.0599 www.plan4it.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	HIV+ General Public Emerging Risk Group – Youth
Project Salud of La Comunidad Hispana Kennett Square Medical Office Building, Suite 2 400 McFarlan Road Kennett Square, PA 19348 412.444.5278 www.lacommunidadhispana.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	Hispanic Heterosexual Hispanic IDU Hispanic MSM
Riverside Care Continuum, Inc. 31 South 10th Avenue, Suite 6 Coatesville, PA 19320 610.383.9600	Counseling, Testing and Referral Services (CTR)	General Public
Southern Chester County Medical Center	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
The Clinic 143 Church Street Phoenixville, PA 19460 610.344.5562	Counseling, Testing and Referral Services (CTR)	General Public
Veterans Affair Medical Center and HIV Clinic Building 2, Room 250 1400 Blackhorse Hill Road Coatesville, PA 19320 610.384.7711	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	HIV+
W.C. Atkinson Case Management 201 Reeceville Road Coatesville, PA 19320 610.383.8348	Outreach, Health Communication/Public Information (HC/PI)	HIV+
West Chester University Health Center Rosedale Avenue West Chester, PA 19383 610.436.1000 www.wcupa.edu	Counseling, Testing and Referral Services (CTR), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual Emerging Risk Group – Youth
DELAWARE COUNTY Population—558,028 (Media)		
AIDS Care Group 2304 Edgemont Avenue Chester, PA 19013 610.872.9101	Counseling, Testing and Referral Services (CTR), Group Level Intervention (GLI), Health Communication/Public Information (HC/PI)	HIV+ IDU MSM Heterosexual
American Red Cross Chester - Wallingford Chapter 1729 Edgemont Avenue Chester, PA 19013 610.874.1484 www.craftech.com/~redcross/	Health Communication/Public Information (HC/PI)	General Public
ChesPenn Health Services 2600 West 9th Street Chester, PA 19013 610.859.2059	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public	HIV+ IDU MSM Heterosexual General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
www.chespenn.org	Information (HC/PI)	
Crozer Chester Medical Center Crozer Chester Community Hospital Chester, PA 19013 610.447.2000 www.crozer.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	HIV+ General Public
Crozer Chester Methadone Clinic Crozer Chester Community Hospital Upland, PA 19013 610.447.2000 www.crozer.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU
Delaware County State Health Center – HIV Clinic 5th and Penn Streets Chester, PA 19013 610.447.3250	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI) HIV/STD Clinics Tuberculosis Clinic	IDU MSM Heterosexual General Public Emerging Risk Groups – Homeless, Immigrants
Family & Community Services of Delaware County 100 West Front Street Media, PA 19063 37 North Glenwood Avenue Clifton Heights, PA 19018 610.566.7540 (Media) 610.626.5800 (Clifton Heights)	Outreach, Health Communication/Public Information (HC/PI)	HIV+ General Public
George W. Hill Correctional Facility Box 23A Thornton, PA 19373 610.358.2150	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public	IDU MSM Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
	Information (HC/PI)	
Harwood Home 9200 West Chester Pike Upper Darby, PA 19082 610.522.0522	Counseling, Testing and Referral Services (CTR)	General Public
Life Guidance Services, Inc. 800 Chester Pike Sharon Hill, PA 19079	Counseling, Testing and Referral Services (CTR)	General Public
Mercy Catholic Medical Center Lansdowne Avenue and Bailey Road Darby, PA 19023 610.237.4000	Counseling, Testing and Referral Services (CTR)	General Public
Mirmont Drug and Alcohol Rehabilitation Center 100 Yearsley Road Lima, PA 19037 610.522.0522	Counseling, Testing and Referral Services (CTR)	General Public
Planned Parenthood of Southeastern PA 216 West State Street Media, PA 19063 610.566.2830 Medical Building B 515 East Lancaster Avenue St. David's, PA 19087 610.687.9410 Parkview Shopping Center 605-607 Cedar Avenue Yeadon, PA 19050 610.626.9482	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
MONTGOMERY COUNTY Population—782,339 (Norristown)		
Alternatives, Inc. 450 Bethlehem Pike Fort Washington, PA 19034 215.641.6863 800.342.5429	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Health	MSM MSM/IDU

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
www.alternatives.com	Communication/Public Information (HC/PI)	
Family Services of Montgomery County, Project Hope 180 West Germantown Pike Suite 3B Norristown, PA 19401 610.272.1520 3125 Ridge Pike Eagleville, PA 19403 610.630.2211	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach	HIV+ IDU MSM Heterosexual General Public
Montgomery County AIDS Task Force 536 Fort Washington Avenue Fort Washington, PA 19034 215.646.3683	Health Communication/Public Information (HC/PI)	General Public
Montgomery County Health Department, Montgomery County Human Services Center 1430 DeKalb Street Norristown, PA 19404 610.278.5117 364 King Street Pottstown, PA 19464 610.970.5040 102 York Road, Suite 401 Willow Grove, PA 19090 (215) 784-5415	CD4 and Viral Load Testing Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI) DEBI Intervention: VOICES/VOCES HIV/STD Clinics Tuberculosis Clinic	HIV+ IDU MSM Heterosexual Emerging Risk Groups – Homeless
Montgomery County Correctional Facility 60 Eagleville Road Norristown PA, 19403 610.278.5117	Counseling, Testing and Referral Services (CTR)	General Public
Montgomery Fornace Family Practice 1330 Powell Street, Suite 409 Norristown, PA 19401	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
610.227.0964	Information (HC/PI)	
Planned Parenthood of Southeastern Pennsylvania 19 Lindenwold Avenue Ambler, PA 19002 215.542.8370 1220 Powell Street Norristown, PA 19401 610.279.6095 644 High Street Pottstown, PA 19469 610.326.8080 78 Second Street Collegeville, PA 19426 610.409.8891	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Valley Forge Medical Center and Hospital 1033 West Germantown Pike Norristown, PA 19403 610.539.8500	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Health Communication/Public Information (HC/PI), Other	HIV+ IDU MSM Heterosexual

AIDNET Region

The AIDSNET region consists of Berks, Carbon, Lehigh, Monroe, Northampton, and Schuylkill Counties. The total population of this region is 1,426,806 (11% of state population and a +10% change since the 2000 Census)

Key: IDU – Injection drug user; MSM – Men who have Sex with Men; MSM/IDU – Men who have Sex with Men who are Injection Drug Users

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
BERKS COUNTY Population—407,125 (Reading)-county seat		
ADAPPT 438 Walnut Street #901-909 Reading, PA	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
American Red Cross 701 Centre Avenue Reading, PA 19601 610.375.4383 www.berks.redcross.org	Other	General Public
Berks AIDS Network 429 Walnut Street PO Box 8626 Reading, PA 19603 610.375.6523 www.berksaidsnetwork.org	Counseling, Testing and Referral Services (CTR) Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI) Comprehensive Risk Counseling and Services (CRCS) DEBI Intervention: VOCES/VOICES	HIV+ IDU MSM Heterosexual
Berks Counseling Center 524 Franklin Street Reading, PA 19602 610.373.4281 www.berkscounselingcenter.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
Berks County Prison 1287 County Welfare Road Leesport, PA 19533 610.208.4800 www.co.berks.pa.us	Counseling, Testing and Referral Services (CTR) Partner Services (PS)	IDU MSM Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Berks County State Health Center HIV Clinic Reading State Building 625 Cherry Street Room 442 Reading, PA 19602 610.378.4377	Counseling, Testing and Referral Services, (CTR) Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Berks County State Health Center Tuberculosis Clinic Reading State Building 625 Cherry Street Room 442 Reading, PA 19602 610.378.4377	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Groups – Homeless
Blue Mountain House of Hope PO Box 67 Kempton, PA 19529	Counseling, Testing and Referral Services (CTR)	General Public
Caron Adolescent Treatment Center 17 Camp Road Wernersville, PA 19565 800.678.2332 www.caron.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual Emerging Risk Group – Youth
Caron Inpatient Galen Hall, Box A Wernersville, PA 19565 800.678.2332 www.caron.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
Caron Outpatient 17 Camp Road Wernersville, PA 19565 800.678.2332 www.caron.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
Center for Mental Health Reading Hospital and Medical Center Building K and Spruce Streets West Reading, PA 19611	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
610.988.8186		
Children's Home of Reading 1010 Centre Avenue Reading, PA 19601 610.478.8266 www.childrenshomeofrdg.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU MSM Heterosexual Emerging Risk Group – Youth
Conewago – Wernersville 165 Main Street Buildings 18,19,27,30 Wernersville, PA 19565 610.685.3733	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
Council of Spanish Speaking Organizations of the Lehigh Valley (CSSOLV) 520 East Fourth Street Bethlehem, PA 18015 610.686.7800	Counseling, Testing and Referral Services (CTR)	Hispanic IDU Hispanic MSM Hispanic Heterosexual
Drug and Alcohol Center	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
Kutztown University PO Box 730 Kutztown, PA 19530 610.683.4000 www.kutztown.edu	Counseling, Testing and Referral Services (CTR)	MSM Heterosexual Emerging Risk Group – Youth
New Directions Treatment Services 22 North Sixth Avenue West Reading, PA 19611 610.478.7164	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU MSM Heterosexual
New Directions Treatment Services (methadone) 1810 Steelstone Road Allentown, PA 18109 610.478.7164	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU
PA Counseling Services – PCS	Counseling, Testing and	IDU

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Reading City 938 Penn Street Reading, PA 19602 610.478.8088 www.pacounseling.org	Referral Services (CTR), Individual Level Intervention (ILI)	Heterosexual
Planned Parenthood of Northeast Pennsylvania 48 South Fourth Street Reading, PA 19602 610.376.8061 www.ppnep.org	Counseling, Testing and Referral Services (CTR)	Heterosexual
Rainbow Home of Berks County Wernersville State Hospital PO Box 300 Wernersville, PA 19565 610.678.6172 www.rainbowhome.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	HIV+
Red Cross Hispanic Mobile Unit 429 Walnut Street Reading, PA 19601 610.375.6523 www.berks.redcross.org	Counseling, Testing and Referral Services (CTR), Outreach	Hispanic Heterosexual Hispanic IDU Hispanic MSM
St. Joseph's Medical Center 215 North Twelfth Street Reading, PA 19603 610.378.2000 www.sjmcberks.org	Counseling, Testing and Referral Services (CTR), Outreach, Health Communication/Public Information (HC/PI)	General Public
Teen Challenge PO Box 98 Rehrersburg, PA 19550 717.933.4181	Counseling, Testing and Referral Services (CTR)	General Public
CARBON COUNTY Population—63,865 (Jim Thorpe)		
American Red Cross of the Lehigh Valley 2200 Avenue A Bethlehem, PA 18017	Other	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
610.865.4400 www.redcrosslv.org		
Carbon County Correctional Facility Route 93 and Broad Street PO Box 69 Nesquehoning, PA 18240 717.325.2211	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Carbon County State Health Center HIV Clinic 616 North Street Jim Thorpe, PA 18229 570.325.6106	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Carbon County State Health Center Tuberculosis Clinic 616 North Street Jim Thorpe, PA 18229 570.325.6106	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Carbon/Monroe/Pike Drug and Alcohol Commission (PHAST) (Pocono HIV/AIDS Support Team) 128 South First Street Lehighton, PA 18235 610.377.5177 www.cmpda.cog.pa.us	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Youth Forestry Camp #2 Hickory Run State Park White Haven, PA 18661 570.443.9524 www.dpw.state.pa.us	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU Heterosexual Emerging Risk Group – Youth

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
LEHIGH COUNTY Population—343,519 (Allentown)		
AIDS Activity Office Lehigh Valley Hospital 17th and Chew Streets 6th Floor PO Box 7017 Allentown, PA 18105 610.402.CARE www.lvh.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	HIV+ General Public
Allentown Health Bureau Alliance Hall 245 North Sixth Street Allentown, PA 18102 610.437.7760 www.allentownpa.org	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Group Level Intervention (GLI), Health Communication/Public Information (HC/PI) DEBI Interventions: Popular Opinion Leader (POL) with MSM VOICES/VOCES with MSM and IDU VOICES/VOCES at prisons VOICES/VOCES at colleges	HIV+ IDU Heterosexual
Allentown Health Bureau HIV Clinic Alliance Hall 245 North Sixth Street Allentown, PA 18102 610.437.7760 www.allentownpa.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Allentown Health Bureau STD Clinic Alliance Hall 245 North Sixth Street Allentown, PA 18102 610.437.7760 www.allentownpa.org	Counseling, Testing and Referral Services (CTR)	MSM Heterosexual General Public
Allentown Health Bureau Tuberculosis Clinic	Counseling, Testing and Referral Services (CTR)	MSM Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Alliance Hall 245 North Sixth Street Allentown, PA 18102 610.437.7760 www.allentownpa.org		General Public Emerging Risk Group – Homeless
Allentown Medical Services 2200 Hamilton Street, Suite 200 Allentown, PA 18104 610.782.0573	Counseling, Testing and Referral Services (CTR)	General Public
American Red Cross of the Greater Lehigh Valley 2200 Avenue A Bethlehem, PA 18017 610.865.4400 www.redcrosslv.org	Health Communication/Public Information (HC/PI)	General Public
Keystone Rural Health Center – Keystone Family Practice 820 Fifth Avenue Chambersburg, PA 717.263.4313 www.keystonehealth.org	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach	Hispanic Heterosexual
Latinos for Healthy Communities – New Directions Treatment Services 716 Chew Street Allentown, PA 18012 610.434.6890	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	Hispanic Heterosexual Hispanic IDU Hispanic MSM
Lehigh County Conference of Churches, Wellness Center 534 Chew Street Allentown, PA 18102 610.433.6421 www.lcconchurch.org	Counseling, Testing and Referral Services (CTR)	General Public
Lehigh County Prison 38 North Fourth Street Allentown, PA 18102 610.782.3270 www.lehighcounty.org	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public	IDU MSM Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
	Information (HC/PI)	
Lehigh County State Health Center HIV Clinic 3730 Lehigh Street Suite 206 Whitehall, PA 18502 610.821.6770	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Lehigh County State Health Center STD Clinic 3730 Lehigh Street Suite 206 Whitehall, PA 18502 610.821.6770	Counseling, Testing and Referral Services (CTR)	Heterosexual
Lehigh County State Health Center Tuberculosis Clinic 3730 Lehigh Street Suite 206 Whitehall, PA 18502 610.821.6770	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
New Directions Treatment Services 716 Chew Street Allentown, PA 18102 610.434.6890	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach DEBI Interventions: Community PROMISE VOCES/VOICES	IDU MSM MSM/IDU Heterosexual Perinatal
Planned Parenthood of Northeast PA 2901 Hamilton Boulevard Allentown, PA 18103 610.439.1033 www.ppnep.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
The Caring Place – Family Health Program 931 Hamilton Street 4th Floor	Counseling, Testing and Referral Services (CTR)	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Allentown, PA 18101 610.433.5683		
The Program for Women and Families 1030 Walnut Street Allentown, PA 18012 610.433.6556	Group Level Intervention (GLI)	IDU MSM Heterosexual Incarcerated General Public Emerging Risk Groups – Youth, Women
Weller Health Education Center 325 Northampton Street Easton, PA 18042 610.258.8500 www.wellercenter.org	Health Communication/Public Information (HC/PI)	Emerging Risk Group – Youth
MONROE COUNTY Population—166,355 (Stroudsburg)		
American Red Cross – Monroe County Chapter 322 Park Avenue Stroudsburg, PA 18360 570.476.3800 www.arcofmonroecounty.com	Health Communication/Public Information (HC/PI), Other	General Public
Carbon/Monroe/Pike Drug and Alcohol Commission (PHAST) (Pocono HIV/AIDS Support Team) 724A Phillips Street Stroudsburg, PA 18360 570.421.1960 www.cmpda.cog.pa.us	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Monroe County Prison 4250 Manor Drive Stroudsburg, PA 18360 717.992.3232	Counseling, Testing and Referral Services (CTR), Partner Services (PS)	IDU MSM Heterosexual
Monroe County State Health Center HIV Clinic RR 2 Box 2003 Stroudsburg, PA 18360	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI),	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
570.424.3020	Outreach, Health Communication/Public Information (HC/PI)	
Monroe County State Health Center Tuberculosis Clinic RR 2 Box 2003 Stroudsburg, PA 18360 570.424.3020	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Planned Parenthood of Northeast Pennsylvania 28 North Seventh Street Stroudsburg, PA 18360 570.424.8306 www.ppnep.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual
Rainbow Mountain 210 Mount Nebo Road East Stroudsburg, PA 18301	Counseling, Testing and Referral Services (CTR)	General Public
NORTHAMPTON COUNTY	**Population—293,970 (Easton)**	
Advocates for Healthy Children, Inc.	Health Communication/Public Information (HC/PI)	Emerging Risk Group – Youth
AIDS Service Center 60 West Broad Street Suite 99 Bethlehem, PA 18018 610.974.8700	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	HIV+ IDU MSM Heterosexual
American Red Cross of the Greater Lehigh Valley 2200 Avenue A Bethlehem, PA 18017 610.865.4400 www.redcrosslv.org	Other	General Public
Bethlehem City Health Bureau 10 East Church Street Bethlehem, PA 18018	Partner Services (PS) DEBI Interventions:	HIV+

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
610.865.7087 www.bethlehem-pa.gov	VOICES (5 sites) Healthy Relationships	
Bethlehem City Health Bureau – HIV Clinic 10 East Church Street Bethlehem, PA 18018 610.865.7087 www.bethlehem-pa.gov	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Bethlehem City Health Bureau – STD Clinic 10 East Church Street Bethlehem, PA 18018 610.865.7087 www.bethlehem-pa.gov	Counseling, Testing and Referral Services (CTR)	Heterosexual
Bethlehem City Health Bureau - Tuberculosis Clinic 10 East Church Street Bethlehem, PA 18018 610.865.7087 www.bethlehem-pa.gov	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
CADA 502 East 4th Street Bethlehem, PA 18015 610.434.6890	Counseling, Testing and Referral Services (CTR)	General Public
Casa Refugio 1436 East 5th Street Bethlehem, PA 18015 610.865.7058	Counseling, Testing and Referral Services (CTR)	General Public
Community Care Center 111 North 4th Street Easton, PA 18042 610.253.9868	Counseling, Testing and Referral Services (CTR)	Heterosexual
Council of Spanish Speaking Organizations of the Lehigh Valley (CSSOLV) 520 East Fourth Street Bethlehem, PA 18015	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach	IDU MSM MSM/IDU Heterosexual Perinatal

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
610.686.7800		
Easton Hospital 250 South 21st Street Easton, PA 610.253.1460 www.easton-hospital.com	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	Heterosexual
Hogar Crea Freemanburg Men 1920 East Market Street Bethlehem, PA 18017 Women 1409 Pembroke Road Bethlehem, PA 18017 610.865.7058	Counseling, Testing and Referral Services (CTR)	General Public
Latino AIDS Outreach Program 128 West Fourth Street Bethlehem, PA 610.868.7800	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	Hispanic IDU Hispanic MSM Hispanic Heterosexual
Latino Outreach Program and Wellness Center 502 East Fourth Street Bethlehem, PA 18015 610.868.7800	Counseling, Testing and Referral Services (CTR)	Hispanic Heterosexual
Marvine Family Center 1400 Lebanon Street Bethlehem, PA 18017 610.868.7126	Counseling, Testing and Referral Services (CTR)	General Public
North Juvenile Detention Center 650 Ferry Street Easton, PA 18042 610.865.7058	Counseling, Testing and Referral Services (CTR)	General Public
Northampton County Jail 666 Walnut Street Easton, PA 18042	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level	IDU MSM Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
610.559.3233	Intervention (ILI), Health Communication/Public Information (HC/PI)	
Northampton County Juvenile Detention Center 370 South Cedarbrook Road Allentown, PA 610.820.3233	Counseling, Testing and Referral Services (CTR)	Emerging Risk Group – Youth
Northampton County State Health Center HIV Clinic 1600 Northampton Street Easton, PA 18042 610.250.1825	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Northampton County State Health Center Tuberculosis Clinic1600 Northampton Street Easton, PA 18042 610.250.1825	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Planned Parenthood of Northeast Pennsylvania 2906 William Penn Highway Easton, PA 610.258.7195	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	Heterosexual General Public
Recovery Revolutions, Inc. 26 Market Street Bangor, PA 18013 610.599.7700	Counseling, Testing and Referral Services (CTR)	General Public
Riverside CARE 44 East Broad Street Bethlehem, PA 18108 158 South 3rd Street Easton, PA 18042 610.865.7058	Counseling, Testing and Referral Services (CTR)	General Public
Safe Harbor Homeless Shelter – Easton	Counseling, Testing and Referral Services (CTR)	IDU Emerging Risk Group –

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
536 Bushkill Drive Easton, PA 610.865.7058		Homeless
St. Luke's Women's Health Centers 801 Ostrum Street East Wing 3 Bethlehem, PA 18015 610.954.4761 414/416 Northampton Street Easton, PA 18042 610.559.2175 www.slhn.lehighvalley.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	Perinatal
The Program for Women and Children 1030 Walnut Street Allentown, PA 18012 610.433.6556	Group Level Intervention (GLI)	IDU MSM Heterosexual Incarcerated
Third Street Alliance 41 North 3rd Street Easton, PA 18045 610.434.6890	Counseling, Testing and Referral Services (CTR)	General Public
Victory House 314 Fillmore Street Bethlehem, PA 18015 610.434.6890	Counseling, Testing and Referral Services (CTR)	General Public
Weaversville Juvenile Intensive Treatment Unit 6710 Weaversville Road Northampton, PA 18067 610.865.7087	Counseling, Testing and Referral Services (CTR)	General Public
SCHUYLKILL COUNTY Population—146,952 (Pottsville)		
American Red Cross – Schuylkill and Eastern Northumberland Counties 1402 Laurel Boulevard Pottsville, PA 17901	Other	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
570.622.9550 www.infionline.net		
Berks AIDS Network 429 Walnut Street PO Box 8626 Reading, PA 19603 610.375.6523 www.berksaidnetwork.org	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	HIV+ Heterosexual IDU MSM
Schuylkill County First Step 108 South Claude A. Lord Boulevard Pottsville, PA 17901 570.621.2890	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
Schuylkill County State Health Center HIV Clinic 405 One Norwegian Plaza Pottsville, PA 17901 570.621.3112	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Schuylkill County State Health Center Tuberculosis Clinic 405 One Norwegian Plaza Pottsville, PA 17901 570.621.3112	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Schuylkill Wellness Services 512-514 North Center Street Pottsville, PA 17901 570.622.3980	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
Shamokin Family Planning 717 Race Street Shamokin, PA 17822 570.648.0582	Counseling, Testing and Referral Services (CTR)	Heterosexual

The North Central Region

The North Central region consists of Bradford, Centre, Clinton, Columbia, Lycoming, Montour, Northumberland, Potter, Snyder, Sullivan, Tioga and Union Counties. The total population for this region is 680,865 (5% of state population and a -.39% change since the 2000 Census)

Key: IDU – Injection drug user; MSM – Men who have Sex with Men; MSM/IDU – Men who have Sex with Men who are Injection Drug Users

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
BRADFORD COUNTY Population—61,131 (Towanda)-county seat		
Bradford County Prison 109 Pine Street Towanda, PA 18848 717.265.8151	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Bradford County State Health Center HIV Clinic RR 1 Box 4A Colonial Drive Towanda, PA 18848 570.265.2194	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual
Bradford County State Health Center Tuberculosis Clinic RR 1 Box 4A Colonial Drive Towanda, PA 18848 570.265.2194	Counseling, Testing and Referral Services (CTR)	IDU Heterosexual Emerging Risk Group – Homeless
Guthrie Family Planning 1 Guthrie Square Department 455 Guthrie Clinic Sayre, PA 18840 717.888.2314	Counseling, Testing and Referral Services (CTR)	Heterosexual
HIV/AIDS Support Network Robert Packard Hospital 96 Hayden Street Sayre, PA 18840 570.882.5805	Individual Level Intervention (ILI), Group Level Intervention (GLI), Health Communication/Public	IDU MSM Heterosexual Perinatal

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
800.388.9416	Information (HC/PI), Other	
Towanda State Health Center 846 Main Street PO Box 29 Towanda, PA 18848 570.265.2194	Counseling, Testing and Referral Services (CTR)	General Public
CENTRE COUNTY Population—146,212 (Bellefonte)		
Centre City Youth Center 148 Paradise Road Bellefonte, PA 16823 814.355.0650	Counseling, Testing and Referral Services (CTR)	General Public
Centre County Prison 213 East High Street Bellefonte, PA 16823 814.355.6794	Counseling, Testing and Referral Services (CTR), Partner Services (PS)	IDU MSM Heterosexual
Centre County State Health Center HIV Clinic 280 West Hamilton Avenue State College, PA 16801 814.865.0932 814.865.0933 814.865.0934	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Centre County State Health Center Tuberculosis Clinic 280 West Hamilton Avenue State College, PA 16801 814.865.0932 814.865.0933 814.865.0934	Counseling, Testing and Referral Services (CTR)	Heterosexual
Centre County Youth Service Bureau 410 South Fraser Street State College, PA 16801 814.237.5731 www.ccysb.com	Individual Level Intervention (ILI)	Emerging Risk Group – Youth
Centre Volunteers in Medicine (CVIM) 251 Easterly Parkway, Suite 102	Counseling, Testing and Referral Services (CTR)	General Public (uninsured)

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
State College, PA 16801 814.231.4843 web.cvim.net		
Gay and Lesbian Switchboard of Harrisburg 1300A North Third Street Harrisburg, PA 17102 717.234.0328 www.askglsh.org	Health Communication/Public Information (HC/PI)	MSM
Pennsylvania State University/University Health Services – Ritenour Health Center 237 Ritenour Building University Park, PA 16802 814.863.0461 www.sa.psu.edu	Counseling, Testing and Referral Services (CTR), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual Emerging Risk Group – Youth
Planned Parenthood of Central Pennsylvania 3091 Enterprise Drive Suite 150 State College, PA 16801 814.867.7778 www.plannedparenthoodpa.org	Counseling, Testing and Referral Services (CTR)	Heterosexual
State College State Health Center 280 West Hamilton Avenue State College, PA 16801 814.865.0932	Counseling, Testing and Referral Services (CTR)	General Public
Tapestry for Health of Centre and Huntingdon Counties 240 Match Factory Place Bellefonte, PA 16823 1231 Warm Springs Avenue Suite 101 Huntingdon, PA 16652 814.355.2762 (Bellefonte) 814.643.5364 (Huntingdon) www.tapestryofhealth.org	Counseling, Testing and Referral Services (CTR), Health Communication/Public Information (HC/PI)	Heterosexual General Public
The AIDS Project	Counseling, Testing and	HIV+

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
of Centre County 315 South Allen Street State College, PA 16801 200 East Presque Isle Street 6th Floor Philipsburg, PA 16866 814.234.7087 (State College) 814.342.6992 (Philipsburg)	Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Other DEBI Interventions: Street Smart Teen AIDS Prevention (TAP)	IDU MSM Heterosexual General Public Perinatal Emerging Risk Group – Youth
CLINTON COUNTY Population—36,799 (Lock Haven)		
Campbell Street Family, Youth and Community Association 600 Campbell Street Williamsport, PA 17701 570.322.5515	Individual Level Intervention (ILI), Group Level Intervention (GLI)	IDU Heterosexual Perinatal Emerging Risk Group – Youth
Center for Independent Living of North Central PA 210 Market Street Suite A Williamsport, PA 17701 570.327.9070 www.cilncp.org	Individual Level Intervention (ILI)	
Clinic of Lock Haven Family Planning 955 Bellefonte Avenue Lock Haven, PA 17745 570.748.7770	Counseling, Testing and Referral Services (CTR)	Heterosexual
Clinton County Prison PO Box 419 McElhattan, PA 17748 717.769.7685 www.clintoncountycorrections.com	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Clinton County State Health Center HIV Clinic 215 East Church Street	Counseling, Testing and Referral Services (CTR), Partner Services (PS),	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Lock Haven, PA 17745 570.893.2437 570.893.2438	Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	
Clinton County State Health Center Tuberculosis Clinic 215 East Church Street Lock Haven, PA 17745 570.893.2437 570.893.2438	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Lock Haven Planned Parenthood 112 West Main Street Lock Haven, PA 17745 570.748.1895	Counseling, Testing and Referral Services (CTR)	General Public
The AIDS Project of Centre County 315 South Allen Street State College, PA 16801 200 East Presque Isle Street 6th Floor Philipsburg, PA 16866 814.234.7087 (State College) 814.342.6992 (Philipsburg)	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Other DEBI Interventions: Street Smart Teen AIDS Prevention (TAP)	IDU MSM Heterosexual Perinatal Emerging Risk Group – Youth
COLUMBIA COUNTY Population—65,111 (Bloomsburg)		
Caring Communities for AIDS 615 Market Street Bloomsburg, PA 17815 570.714.6323 www.caringcommunities4aids.org	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	HIV+ Heterosexual Perinatal Emerging Risk Group - Youth
Columbia County Prison 7th and Iron Streets Bloomsburg, PA 17815 570.784.4805	Counseling, Testing and Referral Services (CTR)	General Public
Columbia County State Health Center HIV Clinic 1123C Old Berwick Road	Counseling, Testing and Referral Services (CTR), Partner Services (PS),	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Bloomsburg, PA 17815 570.387.4257	Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	
Columbia County State Health Center Tuberculosis Clinic 1123C Old Berwick Road Bloomsburg, PA 17815 570.387.4257	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Dr. Ali Alley 301 West Third Street Berwick, PA 570.759.0351	Counseling, Testing and Referral Services (CTR)	Heterosexual
Family Health Network, Berwick	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Family Health Services of Bloomsburg 2201 Fifth Street Hollow Road Suite 1 Bloomsburg, PA 17815 717.387.0236	Counseling, Testing and Referral Services (CTR)	Heterosexual
LYCOMING COUNTY Population—116,840 (Williamsport)		
AIDS Resource Alliance 200 Pine Street Suite 300 Williamsport, PA 17701 570.322.8448 www.charities.org/ara.html	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Other DEBI Interventions: VOICES Real AIDS Prevention	HIV+ IDU MSM Heterosexual Emerging Risk Group – Youth

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
	Project (RAPP) Becoming a Responsible Teen (BART)	
Campbell Street Family, Youth and Community Association 600 Campbell Street Williamsport, PA 17701 570.322.5515	Individual Level Intervention (ILI), Group Level Intervention (GLI), Health Communication/Public Information (HC/PI)	IDU Heterosexual Perinatal Emerging Risk Group – Youth
Choices Recovery Program 307 Laird Street Plains, PA 18702 570.408.9320	Counseling, Testing and Referral Services (CTR)	General Public
Family Center for Reproductive Health Williamsport Hospital and Medical Center 777 Rural Avenue 7th Floor Williamsport, PA 17701 570.321.3131 www.shscares.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Healthy Concepts	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public Perinatal
Lycoming College Student Health Services 700 College Place Williamsport, PA 17701 570.321.4052	Counseling, Testing and Referral Services (CTR)	General Public
Lycoming County Prison 154 West Third Street Williamsport, PA 17701 570.326.4623	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public	IDU MSM Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
	Information (HC/PI)	
Lycoming County State Health Center HIV Clinic 1000 Commerce Park Suite 106 Williamsport, PA 17701 570.327.3440 215 East Church Street Lock Haven, PA 17745 570.893.2437	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Lycoming County State Health Center Tuberculosis Clinic 1000 Commerce Park Suite 106 Williamsport, PA 17701 570.327.3440 215 East Church Street Lock Haven, PA 17745 570.893.2437	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
North Central District AIDS Coalition 8 North Grove Street PO Box 658 Lock Haven, PA 17745 570.748.2850 www.ncdac.org	Health Communication/Public Information (HC/PI)	General Public
Williamsport Hospital and Medical Center 777 Rural Avenue 7th Floor Williamsport, PA 17701 570.321.3131 www.shscares.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual General Public
MONTOUR COUNTY Population—17,715 (Danville)		
AIDS Resource Alliance 200 Pine Street	Individual Level Intervention (ILI), Group	IDU MSM

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Suite 300 Williamsport, PA 17701 570.322.8448 www.charities.org/ara.html	Level Intervention (GLI), Outreach DEBI Interventions: VOICES Real AIDS Prevention Project (RAPP) Becoming a Responsible Teen (BART)	Heterosexual Emerging Risk Group – Youth
Caring Communities for AIDS 570.714.6323 www.caringcommunities4aids.org	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Other	HIV+ Heterosexual Perinatal Emerging Risk Group – Youth
Columbia – Montour Family Health Inc. 2201 Fifth Street Hollow Road Bloomsburg, PA 17815 570.387.0236	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	General Public
Danville Center for Adolescent Females 13 Kirkbride Drive Danville, PA 17821 570.271.4700	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Youth
Montour County Prison 117 Church Street Box 163 Danville, PA 17821 717.275.2306	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Montour County State Health Center HIV Clinic 329 Church Street Box 275 Danville, PA 17821 570.275.7092	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Montour County State Health	Counseling, Testing and	Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Center STD Clinic 329 Church Street Box 275 Danville, PA 17821 570.275.7092	Referral Services (CTR)	
Montour County State Health Center Tuberculosis Clinic 329 Church Street Box 275 Danville, PA 17821 570.275.7092	Counseling, Testing and Referral Services (CTR)	Heterosexual
North Central Secure Treatment Unit 210 Clinic Road Danville, PA 17821 570.271.4711	Counseling, Testing and Referral Services (CTR)	IDU Heterosexual
Northwestern Academy 3800 State Road Route 61 Coal Township, PA 17866 570.644.5344	Counseling, Testing and Referral Services (CTR)	
NORTHUMBERLAND COUNTY Population—91,311 (Sunbury)		
AIDS Resource Alliance 200 Pine Street Suite 300 Williamsport, PA 17701 570.322.8448 www.charities.org/ara.html	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI) DEBI Interventions: VOICES Real AIDS Prevention Project (RAPP) Becoming a Responsible Teen (BART)	IDU MSM Heterosexual Emerging Risk Group – Perinatal, Youth
Center for Independent Living of North Central PA 210 Market Street Suite A Williamsport, PA 17701 570.327.9070	Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
800.984.7492 www.cilncp.org		
Family Planning Services of S.U.N. 717 Race Street Shamokin, PA 17872 717.648.1521	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach	IDU Heterosexual Perinatal Emerging Risk Group – Youth
Northumberland County Prison 39 North Second Street Sunbury, PA 17801 717.286.7981	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Northumberland County State Health Center HIV Clinic 247 Pennsylvania Avenue Sunbury, PA 17801 570.988.5513	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Northumberland County State Health Center STD Clinic 247 Pennsylvania Avenue Sunbury, PA 17801 570.988.5513	Counseling, Testing and Referral Services (CTR)	Heterosexual
Northumberland County State Health Center Tuberculosis Clinic 247 Pennsylvania Avenue Sunbury, PA 17801 570.988.5513	Counseling, Testing and Referral Services (CTR)	Heterosexual
S.U.N. Home Health Services, Inc. 61 Duke Street PO Box 232 Northumberland, PA 17857 888.478.6227 800.634.5232 570.473.8320	Outreach, Health Communication/Public Information (HC/PI)	General Public
Shamokin Family Planning	Counseling, Testing and	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
717 Race Street Shamokin, PA 17872 570.648.0582	Referral Services (CTR)	
POTTER COUNTY Population—16,714 (Coudersport)		
Campbell Street Family, Youth and Community Association 600 Campbell Street Williamsport, PA 17701 570.322.5515	Individual Level Intervention (ILI), Group Level Intervention (GLI),	IDU Perinatal Emerging Risk Group – Youth
Central Potter County Health Center 71 Elk Street Coudersport, PA 16915 814.274.7070	Counseling, Testing and Referral Services (CTR)	General Public
Charles Cole Memorial Hospital Second Street Coudersport, PA 16915	Counseling, Testing and Referral Services (CTR)	General Public
Potter County Prison 102 East Second Street Coudersport, PA 16915 814.274.9790	Counseling, Testing and Referral Services (CTR), Partner Services (PS)	IDU MSM Heterosexual
Potter County State Health Center HIV Clinic 269 Route 6 West, Room 2 Coudersport, PA 16915 814.274.3626	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Potter County State Health Center STD Clinic 269 Route 6 West, Room 2 Coudersport, PA 16915 814.274.3626	Counseling, Testing and Referral Services (CTR)	Heterosexual
Potter County State Health Center Tuberculosis Clinic269 Route 6 West Room 2 Coudersport, PA 16915	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
814.274.3626		
SNYDER COUNTY Population—38,519 (Middleburg)		
Family Planning Services of S.U.N. 713 Bridge Street Suite 7 Selinsgrove, PA 17870 570.372.0637	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach	IDU Heterosexual Perinatal Emerging Risk Group – Youth
S.U.N. Home Health Services, Inc. 61 Duke Street PO Box 232 Northumberland, PA 17857 888.478.6227 800.634.5232 570.473.8320	Outreach, Health Communication/Public Information (HC/PI)	General Public
Snyder County Prison 600 Old Colony Road Selinsgrove, PA 17870 717.374.7912	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Snyder County State Health Center HIV Clinic 207 West Willow Avenue Middleburg, PA 17842 570.837.7981	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Snyder County State Health Center STD Clinic 207 West Willow Avenue Middleburg, PA 17842 570.837.7981	Counseling, Testing and Referral Services (CTR)	Heterosexual
Snyder County State Health Center Tuberculosis Clinic 207 West Willow Avenue Middleburg, PA 17842 570.837.7981	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
SULLIVAN COUNTY Population—6,140 (Laporte)		
AIDS Resource Alliance 200 Pine Street Suite 300 Williamsport, PA 17701 570.322.8448 www.charities.org/ara.html	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI) DEBI Interventions: VOICES Real AIDS Prevention Project (RAPP) Becoming a Responsible Teen (BART)	IDU MSM Heterosexual Emerging Risk Group – Perinatal, Youth
Family Center for Reproductive Health Williamsport Hospital 777 Rural Avenue 7th Floor Williamsport, PA 17701 570.321.3131 www.shscares.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
HIV/AIDS Support Network – Parker Hospital	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach	IDU MSM Heterosexual Perinatal
HIV/AIDS Support Network – Robert Packard Hospital 96 Hayden Street Sayre, PA 18840 570.882.5805 800.388.9416	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Other	Heterosexual Perinatal Emerging Risk Group – Youth
Sullivan County State Health Center 1000 Commerce Park Drive #109 Williamsport, PA 17701 717.327.3400	Counseling, Testing and Referral Services (CTR)	General Public
TIOGA COUNTY Population—40,875 (Wellsboro)		
HIV/AIDS Support Network – Parker Hospital	Individual Level Intervention (ILI), Group Level Intervention (GLI),	IDU MSM Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
	Outreach	Perinatal
HIV/AIDS Support Network – Robert Packard Hospital 96 Hayden Street Sayre, PA 18840 570.882.5805 800.388.9416	Individual Level Intervention (ILI), Group Level Intervention (GLI), Health Communication/Public Information (HC/PI), Other	IDU MSM Heterosexual Perinatal Emerging Risk Group – Youth
Laurel Health Center - Blossburg Family Planning 6 Riverside Plaza Blossburg, PA 16912 570.683.2174	Counseling, Testing and Referral Services (CTR)	Heterosexual
Laurel Health Center - Elkland Family Planning Clinic 103 Forest View Drive Ekland, PA 16920 814.258.5117	Counseling, Testing and Referral Services (CTR)	Heterosexual
Laurel Health Center - Lawrenceville Family Planning Clinic Route 15 Somers Lane Lawrenceville, PA 16929 570.827.0125	Counseling, Testing and Referral Services (CTR)	Heterosexual
Laurel Health Center - Mansfield Family Planning Clinic 40 West Wellsboro Street Mansfield, PA 16933 717.662.2002	Counseling, Testing and Referral Services (CTR)	White Heterosexual
Laurel Health Center - Wellsboro Family Planning Clinic 103 West Avenue Wellsboro, PA 16901 570.724.1010	Counseling, Testing and Referral Services (CTR)	Heterosexual
Laurel Health Center – Westfield Family Planning Clinic 236 East Main Street Westfield, PA 16950	Counseling, Testing and Referral Services (CTR)	Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
814.367.5911		
Tioga County Prison 1768 Shimmery Hill Road Wellsboro, PA 16901 717.724.5911	Counseling, Testing and Referral Services (CTR), Partner Services (PS)	IDU MSM Heterosexual
Tioga County State Health Center HIV Clinic 44 Plaza Lane Wellsboro, PA 16901 570.724.2911	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Tioga County State Health Center Tuberculosis Clinic 144C East A Wellsboro, PA 16901 570.724.2911	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Tioga County Women's Coalition PO Box 933 Wellsboro, PA 16901 717.724.3554	Outreach, Health Communication/Public Information (HC/PI)	Perinatal
UNION COUNTY Population—43,560 (Lewisburg)		
AIDS Resource Alliance 200 Pine Street Suite 300 Williamsport, PA 17701 570.322.8448 www.charities.org/ara.html	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Other DEBI Interventions: VOICES Real AIDS Prevention Project (RAPP) Becoming a Responsible Teen (BART)	IDU MSM Heterosexual Perinatal Emerging Risk Group – Youth
Center for Independent Living of North Central PA 210 Market Street Suite A Williamsport, PA 17701	Individual Level Intervention (ILI)	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
570.327.9070 800.984.7492 www.cilncp.org		
Family Planning Services of S.U.N. 717 Race Street Shamokin, PA 17872 717.648.1521	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach	Heterosexual IDU Perinatal Emerging Risk Group – Youth
Union County Prison 103 South Second Street Lewisburg, PA 17837 717.524.7811	Counseling, Testing and Referral Services (CTR), Partner Services (PS)	IDU MSM Heterosexual
Union County State Health Center HIV Clinic 260 Reitz Boulevard Suite 3 Lewisburg, PA 17837 570.523.1124	Counseling, Testing and Referral Services (CTR), Partner Services (PS)	General Public
Union County State Health Center STD Clinic 260 Reitz Boulevard Suite 3 Lewisburg, PA 17837 570.523.1124	Counseling, Testing and Referral Services (CTR)	Heterosexual
Union County State Health Center Tuberculosis Clinic 260 Reitz Boulevard Suite 3 Lewisburg, PA 17837 570.523.1124	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless

The Northeast Region

The Northeast region consists of Lackawanna, Luzerne, Pike, Susquehanna, Wayne and Wyoming Counties. The total population of this region is 701,966 (6% of state population and a +1% change since the 2000 Census)

Key: IDU – Injection drug user; MSM – Men who have Sex with Men; MSM/IDU – Men who have Sex with Men who are Injection Drug Users

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
LACKAWANNA COUNTY Population—208,801 (Scranton)-county seat		
American Red Cross – Wyoming Valley Chapter 256 North Sherman Street Wilkes-Barre, PA 18702 570.823.7161 www.wyomingvalleyredcross.org	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Other DEBI Interventions: SISTA Safety Counts	IDU MSM Heterosexual Emerging Risk Groups – Homeless, Perinatal, Women, Youth
Circle of Care Maternal and Family Health Center Community Medical Center School of Nursing Building 3rd Floor 315 Colfax Avenue Scranton, PA 18510 570.961.5550 www.mfhs.org	Counseling, Testing and Referral Services (CTR)	General Public
Drug and Alcohol Treatment Services 116 North Washington Avenue 3rd Floor Scranton, PA 18503 570.961.1997	Individual Level Intervention (ILI)	IDU
Keystone College Student Health Services One College Green LaPlume, PA 18440 570.945.5141	Counseling, Testing and Referral Services (CTR)	General Public
Lackawanna County Correctional Facility 1371 North Washington Avenue Scranton, Pa 18503	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level	IDU MSM Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
570.963.6639	Intervention (ILI), Health Communication/Public Information (HC/PI)	
Lackawanna County State Health Center HIV Clinic Room 110 100 Lackawanna Avenue Scranton, PA 18510 570.963.4567	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Lackawanna County State Health Center Tuberculosis Clinic 100 Lackawanna Avenue Scranton, PA 18510 570.963.4567	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Planned Parenthood of Northeast Pennsylvania 316 Penn Avenue Scranton, PA 18503 570.344.2626 www.ppnep.org	Counseling, Testing and Referral Services (CTR)	Heterosexual
Scranton Temple Health Clinic 640 Madison Avenue Scranton, PA 18510 570.941.5670	Counseling, Testing and Referral Services (CTR)	General Public
United Neighborhood Centers of Lackawanna County 410 Olive Street Scranton, PA 18508 570.346.0759	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Other DEBI Interventions: VOICES/VOCES Healthy Relationships	Hispanic Heterosexual Emerging Risk Group – Youth
University of Scranton Student Health Services 800 Linden Street Scranton, PA 18510	Counseling, Testing and Referral Services (CTR)	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
LUZERNE COUNTY Population—312,845 (Wilkes-Barre)		
American Red Cross – Wyoming Valley Chapter 256 North Sherman Street Wilkes-Barre, PA 18702 570.823.7161 www.wyomingvalleyredcross.org	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Other DEBI Interventions: SISTA Safety Counts	IDU MSM Heterosexual Emerging Risk Groups – Homeless, Perinatal, Women, Youth
Genesis Project 329 South Pennsylvania Avenue Wilkes- Barre, PA 18702 570.820.0499	Counseling, Testing and Referral Services (CTR)	General Public
Luzerne County Prison 90 Water Street Wilkes-Barre, PA 18702 717.829.7750	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Luzerne County State Health Center HIV Clinic 297 South Main Street Wilkes-Barre, PA 18701 570.826.2071	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group - Homeless
Luzerne County State Health Center Tuberculosis Clinic 103 Norwegian Plaza Pottsville, PA 17901 717.621.3112	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Northeastern Regional HIV Planning Coalition – United Way 8 West Market Street Wilkes-Barre, PA 18711 570.829.6711	Health Communication/Public Information (HC/PI)	General Public
Planned Parenthood of Northeast Pennsylvania	Counseling, Testing and Referral Services (CTR)	Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
10 West Chestnut Street Hazelton, PA 18201 570.545.0876 www.ppnep.org		
Serento Gardens Alcohol and Drug Services 145 West Broad Street Hazelton, PA 18201 570.445.9902	Individual Level Intervention (ILI)	IDU
United Neighborhood Centers of Lackawanna County 410 Olive Street Scranton, PA 18508 570.346.0759	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Other DEBI Interventions: VOICES/VOCES Healthy Relationships	Hispanic Heterosexual Emerging Risk Group – Youth
Wilkes-Barre City Health Department Kirby Health Center 71 N. Franklin Street Wilkes-Barre, PA 18701 570.208.4268	Counseling, Testing and Referral Services (CTR), Partner Services (PS)	HIV+
Wilkes-Barre City Health Department Tuberculosis Clinic Kirby Health Center 71 N. Franklin Street Wilkes-Barre, PA 18701 570.208.4268	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Wilkes-Barre Family Planning Family Care Center 2 Sharp Street Kingston, PA 18704 570.522.8916	Counseling, Testing and Referral Services (CTR)	General Public
Wyoming Valley AIDS Council 183 Market Street Suite 102	Counseling, Testing and Referral Services (CTR), Health	Emerging Risk Group – Women

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Kingston, PA 18703 570.823.5808	Communication/Public Information (HC/PI)	
Wyoming Valley Alcohol and Drug Services, Inc. 437 North Main Street Wilkes-Barre, PA 18705 570.820.8888 570.655.3900	Individual Level Intervention (ILI)	IDU
PIKE COUNTY Population—60,527 (Milford)		
American Red Cross – Wyoming Valley Chapter 256 North Sherman Street Wilkes-Barre, PA 18702 570.823.7161 www.wyomingvalleyredcross.org	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Other DEBI Interventions: SISTA Safety Counts	IDU MSM Heterosexual General Public Emerging Risk Groups – Homeless, Perinatal, Women, Youth
Carbon/Monroe/Pike Drug and Alcohol Commission 542 US Routes 6 and 209 Milford, PA 18337 570.296.7255 www.cmpda.cog.pa.us	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU
Milford Family Planning Center Milford Professional Plaza 20 Buist Road Suite 103 Milford, PA 18337 570.296.8714	Counseling, Testing and Referral Services (CTR),	General Public
Pike County Prison 175 Pike City Boulevard Lords Valley, PA 18428 717.775.5500	Counseling, Testing and Referral Services (CTR), Partner Services (PS)	IDU MSM Heterosexual
Pike County State Health Center HIV Clinic #10 Buist Road Suite 401 Milford, PA 18337	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
570.296.6512	Communication/Public Information (HC/PI)	
Pike County State Health Center Tuberculosis Clinic #10 Buist Road Suite 401 Milford, PA 18337 570.296.6512	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
United Neighborhood Centers of Lackawanna County 410 Olive Street Scranton, PA 18508 570.346.0759	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Other DEBI Interventions: VOICES/VOCES Healthy Relationships	Hispanic Heterosexual Emerging Risk Group – Youth
SUSQUEHANNA COUNTY Population—40,646 (Montrose)		
American Red Cross – Wyoming Valley Chapter 256 North Sherman Street Wilkes-Barre, PA 18702 570.823.7161 www.wyomingvalleyredcross.org	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Other DEBI Interventions: SISTA Safety Counts	IDU MSM Heterosexual General Public Emerging Risk Groups – Homeless, Perinatal, Women, Youth
Christians for AIDS Awareness	Health Communication/Public Information (HC/PI)	General Public
Drug and Alcohol Treatment Services 116 North Washington Avenue 3rd Floor Scranton, PA 18503 570.961.1997	Individual Level Intervention (ILI)	IDU
Susquehanna County State Health Center HIV Clinic 35 Spruce Street Montrose, PA 18801	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI),	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
570.278.3880	Outreach, Health Communication/Public Information (HC/PI)	
Susquehanna County State Health Center Tuberculosis Clinic Suite 2 35 Spruce Street Montrose, PA 18801 570.278.3880	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
United Neighborhood Centers of Lackawanna County 410 Olive Street Scranton, PA 18508 570.346.0759	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Other DEBI Interventions: VOICES/VOCES Healthy Relationships	Hispanic Heterosexual Emerging Risk Group – Youth
WAYNE COUNTY Population—51,337 (Honesdale)		
American Red Cross – Wyoming Valley Chapter 256 North Sherman Street Wilkes-Barre, PA 18702 570.823.7161 www.wyomingvalleyredcross.org	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Other DEBI Interventions: VOICES/VOCES Healthy Relationships	IDU MSM Heterosexual General Public Emerging Risk Groups – Homeless, Perinatal, Women, Youth
Drug and Alcohol Treatment Services 116 North Washington Avenue 3rd Floor Scranton, PA 18503 570.961.1997	Individual Level Intervention (ILI)	IDU
Honesdale Family Planning Center 321 Grandview Avenue Unit 4 Honesdale, PA 18431	Counseling, Testing and Referral Services (CTR)	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
570.253.5626		
United Neighborhood Centers of Lackawanna County 410 Olive Street Scranton, PA 18508 570.346.0759	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Other DEBI Interventions: VOICES/VOCES Healthy Relationships	Hispanic Heterosexual Emerging Risk Group – Youth
Wayne County State Health Center HIV Clinic 615 Erie Heights Honesdale, PA 18431 570.253.7141	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Wayne County State Health Center Tuberculosis Clinic 615 Erie Heights Honesdale, PA 18431 570.253.7141	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
WYOMING COUNTY Population—27,808 (Tunkhannock)		
American Red Cross – Wyoming Valley Chapter 256 North Sherman Street Wilkes-Barre, PA 18702 570.823.7161 www.wyomingvalleyredcross.org	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Other DEBI Interventions: SISTA Safety Counts	IDU MSM Heterosexual General Public Emerging Risk Groups – Homeless, Perinatal, Women, Youth
Drug and Alcohol Treatment Services	Individual Level Intervention (ILI)	IDU
United Neighborhood Centers of Lackawanna County 410 Olive Street Scranton, PA 18508 570.346.0759	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Other	Hispanic Heterosexual Emerging Risk Group – Youth

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
	DEBI Interventions: VOICES/VOCES Healthy Relationships	
Wyoming County State Health Center HIV Clinic 2 Skyline Complex Tunkhannock, PA 18657 570.836.2981	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Wyoming County State Health Center Tuberculosis Clinic 2 Skyline Complex Tunkhannock, PA 18657 570.836.2981	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Wyoming Valley AIDS Council 67-69 Public Square PO Box 2677 Wilkes-Barre, PA 18703 570.823.5808	Counseling, Testing and Referral Services (CTR), Health Communication/Public Information (HC/PI)	Emerging Risk Group – Women

The Northwest Region

The Northwest region consists of Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, Lawrence, McKean, Mercer, Venango and Warren Counties. The total population for this region is 923, 446 (7% of total state population and a -3% change since the 2000 Census)

Key: IDU – Injection drug user; MSM – Men who have Sex with Men; MSM/IDU – Men who have Sex with Men who are Injection Drug Users.

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
CAMERON COUNTY Population—5,163 (Emporium)-county seat		
Cameron County State Health Center HIV Clinic 778 Washington Street St. Mary's, PA 15857 814.834.5351	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Cameron County State Health Center Tuberculosis Clinic 778 Washington Street St. Mary's, PA 15857 814.834.5351	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Cameron County Health Care Center 90 East Second Street Emporium, PA 15834 814.486.1115	Counseling, Testing and Referral Services (CTR)	Heterosexual
Northwest PA Rural AIDS Alliance 15870 Route 322 Suite 2 Clarion, PA 16214 814.764.6066 www.northwestalliance.org	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	All Risk Groups
CLARION COUNTY Population—39,479 (Clarion)		
Clarion County Drug and Alcohol 214 South 7th Avenue Clarion, PA 16214 814.226.5888	Counseling, Testing and Referral Services (CTR)	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Clarion County Prison 216 Amsler Avenue Shippensville, PA 16254 814.226.9615	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Clarion County State Health Center HIV Clinic Suite D 162 South Second Avenue Clarion, PA 16214 814.226.2170	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Clarion County State Health Center Tuberculosis Clinic 162 South Second Avenue Clarion, PA 16214 814.226.2170	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Clarion University – Keeling Health Center 840 Wood Street Clarion, PA 16214 814.393.2121	Individual Level Intervention (ILI), Group Level Intervention (GLI), Health Communication/Public Information (HC/PI)	Heterosexual Emerging Risk Group – Youth
Family Health Center of Clarion County 1064-A East Main Street Clarion, PA 16214 814.226.7500	Counseling, Testing and Referral Services (CTR), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual General Public
Northwest PA Rural AIDS Alliance 15870 Route 322 Suite 2 Clarion, PA 16214 814.764.6066 www.northwestalliance.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	HIV+ All Risk Groups
CLEARFIELD COUNTY	**Population—82,324 (Clearfield)**	
Clearfield County State Health Center HIV Clinic	Counseling, Testing and Referral Services (CTR),	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
1123 Linden Street Clearfield, PA 16830 814.765.0542	Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	
Clearfield County State Health Center Tuberculosis Clinic 1123 Linden Street Clearfield, PA 16830 814.765.0542	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Discovery House CU 3888 Curwenville Grampian Road Curwenville, PA 16833 814.236.1929	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	IDU Non-IDU
Family Health Council 1036 Park Avenue Extension Clearfield, PA 16830 814.765.9677 www.fhcinc.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual General Public
Northwest PA Rural AIDS Alliance 15870 Route 322 Suite 2 Clarion, PA 16214 814.764.6066 www.northwestalliance.org	Prevention for Positives, Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	HIV+ All Risk Groups
CRAWFORD COUNTY Population—88,521 (Meadville)		
Conneaut Valley Health Center PO Box E 906 Washington Street Conneautville, PA 16406 814.587.2021	Counseling, Testing and Referral Services (CTR), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual
Crawford County Correctional Facility 2100 Independence Drive	Counseling, Testing and Referral Services (CTR), Partner Services (PS),	IDU MSM Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Saegertown, PA 16433 814.763.1190	Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	
Crawford County State Health Center HIV Clinic 900 Water Street Meadville, PA 16335 814.332.6947	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Crawford County State Health Center Tuberculosis Clinic 900 Water Street Meadville, PA 16335 814.332.6947	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Erie County Health Department – Corry Office 43 East Washington Street Corry, PA 16407 814.663.3891 814.664.3978 www.ecdh.org	Counseling, Testing and Referral Services (CTR)	General Public
Family Planning of Crawford County 747 Terrace Street Meadville, PA 16335 814.333.7088	Counseling, Testing and Referral Services (CTR)	Heterosexual
Greenville Family Planning 74 Shenango Street Greenville, PA 16125 724.588.2272	Counseling, Testing and Referral Services (CTR)	General Public
Northwest PA Rural AIDS Alliance 15870 Route 322 Suite 2 Clarion, PA 16214	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	All Risk Groups

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
814.764.6066 www.northwestalliance.org		
SCI Cambridge Springs 451 Fullerton Avenue Cambridge Springs, PA 16403 814.398.5400	Group Level Intervention (GLI)	IDU Heterosexual
ELK COUNTY Population—32,011 (Ridgeway)		
American Red Cross – Elk/Cameron Counties Chapter 21 North Mary's St. Mary's, PA 15857 814.834.2915	Health Communication/Public Information (HC/PI)	General Public
Elk County Prison Box 448 Courthouse Ridgeway, PA 15853 814.776.5342	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Elk County State Health Center HIV Clinic 778 Washington Street St. Mary's, PA 15857 814.834.5351	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Elk County State Health Center Tuberculosis Clinic 778 Washington Street St. Mary's, PA 15857 814.834.5351	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Family Health Council 776 Washington Street St. Mary's, PA 15857 814.834.3090	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual
Northwest PA Rural AIDS	Individual Level	All Risk Groups

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Alliance 15870 Route 322 Suite 2 Clarion, PA 16214 814.764.6066 www.northwestalliance.org	Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	
ERIE COUNTY Population—280,291 (Erie)		
Abraxas II 502 West 6th Street Erie, PA 16507 814.459.0618	Counseling, Testing and Referral Services (CTR)	General Public
Booker T. Washington Center 1720 Holland Street Erie, PA 16503 814.453.5744	Counseling, Testing and Referral Services (CTR) DEBI Intervention: SISTA	General Public
Community Health Network 1202 State Street Erie, PA 16501	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	Emerging Risk Group – Homeless
Cove Forge Drug and Alcohol Center 2000 West 8th Street Erie, PA 16505 814.452.5603	Counseling, Testing and Referral Services (CTR)	General Public
Deerfield Dual Diagnosis Substance Abuse Services 2610 German Street Erie, PA 16504 814.878.2103 stairwaysbh.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI)	IDU Heterosexual
Dr. Daniel Snow Recovery House 414 West Fifth Street Erie, PA 16507 814.456.5758	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
Edinboro Family Planning 118 East Plum Street	Counseling, Testing and Referral Services (CTR)	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Edinboro, PA 16412 814.734.7600		
Edinboro University of Pennsylvania Edinboro, PA 16444 814.732.2000	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	Heterosexual
Edmund L. Thomas Juvenile Detention Center 4728 Lake Pleasant Road Erie, PA 16504 814.451.6191	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	Emerging Risk Group – Youth
Erie County Department of Health 606 West Second Street Erie, PA 16507 814.451.6700 www.ecdh.org	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI) DEBI Interventions: Safety Counts Healthy Relationships	HIV+ IDU MSM Heterosexual General Public Emerging Risk Group - Youth
Erie County Department of Health – Corry Office 43 East Washington Street Corry, PA 16407 814.663.3891 www.ecdh.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Erie County Department of Health HIV Clinic 606 West Second Street Erie, PA 16507 814.451.6700 www.ecdh.org	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Erie County Department of Health STD Clinic 606 West Second Street Erie, PA 16507 814.451.6700 www.ecdh.org	Counseling, Testing and Referral Services (CTR)	Heterosexual
Erie County Department of Health Tuberculosis Clinic 606 West Second Street Erie, PA 16507 814.451.6700 www.ecdh.org	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Erie County Prison 1618 Ash Street Erie, PA 16503 814.451.7524 814.451.7525	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Erie County Prison Pre-release Program 1618 Ash Street Erie, PA 16503 814.451.7524 814.451.7525	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Esper Treatment Center 25 West 18th Street Erie, PA 16501 814.451.6716	Counseling, Testing and Referral Services (CTR)	General Public
Gateway Rehabilitation Drug and Alcohol Detention Center 2860 East 28th Street Erie, PA 16510 814.899.0081	Counseling, Testing and Referral Services (CTR)	General Public
Gaudenzia Crossroads 414 West Fifth Street Erie, PA 16507	Counseling, Testing and Referral Services (CTR), Individual Level	IDU Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
814.459.4775 www.gaudenzia.erie.org	Intervention (ILI), Group Level Intervention (GLI)	
Gaudenzia Intermediate Punishment Program 414 West Fifth Street Erie, PA 16507 814.459.4775 www.gaudenzia.erie.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI)	IDU Heterosexual
Gaudenzia Outpatient and Partial Treatment Center 414 West Fifth Street Erie, PA 16507 814.459.4775 www.gaudenzia.erie.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI)	IDU MSM Heterosexual
Gaudenzia Residential Treatment Program 414 West Fifth Street Erie, PA 16507 814.459.4775 www.gaudenzia.erie.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI)	IDU Heterosexual
GECAC Treatment Services 18 West Ninth Street Erie, PA 16501 814.459.4581 800.769.2436 www.gecac.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI)	IDU Heterosexual
GECAC Youth Empowerment Program 18 West Ninth Street Erie, PA 16501 814.459.4581 800.769.2436 www.gecac.org	Individual Level Intervention (ILI)	Emerging Risk Group – Youth
Greater Calvary Full Gospel Baptist Church 2624 German Street Erie, PA 16504	Counseling, Testing and Referral Services (CTR)	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
814.459.1787 www.greatercalvaryfgbc.org		
Harbor Creek Youth Services 5712 Iroquois Avenue Harborcreek, PA 16421 814.899.7664 www.hys-erie.org	Individual Level Intervention (ILI)	Emerging Risk Group – Youth
Hispanic American Council of Erie 554 East 10th Street Erie, PA 16507 814.455.0212	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	Hispanic Heterosexual Hispanic IDU Hispanic MSM
John F. Kennedy Center 2021 East 20th Street Erie, PA 16510 814.898.0400 users.stargate.net/~jfkdn/	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach	IDU Heterosexual
Martin Luther King Center 312 Chestnut Street Erie, PA 16502 814.459.2761	Individual Level Intervention (ILI)	Heterosexual
Mercyhurst College 501 East 38th Street Erie, PA 16546 814.824.2000 www.mercyhurst.edu	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	Heterosexual Heterosexual
Minority Health Education Delivery System (MHEDS) 2928 Peach Street Erie, PA 16508 814.453.6229	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Health Communication/Public Information (HC/PI) DEBI Intervention: VOCES/VOICES	Black Heterosexual Hispanic IDU Hispanic MSM Hispanic Heterosexual Emerging Risk Group – Asian/Pacific Islander

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Northwest PA Rural AIDS Alliance 15870 Route 322 Suite 2 Clarion, PA 16214 814.764.6066 www.northwestalliance.org	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Prevention for Positives	HIV+ General Public All Risk Groups
Safenet 1702 French Street Erie, PA 16507 814.458.8161	Counseling, Testing and Referral Services (CTR)	General Public
SCI Albion 10745 Route 18 Albion, PA 16475 814.756.5778	Group Level Intervention (GLI)	IDU MSM Heterosexual
SHOUT Outreach Program, Gaudenzia Crossroads 414 West Fifth Street Erie, PA 16507 814.459.4775 www.gaudenzia.erie.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	IDU Heterosexual Emerging Risk Group – Youth
St. Paul's Neighborhood Free Clinic 1608 Walnut Street Erie, PA 16502 814.454.8755 www.stpaulfreeclinic.org	Counseling, Testing and Referral Services (CTR)	General Public
Street Outreach Prevention (STOP) Erie 606 West 2nd Street Erie, PA 16507 814.451.6700	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach	Black/Hispanic IDU MSM Heterosexual
The Pennsylvania State University - Behrend College 5091 Station Road	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health	Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Erie, PA 814.898.6100	Communication/Public Information (HC/PI)	
FOREST COUNTY	**Population—6,775 (Tionesta)**	
Cornell Abraxas I Blue Jay Village North Forest Street Marienville, PA 16239 814.927.6615	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU MSM Heterosexual Emerging Risk Group – Youth
Forest County State Health Center HIV Clinic PO Box 405 South Elm Street Tionesta, PA 16353 814.755.3564	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Forest County State Health Center STD Clinic PO Box 405 South Elm Street Tionesta, PA 16353 814.755.3564	Counseling, Testing and Referral Services (CTR)	Heterosexual
Forest County State Health Center Tuberculosis Clinic PO Box 405 South Elm Street Tionesta, PA 16353 814.755.3564	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Northwest PA Rural AIDS Alliance 15870 Route 322 Suite 2 Clarion, PA 16214 814.764.6066 www.northwestalliance.org	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	All Risk Groups
JEFFERSON COUNTY	**Population—44,634 (Brookville)**	
Family Health Council -	Counseling, Testing and	Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Punxsutawney 203 North Main Street Punxsutawney, PA 15767 814.938.3421	Referral Services (CTR)	
Jefferson County Prison 578 Service Center Road Brookville, PA 15825 814.849.1933	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Jefferson County State Health Center HIV Clinic 203 North Main Street Punxsutawney, PA 15767 814.938.6630	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Jefferson County State Health Center STD Clinic 203 North Main Street Punxsutawney, PA 15767 814.938.6630	Counseling, Testing and Referral Services (CTR)	Heterosexual
Jefferson County State Health Center Tuberculosis Clinic 203 North Main Street Punxsutawney, PA 15767 814.938.6630	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Northwest PA Rural AIDS Alliance 15870 Route 322 Suite 2 Clarion, PA 16214 814.764.6066 www.northwestalliance.org	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	All Risk Groups
Punxsutawney State Health Center	Counseling, Testing and Referral Services (CTR)	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
1000 West Mahoning Street Punxsutawney, PA 15767 814.938.6630		
LAWRENCE COUNTY	**Population—90,160 (New Castle)**	
Family Health Council 2 Cascade Galleria Plaza New Castle, PA 16101 724.658.6681 www.fhcinc.org	Counseling, Testing and Referral Services (CTR), Group Level Intervention (GLI), Health Communication/Public Information (HC/PI)	Heterosexual Emerging Risk Group - Youth
Lawrence County Prison 433 Court Street New Castle, PA 16101 412.654.5384	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Lawrence County State Health Center HIV Clinic 106 Margaret Street New Castle, PA 16101 724.656.3088	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Lawrence County State Health Center Tuberculosis Clinic 106 Margaret Street New Castle, PA 16101 724.656.3088	Counseling, Testing and Referral Services (CTR)	Heterosexual
New Castle Family Planning 15 West Washington Street New Castle, PA 16101 724.658.6681	Counseling, Testing and Referral Services (CTR)	General Public
Northwest PA Rural AIDS Alliance 15870 Route 322 Suite 2	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health	All Risk Groups

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Clarion, PA 16214 814.764.6066 www.northwestalliance.org	Communication/Public Information (HC/PI)	
MCKEAN COUNTY	**Population—43,196 (Smithport)**	
Family Planning Services of McKean County 70 ½ Mechanic Street Bradford, PA 16701 814.368.6129	Counseling, Testing and Referral Services (CTR)	Heterosexual
McKean County State Health Center HIV Clinic 84-90 Boyleston Street Bradford, PA 16701 814.368.0426	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
McKean County State Health Center Tuberculosis Clinic 84-90 Boyleston Street Bradford, PA 16701 814.368.0426	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Northwest PA Rural AIDS Alliance 15870 Route 322 Suite 2 Clarion, PA 16214 814.764.6066 www.northwestalliance.org	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	All Risk Groups
MERCER COUNTY	**Population—116,071 (Mercer)**	
AIDS Service Program of Mercer County 87 Stambaugh Avenue Suite 1 Sharon, PA 16146 724.981.3670	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	HIV+ General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
724.981.1671		
Discovery House 1868 East State Street Hermitage, PA 16148 724.981.9815	Counseling, Testing and Referral Services (CTR)	General Public
Family Planning of Mercer County 87 Stambaugh Avenue Suite 1 Sharon, PA 16146 724.981.3670 724.981.1671	Counseling, Testing and Referral Services (CTR), Group Level Intervention (GLI), Health Communication/Public Information (HC/PI)	Heterosexual Emerging Risk Group – Youth
Family Planning of Mercer County - Greenville 74 Shenango Street Greenville, PA 16125 724.588.2272	Counseling, Testing and Referral Services (CTR)	Heterosexual
Family Planning of Mercer County – Grove City 408B Hillcrest Medical Center Grove City, PA 16127 724.458.8505	Counseling, Testing and Referral Services (CTR), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual General Public
Farrell Primary Health Network 602 Roemer Boulevard Farrell, PA 16121 724.285.2216	Counseling, Testing and Referral Services (CTR)	Heterosexual
Mercer Behavioral Health Commission 8406 Sharon Mercer Road Mercer, PA 16137 724.662.1550	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual General Public Emerging Risk Group – Youth
Mercer County Prison 138 South Diamond Street Mercer, PA 16137	Counseling, Testing and Referral Services (CTR), Partner Services (PS),	IDU MSM Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
412.662.2700	Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	
Mercer County State Health Center HIV Clinic 25 McQuiston Drive Jackson Center, PA 16133 724.662.4000	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Mercer County State Health Center Tuberculosis Clinic 25 McQuiston Drive Jackson Center, PA 16133 724.662.4000	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Northwest PA Rural AIDS Alliance 15870 Route 322 Suite 2 Clarion, PA 16214 814.764.6066 www.northwestalliance.org	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Prevention for Positives	HIV+ All Risk Groups
VENANGO COUNTY	**Population—54,183 (Franklin)**	
Family Health Council, Seneca Route 257 Box 409 Seneca, PA 16346 814.676.1811	Counseling, Testing and Referral Services (CTR)	General Public
Family Planning Service of Venango County PO Box 409 Seneca, PA 16346 814.676.1811	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	Heterosexual
Northwest PA Rural AIDS Alliance 15870 Route 322 Suite 2 Clarion, PA 16214	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public	HIV+ All Risk Groups

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
814.764.6066 www.northwestalliance.org	Information (HC/PI), Prevention for Positives	
Titusville Area Hospital 406 West Oak Street Titusville, PA 16354 814.827.1851 www.titusvillehospital.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	General Public
Turning Point PO Box 1030 Franklin, PA 16323 814.437.5393	Counseling, Testing and Referral Services (CTR)	General Public
Venango County Prison 1186 Elk Street Franklin, PA 16323 814.432.9629	Counseling, Testing and Referral Services (CTR), Partner Services (PS)	IDU MSM Heterosexual
Venango County State Health Center HIV Clinic Box 191 Seneca, PA 16346 814.677.0672	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Venango County State Health Center STD Clinic Box 191 Seneca, PA 16346 814.677.0672	Counseling, Testing and Referral Services (CTR)	Heterosexual
Venango County State Health Center Tuberculosis Clinic Box 191 Seneca, PA 16346 814.677.0672	Counseling, Testing and Referral Services (CTR)	Heterosexual General Public Emerging Risk Group – Homeless
WARREN COUNTY	**Population—40,638 (Warren)**	
Family Health Council of Warren County	Counseling, Testing and Referral Services (CTR)	Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
514 Third Avenue Amex Building North Warren, PA 16365 814.723.5852		
Family Planning Services of Warren County 2 South State Street North Warren, PA 16365 814.723.5852	Counseling, Testing and Referral Services (CTR)	General Public
Northwest PA Rural AIDS Alliance 15870 Route 322 Suite 2 Clarion, PA 16214 814.764.6066 www.northwestalliance.org	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI), Prevention for Positives	HIV+ All Risk Groups
Warren County Prison 407 Market Street Warren, PA 16365 814.723.7553	Counseling, Testing and Referral Services (CTR), Partner Services (PS)	IDU MSM Heterosexual
Warren County State Health Center HIV Clinic 223 North State Street North Warren, PA 16365 814.728.3566	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Warren County State Health Center Tuberculosis Clinic 223 North State Street North Warren, PA 16365 814.728.3566	Counseling, Testing and Referral Services (CTR)	Heterosexual General Public Emerging Risk Group – Homeless

The South Central Region

The South Central region consists of Adams, Bedford, Blair, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Juniata, Lancaster, Lebanon, Mifflin, Perry and York Counties. The total population of this region is 1,930,431 (15% of state population and a -4% change since the 2000 Census)

Key: IDU – Injection drug user; MSM – Men who have Sex with Men; MSM/IDU – Men who have Sex with Men who are Injection Drug Users.

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
ADAMS COUNTY	**Population—102,323 (Gettysburg)-county seat**	
Adams County Prison 625 Biglerville Road Gettysburg, PA 17325 717.344.7671	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Adams County Shelter for the Homeless 102 North Stratton Street Gettysburg, PA 17325 717.337.2413 717.337.2474	Outreach, Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual Emerging Risk Group – Homeless
Adams County State Health Center HIV Clinic 414 East Middle Street Gettysburg, PA 17325 717.334.2112	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Adams County State Health Center Tuberculosis Clinic 414 East Middle Street Gettysburg, PA 17325 717.334.2112	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
American Red Cross – Adams County Chapter 11 Lincoln Square Gettysburg, PA 17325 717.334.1814	Health Communication/Public Information (HC/PI)	General Public
Gettysburg Health Center at	Counseling, Testing and	Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Herr's Ridge PO Box 378 820 Chambersburg Road Gettysburg, PA 17325 717.337.4400	Referral Services (CTR)	
Gettysburg Hospital 147 Gettysburg Street Gettysburg, PA 17325 717.334.2121 717.337.4125	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	General Public
Keystone Farm Worker Program 424 East Middle Street Gettysburg, PA 17325 717.334.0001	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	Hispanic Heterosexual Hispanic IDU Hispanic MSM
Planned Parenthood of Central Pennsylvania 963 Biglerville Road Gettysburg, PA 17325 717.344.9275 www.ppcpa.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual General Public Emerging Risk Groups – Youth, Perinatal
BEDFORD COUNTY	**Population—49,579 (Bedford)**	
Alum Bank Community Health Center 121 Rolling Acres Drive Alum Bank, PA 15521 814.839.4191	Counseling, Testing and Referral Services (CTR)	General Public
Bedford County Prison 204 South Thomas Street Bedford, PA 15222 814.623.6513	Counseling, Testing and Referral Services (CTR), Partner Services (PS)	IDU MSM Heterosexual
Bedford County State Health Center HIV Clinic 130 Vondersmith Avenue Bedford, PA 15522 814.623.2001	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI),	Heterosexual General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
	Outreach, Health Communication/Public Information (HC/PI)	
Bedford County State Health Center STD Clinic 130 Vondersmith Avenue Bedford, PA 15522 814.623.2001	Counseling, Testing and Referral Services (CTR), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual
Bedford County State Health Center Tuberculosis Clinic 130 Vondersmith Avenue Bedford, PA 15522 814.623.2001	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Home Nursing Agency – AIDS Intervention Project 201 Chestnut Avenue PO Box 352 Altoona, PA 16603 814.944.2982 800.445.6262 www.homenursingagency.com	Partner Services (PS), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual General Public Emerging Risk Groups – Homeless, Perinatal
UPMC Family Health Services 602 East Pitt Street Bedford, PA 15522	Counseling, Testing and Referral Services (CTR)	General Public
BLAIR COUNTY	**Population—126,127 (Hollidaysburg)**	
Altoona Hospital Family Planning Center 501 Howard Avenue Building C Altoona, PA 16001 814.946.2012	Counseling, Testing and Referral Services (CTR), Health Communication/Public Information (HC/PI)	Heterosexual
Blair County Prison 422 Mulberry Street Holidaysburg, PA 16648 814.695.9731	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Blair County State Health Center HIV Clinic 615 Howard Avenue Altoona, PA 16601 814.946.7300	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Blair County State Health Center STD Clinic 615 Howard Avenue Altoona, PA 16601 814.946.7300	Counseling, Testing and Referral Services (CTR)	Heterosexual
Blair County State Health Center Tuberculosis Clinic 615 Howard Avenue Altoona, PA 16601 814.946.7300	Counseling, Testing and Referral Services (CTR)	IDU Heterosexual Emerging Risk Group – Homeless
Home Nursing Agency – AIDS Intervention Project 201 Chestnut Avenue PO Box 352 Altoona, PA 16603 814.944.2982 800.445.6262 www.homenursingagency.com	Individual Level Intervention (ILI) Group Level Intervention (GLI) Public Information	IDU MSM Heterosexual General Public Emerging Risk Groups – Homeless Transgender
CUMBERLAND COUNTY	**Population—232,483 (Carlisle)**	
AIDS Community Alliance 401 Division Street Suite 100 Harrisburg, PA 17110 717.233.7190 800.867.1550 www.aca-pa.com	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach	White IDU White MSM White MSM/IDU Emerging Risk Groups – Perinatal, Youth
Cumberland County Prison 1101 Claremont Road Carlisle, PA 17013 717.245.8787	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health	IDU MSM Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
	Communication/Public Information (HC/PI)	
Cumberland County State Health Center HIV Clinic 431 East North Street Carlisle, PA 17013 717.243.5151	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Cumberland County State Health Center Tuberculosis Clinic 431 East North Street Carlisle, PA 17013 717.243.5151	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Dickinson College PO Box 1773 Cherry and Louther Streets Carlisle, PA 17013 717.243.5121	Counseling, Testing and Referral Services (CTR)	MSM Heterosexual Emerging Risk Group – Youth
Planned Parenthood of the Susquehanna Valley 977 Walnut Bottom Road Carlisle, PA 17013 717.243.0515 www.ppsv.net	Counseling, Testing and Referral Services (CTR), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual
PROGRAM for Female Offenders 1515 Derry Street Harrisburg, PA 17104 717.238.9950	Group Level Intervention (GLI), Comprehensive Risk Counseling and Services (CRCS)	Heterosexual Emerging Risk Groups – Perinatal, Youth
Sadler Health Center 100 North Hanover Street Carlisle, PA 17013 717.218.6671	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Tri-County Planned	Counseling, Testing and	Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Parenthood 206 East King Street Shippensburg, PA 17257 717.532.7896	Referral Services (CTR)	
DAUPHIN COUNTY	**Population—258,934 (Harrisburg)**	
Adult Ambulatory Care Center 3645 North 3rd Street Harrisburg, PA 17110 717.782.2712	Counseling, Testing and Referral Services (CTR)	General Public
AIDS Community Alliance 401 Division Street Suite 100 Harrisburg, PA 17110 717.233.7190 800.867.1550 www.aca-pa.com	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach	IDU MSM MSM/IDU Emerging Risk Groups – Perinatal, Youth
Battered Women's Shelter Contact YWCA 717.243.7273 800.654.1211	Individual Level Intervention (ILI)	Heterosexual Emerging Risk Group – Perinatal
Bethesda Mission Men's Shelter 611 Reily Street Harrisburg, PA 17102 717.257.4442 www.bethesda-mission.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual Emerging Risk Group – Homeless
Capital Pavilion Half Way House 2012 North 4th Street Harrisburg, PA 17102 717.236.0132	Individual Level Intervention (ILI)	IDU
Conewago Place 424 Nye Road Hummelstown, PA 17036 717.533.0428	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
Dauphin County Prison 501 Mall Road	Counseling, Testing and Referral Services (CTR),	IDU MSM

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Harrisburg, PA 17111 717.780.6800	Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	Heterosexual
Dauphin County State Health Center 30 Kline Plaza Harrisburg, PA 17104 717.787.8092	Counseling, Testing and Referral Services (CTR)	General Public
Daystar Center 123 North 18th Street Harrisburg, PA 17103 717.230.9898	Individual Level Intervention (ILI)	IDU Heterosexual
Discovery House 99 South Cameron Street Harrisburg, PA 17101 717.233.7290	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU
Evergreen House 100 Evergreen Drive Harrisburg, PA 17102 717.238.6343	Counseling, Testing and Referral Services (CTR)	General Public
Frederick Health Center 100 Evelyn Drive Millersburg, PA 17061 717.692.4761	Counseling, Testing and Referral Services (CTR)	General Public
Gaudenzia Common Ground 2835 North Front Street Harrisburg, PA 17110 717.238.5553	Counseling, Testing and Referral Services (CTR)	General Public
Gaudenzia Concept 90 PO Box 10396 Harrisburg, PA 17105 717.232.3232	Counseling, Testing and Referral Services (CTR)	General Public
Gaudenzia Inc., Outpatient 2039 North Second Street Harrisburg, PA 17102	Counseling, Testing and Referral Services (CTR), Individual Level	IDU Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
717.233.3424	Intervention (ILI)	
Gay and Lesbian Switchboard of Harrisburg 1300A North Third Street Harrisburg, PA 17102 717.234.0328	Health Communication/Public Information (HC/PI)	MSM
Hamilton Health Center 1821 Fulton Street Harrisburg, PA 17102 717.232.9971 1650 Walnut Street Harrisburg, PA 17110 717.230.3946	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	Black IDU Hispanic IDU Black Heterosexual Hispanic Heterosexual Emerging Risk Group – Perinatal
Harrisburg Area YMCA 410 Fallowfield Road Camp Hill, PA 17011 717.975.1897	Individual Level Intervention (ILI)	IDU Heterosexual
Kline Plaza Medical Center 43 Kline Village Harrisburg, PA 17104 717.232.0500	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	General Public
Outbound House 2901 North 6th Street Harrisburg, PA 17102 717.233.1035	Counseling, Testing and Referral Services (CTR)	General Public
Pediatric Comprehensive Care Clinic Milton Hershey Medical Center PO Box 850 Hershey, PA 17033 717.531.8882 717.531.7531 717.531.8521	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	HIV+
Pinnacle Health Adult Clinic 2645 North Third Street	Counseling, Testing and Referral Services (CTR),	Heterosexual General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
4th Floor Harrisburg, PA 17110 717.782.2421	Individual Level Intervention (ILI)	
Pinnacle Health at Polyclinic Hospital 2601 North Third Street Harrisburg, PA 17110 717.782.6800 877.543.5018	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	HIV+
Pinnacle Health at Polyclinic Hospital - Children's Resource Center 2601 North Third Street Harrisburg, PA 17110 717.782.6800 877.543.5018	Counseling, Testing and Referral Services (CTR)	Emerging Risk Group – Youth
Planned Parenthood of the Susquehanna Valley 1514 North 2nd Street Harrisburg, PA 17102 717.234.2479	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual General Public
PROGRAM for Female Offenders 1515 Derry Street Harrisburg, PA 17104 717.238.9950	Counseling, Testing and Referral Services (CTR), Group Level Intervention (GLI), Comprehensive Risk Counseling and Services (CRCS)	Heterosexual Emerging Risk Groups – Perinatal, Youth
Salvation Army 125 South Hanover Street Carlisle, PA 17103 717.249.1411 112 Green Street Harrisburg, PA 17102 717.233.6755 2328 Locust Lane Harrisburg, PA 17109 717.238.8678	Individual Level Intervention (ILI)	IDU

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
50 East King Street York, PA 17401 717.848.2364 3650 Vartan Way Box 60095 Harrisburg, PA 17106 717.233.1035		
Sienna House PO Box 60217 Harrisburg, PA 17106 717.238.7455	Counseling, Testing and Referral Services (CTR)	General Public
The Naaman Center 4600 East Harrisburg Pike Elizabethtown, PA 17022 717.367.9115 888.243.4316 www.naamancenter.com	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
Visiting Nurses Association of Central PA 3315 Derry Street Harrisburg, PA 17111 717.233.1035 800.995.8207 www.vnacentrapa.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	Black Heterosexual Hispanic Heterosexual
White Deer Run Governor's Plaza S 2001 South Front Street Street Building 1 Suites 212-214 Harrisburg, PA 17102 717.221.8712 www.whitedeerrun.com	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
FRANKLIN COUNTY	**Population—144,994 (Chambersburg)**	
Family Health Services of South Central Pennsylvania 1854 Wayne Avenue Chambersburg, PA 17201	Counseling, Testing and Referral Services (CTR)	Black Heterosexual White Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
717.264.4666 www.ppcpa.org		
Franklin County Prison 625 Franklin Farm Lane Chambersburg, PA 17201 717.264.9513	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Franklin County State Health Center HIV Clinic 518 Cleveland Avenue Chambersburg, PA 17201 717.264.4666	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Franklin County State Health Center Tuberculosis Clinic 518 Cleveland Avenue Chambersburg, PA 17201 717.264.4666	Counseling, Testing and Referral Services (CTR)	Heterosexual
Keystone Rural Health Center Keystone Family Practice 820 Fifth Avenue Chambersburg, PA 717.263.4313 www.keystonehealth.org	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach	Hispanic Heterosexual
Planned Parenthood of Central PA 1854 Wayne Avenue Chambersburg, PA 17201 717.264.4666 www.plannedparenthood.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual General Public Emerging Risk Groups – Perinatal, Youth
FULTON COUNTY	**Population—144,852 (McConnelsburg)**	
Fulton County Prison North Second Street McConnellsburg, PA 17233	Counseling, Testing and Referral Services (CTR), Partner Services (PS),	IDU MSM Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
717.485.4221	Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	
Fulton County State Health Center HIV Clinic Penn's Village Shopping Center PO Box 248 McConnellsburg, PA 17233 717.485.5137	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Fulton County State Health Center STD Clinic Penn's Village Shopping Center PO Box 248 McConnellsburg, PA 17233 717.485.5137	Counseling, Testing and Referral Services (CTR)	Heterosexual
Fulton County State Health Center Tuberculosis Clinic Penn's Village Shopping Center PO Box 248 McConnellsburg, PA 17233 717.485.5137	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group - Homeless
Home Nursing Agency – AIDS Intervention Project 201 Chestnut Avenue PO Box 352 Altoona, PA 16603 814.944.2982 800.445.6262 www.homenursingagency.com	Partner Services (PS), Individual Level Intervention (ILI), Outreach, Comprehensive Risk Counseling and Services (CRCS), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual General Public Emerging Risk Group –
Planned Parenthood of Central PA 1854 Wayne Avenue Chambersburg, PA 17201 717.264.4666 www.plannedparenthood.org	Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual General Public Emerging Risk Groups – Perinatal, Youth

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
HUNTINGDON COUNTY	**Population—45,345 (Lewistown)**	
Home Nursing Agency – AIDS Intervention Project 201 Chestnut Avenue PO Box 352 Altoona, PA 16603 814.944.2982 800.445.6262 www.homenursingagency.com	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual General Public Emerging Risk Group – Perinatal
Huntingdon County Prison 300 Church Street Huntingdon, PA 16652 814.643.2490	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Huntingdon County State Health Center HIV Clinic 6311 Margy Drive, Suite 1 Huntingdon, PA 16652 814.627.1251	Counseling, Testing and Referral Services (CTR), Partner Services (PS)	General Public
Huntingdon County State Health Center STD Clinic 6311 Margy Drive, Suite 1 Huntingdon, PA 16652 814. 627.1251	Counseling, Testing and Referral Services (CTR)	Heterosexual
Huntingdon County State Health Center Tuberculosis Clinic 6311 Margy Drive, Suite 1 Huntingdon, PA 16652 814. 627.1251	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group - Homeless
Huntingdon Family Health Services JC Blair Hospital 1227 Warm Springs Avenue Huntingdon, PA 16652 814.643.5364	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
JUNIATA COUNTY	**Population—23,118 (Mifflintown)**	
AIDS Community Alliance 401 Division Street Suite 100 Harrisburg, PA 17110 717.233.7190 800.867.1550 www.aca-pa.com	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach	IDU MSM Heterosexual Emerging Risk Groups – Perinatal, Youth
Juniata County Prison Third and Bridge Streets Mifflintown, PA 17059 717.436.8448	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Juniata County State Health Center HIV Clinic 809 Market Street Port Royal, PA 17082 717.527.4185	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Juniata County State Health Center STD Clinic 809 Market Street Port Royal, PA 17082 717.527.4185	Counseling, Testing and Referral Services (CTR)	Heterosexual
Juniata County State Health Center Tuberculosis Clinic 809 Market Street Port Royal, PA 17082 717.527.4185	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group - Homeless
LANCASTER COUNTY	**Population—507,766 (Lancaster)**	
ACA Community Life Network 401 Division Street Suite 100 Harrisburg, PA 17110	Counseling, Testing and Referral Services (CTR)	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
717.233.7190		
AIDS Community Alliance Southeast Lancaster Health Center 625 South Duke Street Lancaster, Pa 17602 717.299.6372 800.867.1550 www.aca-pa.com	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach	IDU MSM Emerging Risk Groups – Perinatal, Youth
Brethren Mennonite AIDS Hotline 128 South Ann Lancaster, PA 17602 717.937.7140 717.299.7597	Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Elizabethtown College One Alpha Drive Elizabethtown, PA 17022 717.736.1400 www.etown.edu	Individual Level Intervention (ILI)	MSM Heterosexual
Ephrata Community Hospital 169 Martin Avenue Ephrata, PA 17522 717.733.0311	Counseling, Testing and Referral Services (CTR), Health Communication/Public Information (HC/PI)	General Public
Lancaster County Prison 625 East King Street Lancaster, PA 17602 www.prison.co.lancaster.pa.us	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Lancaster County State Health Center HIV Clinic 1661 Old Philadelphia Pike Lancaster, PA 17602 717.299.7597	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Lancaster County State Health Center Tuberculosis Clinic	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group -

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
1661 Old Philadelphia Pike Lancaster, PA 17602 717.299.7597		Homeless
Lancaster General Hospital HIV and STD Clinics PO Box 355 554 North Duke Street Lancaster, PA 17602 717.290.5511 717.299.7800	Counseling, Testing and Referral Services (CTR)	Heterosexual
Lancaster General Hospital 555 North Duke Street Lancaster, PA 17602 717.290.5511 717.299.7800	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	General Public
Lancaster General Hospital – Susquehanna Division 306 North 7th Street Columbia, PA 17512 717.684.2841	Counseling, Testing and Referral Services (CTR)	General Public
Millersville University 1 South George Street PO Box 1002 Millersville, PA 17551 717.872.3011 www.millersville.edu	Individual Level Intervention (ILI)	Heterosexual MSM
Nuestra Clinica 445 East King Street Lancaster, PA 17602 717.295.7994	Counseling, Testing and Referral Services (CTR)	General Public
Planned Parenthood of the Susquehanna Valley 31 South Lime Street Lancaster, Pa 17602 717.299.2891 www.ppsv.net	Counseling, Testing and Referral Services (CTR)	Heterosexual
Southeast Lancaster Health	Counseling, Testing and	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Center 625 South Duke Street Lancaster, PA 17602 717.299.6371	Referral Services (CTR)	
Southeast Lancaster Health Services - HIV and STD Clinics 625 South Duke Street PO Box 598 Lancaster, PA 17602 717.299.6372 www.selhs.org	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Spanish American Civic Association – Nuestra Clinica 445 East King Street Lancaster, PA 17602 717.295.7994	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Health Communication/Public Information (HC/PI)	Hispanic Heterosexual Hispanic IDU Hispanic MSM General Public Emerging Risk Groups – Youth
Summit Quest Academy 1170 South State Street Ephrata, PA 17522 800.441.7345	Counseling, Testing and Referral Services (CTR)	General Public
The Gathering Place PO Box 1222 440 Pershing Avenue Lancaster, PA 17602 717.295.4630	Counseling, Testing and Referral Services (CTR), Health Communication/Public Information (HC/PI)	HIV+ General Public
Ujima Outreach Services 512 East Strawberry Street Lancaster, PA 17602 717.509.1790	Individual Level Intervention (ILI)	Black Heterosexual Black IDU Black MSM
Urban League of Lancaster County 502 South Duke Street Lancaster, PA 17602 717.394.1966	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	HIV+ Black/Hispanic IDU MSM Heterosexual General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Visiting Nurse Association/VNA Hospice 1181 Old Homestead Lane Suite 105 Lancaster, PA 17601 717.397.8251 www.lancastergeneral.org	Health Communication/Public Information (HC/PI)	HIV+ General Public
LEBANON COUNTY	**Population—130,506 (Lebanon)**	
AIDS Community Alliance 9 North 9th Street Lebanon, PA 17042 717.272.2044 800.867.1550 www.aca-pa.com	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach	IDU MSM MSM/IDU Emerging Risk Groups – Perinatal, Youth
Good Samaritan Family Practice Hyman S. Caplan Pavilion 2nd Floor 4th and Willow Streets Lebanon, PA 17042 717.274.0474	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual General Public
Lebanon County Prison 730 West Walnut Street Lebanon, PA 17042 717.274.5451	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Lebanon County State Health Center HIV Clinic 9 North Ninth Street Lebanon, Pa 17042 717.272.2044	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Lebanon County State Health Center Tuberculosis Clinic 9 North Ninth Street Lebanon, Pa 17042	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
717.272.2044		
Lebanon Family Health Services 615 Cumberland Street Lebanon, PA 17042 717.233.7190 www.lebanonfhs.org	Counseling, Testing and Referral Services (CTR)	Heterosexual
Veterans' Affairs Medical Center, HIV Clinic 1700 South Lincoln Avenue Lebanon, PA 17042 717.272.6621	Health Communication/Public Information (HC/PI)	HIV+ Emerging Risk Group – Homeless
MIFFLIN COUNTY	**Population—45,957 (Lewistown)**	
AIDS Community Alliance 401 Division Street Suite 100 Harrisburg, PA 17110 717.233.7190 800.867.1550 www.aca-pa.com	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach	IDU MSM MSM/IDU Emerging Risk Groups – Perinatal, Youth
Lewistown Women's Health Services 516 West 4th Street Lewistown, PA 17044 717.248.0175	Counseling, Testing and Referral Services (CTR)	General Public Emerging Risk Group - Perinatal
Mifflin County Prison 103 West Market Street Mifflin, Pa 17044 717.248.1130	Counseling, Testing and Referral Services (CTR)	IDU MSM Heterosexual
Mifflin County State Health Center HIV Clinic 21 South Brown Street Lewistown, PA 17044 717.242.1252	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Mifflin County State Health	Counseling, Testing and	Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
Center STD Clinic 21 South Brown Street Lewistown, PA 17044 717.242.1252	Referral Services (CTR)	
Mifflin County State Health Center Tuberculosis Clinic 21 South Brown Street Lewistown, PA 17044 717.242.1252	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
PERRY COUNTY	**Population—45,502 (New Bloomfield)**	
AIDS Community Alliance 401 Division Street Suite 100 Harrisburg, PA 17110 717.233.7190 800.867.1550 www.aca-pa.com	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach	IDU MSM MSM/IDU Emerging Risk Groups – Perinatal, Youth
Loysville Youth Detention Center RD #2 Box 365B Loysville, PA 17047 717.789.5501	Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU Heterosexual Emerging Risk Group – Youth
Perry County Prison Box 6 South Carlisle Street New Bloomfield, PA 17068 717.582.2727	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Perry County State Health Center HIV Clinic RR #1 Box 35E 135 Red Hill Road Newport, PA 17074 717.567.2011	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Perry County State Health Center Tuberculosis Clinic RR #1 Box 35E	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
135 Red Hill Road Newport, PA 17074 717.567.2011		
Planned Parenthood of the Susquehanna Valley 133 South Fifth Street Newport, Pa 17074 717.567.3002 www.ppsv.net	Counseling, Testing and Referral Services (CTR)	Heterosexual
YORK COUNTY	**Population—425,937 (York)**	
Atkins House 313 East King Street York, PA 17403 717.848.5454 www.atkinshouse.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Health Communication/Public Information (HC/PI)	IDU Heterosexual Emerging Risk Group – Perinatal
Caring Together 116 South George Street York, PA 17403 717.851.3643 717.846.6776	Individual Level Intervention (ILI), Group Level Intervention (GLI), Health Communication/Public Information (HC/PI)	HIV+
Family First Health Hanover Health Center 404 York Street York, PA 17331 717.632.9052 www.familyfirsthealth.com	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	General Public
Family First Health Prevention Case Management Project 116 South George Street York, PA 17401 717.846.6776 www.familyfirsthealth.com	Comprehensive Risk Counseling and Services (CRCS)	HIV+ Heterosexual
Family First Health 116 South George Street	Counseling, Testing and Referral Services (CTR),	IDU MSM

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
York, PA 17401 717.845.8617 www.familyfirsthealth.com	Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual
Hannah Penn Health Center 415 East Boundary Avenue York, PA 17403 717.843.5174	Counseling, Testing and Referral Services (CTR)	General Public
Hanover General Hospital 300 Highland Avenue Hanover, PA 17331 717.633.2123	Counseling, Testing and Referral Services (CTR), Health Communication/Public Information (HC/PI)	General Public
Hanover Health Center 55 Frederick Street Hanover, PA 17331 717.632.9052	Counseling, Testing and Referral Services (CTR)	General Public
Homer Hetrick Center 308 Market Street Lewisberry, PA 17339 717.938.6695	Counseling, Testing and Referral Services (CTR)	General Public
Planned Parenthood of Central PA 728 South Beaver Street York, PA 17401 717.845.9681 2997 Caper Horn Road Red Lion, PA 17356 717.244.1412 Center Square Hanover, PA 17331 717.637.6544	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual General Public Emerging Risk Groups – Perinatal, Youth
York City Health Bureau 435 West Philadelphia Street York, PA 17401 717.849.2252	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Outreach, Health Communication/Public	HIV+ IDU MSM Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION (S)
	Information (HC/PI) DEBI Interventions: SISTA Condom Skills Education	
York City Health Bureau – Tuberculosis Program 435 West Philadelphia Street York, PA 17401 717.849.2252	Counseling, Testing and Referral Services (CTR)	General Public
York County Prison 3400 Concord Road York, PA 17402 717.840.7580	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI)	IDU MSM Heterosexual General Public
York County State Health Center HIV Clinic 1750 North George Street York, PA 17404 717.771.1336	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
York County State Health Center Tuberculosis Clinic 1750 North George Street York, PA 17404 717.771.1336	Counseling, Testing and Referral Services (CTR)	General Public
York Development Center 3564 Meindel Road York, PA 17042 717.771.9570	Counseling, Testing and Referral Services (CTR)	General Public
Youth Detention Center 3564 Meindel Road York, PA 17402 717.840.7570	Counseling, Testing and Referral Services (CTR)	Emerging Risk Group – Youth

Southwest Region

The Southwest region consists of Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Somerset, Washington and Westmoreland Counties. The total population of this region is 2,702,603 (21% of state population and a -3% change since the 2000 Census)

Key: IDU – Injection drug user; MSM – Men who have Sex with Men; MSM/IDU – Men who have Sex with Men who are Injection Drug Users.

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
ALLEGHENY COUNTY Population—1,281,444 (Pittsburgh)-county seat		
Adagio Health 100 Forbes Avenue Kossman Building Suite 1000 Pittsburgh, PA 15222 412.288.2140	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual Emerging Risk Group – Perinatal
Allegheny County Health Department 3441 Forbes Avenue Pittsburgh, PA 15213 412.578.8080 412.578.8332 www.achd.net	Partner Services (PS)	HIV+
Allegheny County Health Department – Outreach Workers 3441 Forbes Avenue Pittsburgh, PA 15213 412.578.8080 412.578.8332 www.achd.net	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach	IDU MSM Heterosexual
Allegheny County Health Department HIV Clinic 3441 Forbes Avenue Pittsburgh, PA 15213 412.578.8080 412.578.8332 www.achd.net	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Allegheny County Health Department STD Clinic 3441 Forbes Avenue Pittsburgh, PA 15213	Counseling, Testing and Referral Services (CTR)	Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
412.578.8080 412.578.8332 www.achd.net		
Allegheny County Health Department Tuberculosis Clinic 3441 Forbes Avenue Pittsburgh, PA 15213 412.578.8080 412.578.8332 www.achd.net	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Groups – Youth, Homeless
Allegheny County Jail 950 Second Avenue Pittsburgh, PA 15219 412.350.2000	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI)	IDU MSM Heterosexual
Alpha House – Substance Abuse Treatment 435 Shady Avenue Pittsburgh, PA 15206 412.363.4220 www.alphahouseinc.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
Alternatives Regional Chemical Abuse Program 70 South 22nd Avenue Pittsburgh, PA 15203 412.381.2100	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
American Red Cross Southwestern PA Chapter PO Box 1769 225 Boulevard of the Allies Pittsburgh, PA 15230 412.263.3100	Health Communication/Public Information (HC/PI)	General Public
American Women's Services 320 Fort Pitt Boulevard Pittsburgh, PA 412.765.3660	Counseling, Testing and Referral Services (CTR)	General Public
Bethlehem Haven of Pittsburgh	Counseling, Testing and Referral Services (CTR),	Emerging Risk Groups – Homeless, Perinatal,

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
Fifth Avenue Commons 905 Watson Street Pittsburgh, PA 15219 412.391.1348 www.bethlehemhaven.org	Health Communication/Public Information (HC/PI)	Women
Carnegie Mellon University Student Health Center 1060 Morewood Avenue Pittsburgh, PA 15213 412.268.2157 www.cmu.edu	Counseling, Testing and Referral Services (CTR)	MSM Heterosexual Emerging Risk Group – Youth
Central Outreach & Referral Center 2040 Centre Avenue Pittsburgh, PA 15219 412-471-9806		
Cornell Abraxas Center for Adolescent Females 306 Penn Avenue Pittsburgh, PA 15221 412.244.3710 www.cornellcompanies.com	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual Emerging Risk Groups – Perinatal, Youth
Cornell Abraxas III 437 Turrett Street Pittsburgh, PA 15206 412.691.0904 www.cornellcompanies.com	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual Emerging Risk Group – Youth
Discovery House 1391 Washington Boulevard Pittsburgh, PA 15206 412.661.9222	Counseling, Testing and Referral Services (CTR)	IDU
East End Cooperative Ministry House of the Good Samaritan 6545 Hamilton Street Pittsburgh, PA 15206 412.441.0259	Outreach, Health Communication/Public Information (HC/PI)	IDU Emerging Risk Group – Homeless
East Liberty Family Health	Counseling, Testing and	Black Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
Care Center 7171 Churchland Street Pittsburgh, PA 15206 412.661.2802 (East Liberty) 412.361.8284 (Lincoln/Lemington)	Referral Services (CTR)	Hispanic IDU General Public
Family Links – Family Counseling Center 844 Proctor Way Pittsburgh, PA 15210 Outpatient Treatment Center Hosanna House 807 Wallace Avenue Suite 204 Pittsburgh, PA 15221 412.381.8230 (Allentown) 412.661.1800 (East Liberty) www.familylinks.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual Emerging Risk Group – Youth
Forbes Family Practice 2570 Haymaker Road Monroeville, PA 15146 412.858.2760	Outreach	General Public
Forbes Metro Family Practice 901B West Street Pittsburgh, PA 15221 412.247.2310 www.metrofamilypractice.org	Outreach	General Public
Gateway Rehabilitation Center Moffett Run Road Aliquippa, PA 15001 412.766.8700 800.472.1177 www.gatewayrehab.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
Health Care to Underserved Populations Montefiore Hospital Suite 933W	Counseling, Testing and Referral Services (CTR)	Emerging Risk Group – Homeless

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
200 Lothrop Street Pittsburgh, PA 15213 412.692.4706		
Hemophilia Center of Western PA 3636 Boulevard of the Allies Pittsburgh, PA 15213 412.209.7280 412.209.7288 412.209.7293	Outreach	Hemophiliacs
Holy Family Institute 8235 Ohio River Boulevard Pittsburgh, PA 15202 412.766.5434	Counseling, Testing and Referral Services (CTR)	General Public
Homewood Brushton YMCA Counseling Services 7140 Bennett Street Pittsburgh, PA 15208 412.243.2900	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
House of Crossroads – Substance Abuse Treatment 2012 Centre Avenue Pittsburgh, Pa 15219 412.281.5080	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
Housing Authority of the City of Pittsburgh 700 Fifth Avenue 4th Floor Pittsburgh, PA 15219 412.456.5079 www.hacp.org	Counseling, Testing and Referral Services (CTR), Outreach, Health Communication/Public Information (HC/PI)	HIV+ IDU Heterosexual
JAMAA -Ministry AOD Family Center 216 North Highland Avenue Pittsburgh, PA 15206 412.362.8054 www.operationnehemiah.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
Kingsley Association	Counseling, Testing and	Black Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
6435 Frankstown Avenue Pittsburgh, PA 15206 412.661.8751 www.kingsleyassociation.org	Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	Emerging Risk Group – Youth
Latterman Family Health Center 2347 Fifth Avenue McKeesport, PA 15132 412.673.5504	Counseling, Testing and Referral Services (CTR), Outreach, Health Communication/Public Information (HC/PI)	HIV+ General Public
Lydia's Place 710 Fifth Avenue Pittsburgh, PA 15219 412.391.1013 www.lydiasplace.org	Counseling, Testing and Referral Services (CTR) DEBI Intervention: SISTA	HIV+ Black Heterosexual General Public
Macedonia F.A.C.E. 2851 Bedford Avenue Pittsburgh, PA 15219 412.687.8004	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	Black IDU Black MSM Black Heterosexual
Magee Women's Hospital 300 Halkett Street Pittsburgh, PA 15213 412.641.4455 www.magee.edu	Counseling, Testing and Referral Services (CTR)	Black Heterosexual Emerging Risk Groups – Perinatal, Women
Mathilda H. Theiss Health Center UPMC 373 Burrows Street Pittsburgh, PA 15213 412.383.1550	Counseling, Testing and Referral Services (CTR), Outreach, Health Communication/Public Information (HC/PI)	Black Heterosexual General Public
McKeesport Family Health Center 627 Lysle Boulevard McKeesport, PA 15132 412.664.4112	Counseling, Testing and Referral Services (CTR), Outreach, Health Communication/Public Information (HC/PI)	Black Heterosexual General Public
Mercy Behavioral Health 1200 Reedsdale Street Pittsburgh, PA 15233	Counseling, Testing and Referral Services (CTR), Individual Level Intervention	IDU Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
412.323.4500 412.488.4040 888.424.2287 www.mercybehavioral.org	(ILI)	
Mercy Family Health Center North 5700 Corporate Drive, Suite 265 Pittsburgh, PA 15237 412.369.5900 www.mercylink.org	Counseling, Testing and Referral Services (CTR)	General Public
Mercy Hospital of Pittsburgh Operation Safety Net 1400 Locust Street Pittsburgh, PA 15219 412.232.5739 www.mercylink.org	Counseling, Testing and Referral Services (CTR)	Emerging Risk Group – Homeless
Metro Family Practice 901B West Street Pittsburgh, PA 15221 412.247.2310 www.metrofamilypractice.org	Health Communication/Public Information (HC/PI)	HIV+
Mon Yough Community Services 331 Shaw Avenue McKeesport, PA 15132 412.675.8500 www.mycs.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU MSM Heterosexual Emerging Risk Group – Women
Mon Yough Drug and Alcohol Community Services 335 Shaw Avenue McKeesport, PA 15132 412.675.8560 412.375.8500	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
New Life Ministries 1008 7th Avenue Suite 206 Beaver Falls, PA 15011	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach,	IDU Heterosexual Emerging Risk Groups – Youth, Transgender

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
724.843.8540	Comprehensive Risk Counseling and Services (CRCS), Health Communication/Public Information (HC/PI)	
Ohio Valley General Hospital PO Box 113 McKees Rocks, PA 15136 412.777.6161	Counseling, Testing and Referral Services (CTR)	General Public
PA/Mid Atlantic AIDS Education and Training Center 200 Lothrop Street Pittsburgh, PA 15213 412.647.7228 www.publichealth.pitt.edu	Health Communication/Public Information (HC/PI), Community Level Intervention (CLI)	General Public
Partnership for Minority HIV/AIDS Prevention 201 S. Highland Avenue Suite 101 Pittsburgh, PA 15206 412.441.0259 www.pmhap.org	Counseling, Testing Referral Services (CTR), Outreach, Group Level and Individual Level Interventions, Health Communication/Public Information (HC/PI)	IDU Black Heterosexual Emerging Risk Group – Black Youth
Pediatric HIV Center of Children's Hospital 3705 Fifth Avenue Pittsburgh, PA 15213 412.683.6073 412.692.5355 www.chp.edu	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	HIV+
PERSAD Center 5150 Penn Avenue Pittsburgh, PA 15224 412.441.9786 www.persadcenter.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	HIV+ IDU MSM MSM/IDU
Pitt Men's Study PO Box 7319	Counseling, Testing and Referral Services (CTR),	IDU MSM

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
Pittsburgh, PA 15213 412.624.2008 800.987.1963 www.stophiv.com/pms/	Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	
Pittsburgh AIDS Center for Treatment (PACT) 200 Lothrop Street, Room 607 Pittsburgh, PA 15213 412.647.7228 412.647.3112	Counseling, Testing and Referral Services (CTR), Outreach	HIV+ General Public
Pittsburgh AIDS Task Force 5913 Penn Avenue Pittsburgh, PA 15206 412.345.0576 www.patf.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI) DEBI Interventions: Popular Opinion Leader (POL) SISTA	HIV+ MSM Heterosexual Emerging Risk Groups – Youth, Perinatal, Women
Planned Parenthood of Western Pennsylvania - Women's Health Services 933 Liberty Avenue Pittsburgh, PA 15222 412.434.8971 www.ppwp.org	Counseling, Testing and Referral Services (CTR), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual General Public Emerging Risk Group – Women
Positive Health Clinic of Allegheny General Hospital 320 East North Avenue Pittsburgh, PA 15212 412.359.3360 412.359.3131 www.wpahs.org/AGH	Counseling, Testing and Referral Services (CTR), Outreach, Health Communication/Public Information (HC/PI)	HIV+ IDU
Prevention Point Pittsburgh 907 West Street	Individual Level Intervention (ILI), Outreach,	HIV+ IDU

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
5th Floor Pittsburgh, PA 15208 412.491.0916 412.247.3404 www.pppgh.org	Comprehensive Risk Counseling and Services (CRCS), Health Communication/Public Information (HC/PI)	
Primary Care Health Services 7227 Hamilton Avenue Pittsburgh, PA 15208 412.244.4700	Counseling, Testing and Referral Services (CTR), Health Communication/Public Information (HC/PI)	General Public
Project Pinova	Comprehensive Risk Counseling and Services (CRCS)	Emerging Risk Group – Black Youth
Pyramid Health Care Birmingham Towers Suite 321, 2100W Pittsburgh, PA 15203 412.241.5341	Counseling, Testing and Referral Services (CTR)	General Public
Rainbow Health Center	Counseling, Testing and Referral Services (CTR), Outreach, Health Communication/Public Information (HC/PI)	General Public
Salvation Army Public Inebriate Program/Adult Rehabilitation Center 54 South 9th Street Pittsburgh, PA 15203 412.481.7900	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual Emerging Risk Group – Homeless
SCI – Pittsburgh PO Box 99901 Pittsburgh, PA 15233 412.761.1955	Counseling, Testing and Referral Services (CTR), Group Level Intervention (GLI)	HIV+
Seven Project, Inc. 305 Pennoak Drive Pittsburgh, PA 15235 412.867.5057	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public	HIV+ Black MSM Black Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
	Information (HC/PI)	
Shadyside Hospital 5230 Centre Avenue Pittsburgh, PA 15232 412.623.2121	Counseling, Testing and Referral Services (CTR), Outreach, Health Communication/Public Information (HC/PI)	General Public
Shepherd Wellness Community 4800 Sciota Street Pittsburgh, PA 15224 412.683.4477 www.swonline.org	Health Communication/Public Information (HC/PI)	MSM Emerging Risk Group – Transgender
Shuman Juvenile Detention Center 7150 Highland Drive Pittsburgh, PA 15206 412.665.4143	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	Emerging Risk Group – Youth
TADISO 1524 Beaver Avenue Pittsburgh, PA 15233 5907 Penn Avenue Pittsburgh, PA 15206 412.322.8415 www.tadiso.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
UPMC Downtown Clinic 339 6th Avenue 5th Floor Pittsburgh, PA 15222 412.560.8762	Counseling, Testing and Referral Services (CTR)	General Public
UPMC Family HIV Clinic 200 Lothrop Street Pittsburgh, PA 15213 412.647.3112	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	HIV+ Emerging Risk Group - Youth
UPMC Hazelwood 4918 Second Avenue Pittsburgh, PA 15207 412.521.6705	Counseling, Testing and Referral Services (CTR), Health Communication/Public Information (HC/PI)	General Public Emerging Risk Group – Perinatal
Veteran's Pittsburgh Health	Counseling, Testing and	HIV+

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
Care System University Drive CIIIE-U Pittsburgh, PA 15240 412.688.6000	Referral Services (CTR), Health Communication/Public Information (HC/PI)	General Public
Whale's Tale 250 Shady Avenue Pittsburgh, PA 15208 412.661.1800	Counseling, Testing and Referral Services (CTR)	General Public
Wilkinsburg Family Health Center Hosanna House 807 Wallace Avenue 2nd Floor Suite 203 Pittsburgh, PA 15221 412.247.5216	Counseling, Testing and Referral Services (CTR), Health Communication/Public Information (HC/PI)	General Public
YMCA of Pittsburgh 2621 Centre Avenue Pittsburgh, PA 15219 412.621.1762	Outreach	Emerging Risk Group – Homeless
Youth Empowerment Project www.persadcenter.org	Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	Black MSM White MSM Emerging Risk Group – Youth
YWCA Bridge Housing PO Box 8645 Pittsburgh, PA 15221 412.371.2723	Health Communication/Public Information (HC/PI)	Emerging Risk Groups – Homeless, Women
ARMSTRONG COUNTY Population—67,851 (Kittanning)		
Armstrong County Prison 171 Staley's Court Road Kittanning, PA 16201 724.545.9222	Counseling, Testing and Referral Services (CTR), Partner Services (PS)	IDU MSM Heterosexual
Armstrong County State	Counseling, Testing and	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
Health Center HIV Clinic 239 Butler Road Kittanning, PA 16201 724.543.2818 724.543.2700	Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	
Armstrong County State Health Center Tuberculosis Clinic 239 Butler Road Kittanning, PA 16201 724.543.2818 724.543.2700	Counseling, Testing and Referral Services (CTR)	Black Heterosexual White Heterosexual Emerging Risk Group - Homeless
Department of Health Westmoreland County Regional HIV Health Nurse Southwestern PA 233 West Otterman Street Greensburg, PA 15601 (724)-830-2701	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	General Public HIV+ IDU MSM Heterosexual
Armstrong Family Planning 310 Market Street Kittanning, PA 16201 724.543.7035	Counseling, Testing and Referral Services (CTR)	General Public
Irene Stacy Community Mental Health Center 112 Hillvue Drive Butler, PA 16001 724.287.0791	Counseling, Testing and Referral Services (CTR)	Heterosexual
BEAVER COUNTY Population—171,673 (Beaver Falls)		
Adagio Health 468 Franklin Avenue Aliquippa, PA 15001 724.375.8110	Counseling, Testing and Referral Services (CTR), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	General Public Emerging Risk Group – Youth
Aliquippa Family Planning 468 Franklin Avenue Aliquippa, PA 15001	Counseling, Testing and Referral Services (CTR)	Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
724.375.8110		
Aliquippa Hospital	Counseling, Testing and Referral Services (CTR)	Heterosexual
American Red Cross – Beaver/Lawrence County Chapter 133 Friendship Circle Beaver, PA 15009 1.800.999.2566 www.forcomm.net/arcbeaver/	Health Communication/Public Information (HC/PI)	General Public
Beaver County Prison 6000 Woodlawn Road Aliquippa, PA 15001 724.378.8177	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU MSM Heterosexual
Beaver County State Health Center HIV Clinic 300 South Walnut Lane Beaver, PA 15090 412.773.7436	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Beaver County State Health Center STD Clinic 300 South Walnut Lane Beaver, PA 15090 412.773.7436	Counseling, Testing and Referral Services (CTR)	Heterosexual
Beaver County State Health Center Tuberculosis Clinic 300 South Walnut Lane Beaver, PA 15090 412.773.7436	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group - Homeless
Department of Health Westmoreland County Regional HIV Health Nurse Southwestern PA 233 West Otterman Street Greensburg, PA 15601 (724)-830-2701	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	General Public HIV+ IDU MSM Heterosexual
Gateway Rehabilitation	Counseling, Testing and	IDU

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
Center Moffett Run Road Aliquippa, PA 15001 412.766.8700 724.378.4461 www.gatewayrehab.org	Referral Services (CTR), Individual Level Intervention (ILI)	Heterosexual
Life and Liberty 761 Merchant Street PO Box 761 Ambridge, PA 15003 724.266.5951	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	Black IDU Black MSM Black Heterosexual
Open Door Community Outreach Center PO Box 606 Aliquippa, PA 15001 724.378.5489	Counseling, Testing and Referral Services (CTR)	General Public
Pittsburgh AIDS Task Force Penn Office West 905 West Street 4th Floor Pittsburgh, PA 15221 412.242.2500 www.patf.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI) DEBI Interventions: SISTA POL	Black Heterosexual Emerging Risk Groups – Black Youth, Perinatal
BUTLER COUNTY Population—184,694 (Butler)		
Adagio Health 255 Grove City Road Slippery Rock, PA 16057 724.794.2060	Counseling, Testing and Referral Services (CTR)	General Public
Butler County Prison 121 Vogeley Way PO Box 1208 Butler, PA 16003 724.284.5256	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
Butler Family Health Council 165 Brugh Avenue Suite 306 Butler, PA 16001 724.282.2730	Counseling, Testing and Referral Services (CTR)	Heterosexual
Butler Memorial Hospital 216 North Washington Street Butler, PA 16001 724.283.0322 www.butlerhealthsystem.org	Counseling, Testing and Referral Services (CTR)	Heterosexual
Butler/Armstrong AIDS Alliance 112 Hillvue Drive Butler, PA 16001 724.283.3636 800.531.1793	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Group Level Intervention (GLI), Outreach, Health Communication/Public Information (HC/PI)	HIV+ IDU MSM General Public
Department of Health Westmoreland County Regional HIV Health Nurse Southwestern PA 233 West Otterman Street Greensburg, PA 15601 (724)-830-2701	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	General Public HIV+ IDU MSM Heterosexual
Discovery House 326 Thompson Park Drive Cranberry Township, PA 16066 724.779.2012	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU
Family Planning Services of Butler County 323 Sunset Drive Butler, PA 16001 724.282.2730	Counseling, Testing and Referral Services (CTR), Outreach, Health Communication/Public Information (HC/PI)	General Public
Irene Stacy Community Mental Health Center 112 Hillvue Drive Butler, PA 16001	Counseling, Testing and Referral Services (CTR)	IDU MSM Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
724.287.0791		
Sharing of Hope 200 Second Avenue Freedom, PA 15042 724.869.2902 412.634.2024	Outreach	HIV+
Slippery Rock University McLachlin Student Health Center Slippery Rock, PA 16057 724.738.2052 www.sru.edu	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Youth
CAMBRIA COUNTY Population—143,998 (Ebensburg)		
Cambria County Prison 425 Manor Drive Box 595 Ebensburg, PA 15931	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	**Incarcerated** IDU MSM Heterosexual
Cambria County State Health Center /HIV Clinic/Tuberculosis Clinic 184 Donald Lane, Suite #1 Johnstown, PA 15901 (814)-248-3120	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public IDU MSM Heterosexual Emerging Risk Group - Homeless
Christ Centered Community Church 227 Market St (Outreach Bldg.) Johnstown, PA 15901 (814)-535-7532	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	Heterosexual
Conemaugh Health Systems Family Medical Center 1086 Franklin St, Johnstown, PA 15905	Individual Level Intervention (ILI)	HIV+

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
814-		
Community Care Management Conemaugh Hospital, Lee Campus 320 Main Street, Room B111 Johnstown, PA 15901 (814)-534-6732	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI),Outreach, Health Communication/Public Information (HC/PI) Group Level Intervention (GLI)	HIV+ IDU MSM Heterosexual White MSM Emerging Risk Group-Youth
Department of Health Westmoreland County Regional HIV Health Nurse Southwestern PA 233 West Otterman Street Greensburg, PA 15601 (724)-830-2701	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	General Public HIV+ IDU MSM Heterosexual
Planned Parenthood of Western PA 817 Franklin Street Johnstown, PA 15901 (814)-535-5545	Counseling, Testing and Referral Services (CTR), Outreach, Health Communication/Public Information (HC/PI)	Heterosexual
White Deer Run of Western PA 109 Sumner Street, Box 286 Cresson, PA 16630	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	IDU Heterosexual
FAYETTE COUNTY Population—142,605 (Uniontown)		
Adagio Health 22 Mill Street Uniontown, PA 15401 724.437.1582	Counseling, Testing and Referral Services (CTR)	Heterosexual
Albert Gallatin AIDS Program 22 South Main Street Masontown, PA 15461 724.583.7822	Health Communication/Public Information (HC/PI)	HIV+ General Public
Department of Health Westmoreland County	Counseling, Testing and Referral Services (CTR),	General Public HIV+

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
Regional HIV Health Nurse Southwestern PA 233 West Otterman Street Greensburg, PA 15601 (724)-830-2701	Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual
Fayette County State Health Center HIV Clinic 100 New Salem Road Uniontown, PA 15401 412.439.7400	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Fayette County State Health Center STD Clinic 100 New Salem Road Uniontown, PA 15401 412.439.7400	Counseling, Testing and Referral Services (CTR)	Heterosexual
Fayette County State Health Center Tuberculosis Clinic 100 New Salem Road Uniontown, PA 15401 412.439.7400	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group – Homeless
Highlands Hospital 401 East Murphy Avenue Connellsville, PA 15425 724.628.1500	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	General Public
GREENE COUNTY Population—39,245 (Waynesburg)		
Department of Health Westmoreland County Regional HIV Health Nurse Southwestern PA 233 West Otterman Street Greensburg, PA 15601 (724)-830-2701	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	General Public HIV+ IDU MSM Heterosexual
Greene County AIDS Task Force Greene County Memorial Hospital Bonar and 7th Streets	Health Communication/Public Information	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
Waynesburg, PA 15370 724.627.3101		
Greene County State Health Center HIV Clinic 423 East Oak View Drive Waynesburg, PA 15370 724.627.3168	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Greene County State Health Center STD Clinic 423 East Oak View Drive Waynesburg, PA 15370 724.627.3168	Counseling, Testing and Referral Services (CTR)	Heterosexual
Greene County State Health Center Tuberculosis Clinic 423 East Oak View Drive Waynesburg, PA 15370 724.627.3168	Counseling, Testing and Referral Services (CTR)	Heterosexual Emerging Risk Group - Homeless
INDIANA COUNTY Population—87,450 (Indiana)		
Community Care Management Conemaugh Hospital Lee Campus 320 Main Street, Room B111 Johnstown, PA 15901 814-534-6732	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI),Outreach, Health Communication/Public Information (HC/PI) Group Level Intervention (GLI)	HIV+ HIV+ IDU MSM Heterosexual Emerging Risk Group-Youth
Conemaugh Health Systems Family Medical Center 1086 Franklin St, Johnstown, PA 15905	Individual Level Intervention (ILI)	HIV+
Department of Health Westmoreland County Regional HIV Health Nurse Southwestern PA 233 West Otterman Street Greensburg, PA 15601 (724)-830-2701	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	General Public HIV+ HIV+ IDU MSM Heterosexual
Indiana County Prison	Counseling, Testing and	**Incarcerated**

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
55 North 9th Street Indiana, PA 15701 412.349.2225	Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	HIV+ IDU MSM Heterosexual
Indiana County State Health Center HIV Clinic/STD Clinic/Tuberculosis Clinic 75 North 2nd Street Indiana, PA 15701 724.357.2995	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public Heterosexual Emerging Risk Group - Homeless
Adagio Health 1097 Oak Street Indiana, PA 15701 724.349.2022	Counseling, Testing and Referral Services (CTR)	Heterosexual
SOMERSET COUNTY Population—76,953 (Somerset)		
Conemaugh Health Systems Family Medical Center 1086 Franklin St, Johnstown, PA 15905 814-	Individual Level Intervention (ILI)	HIV+
Community Care Management Conemaugh Hospital, Lee Campus 320 Main Street, Room B111 Johnstown, PA 15901 (814)-534-6732	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI),Outreach, Health Communication/Public Information (HC/PI) Group Level Intervention (GLI)	HIV+ IDU MSM Heterosexual Emerging Risk Group-Youth
Somerset County Prison 127 East Fairview Street Somerset, PA 15501 814.443.3679	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention(ILI), Outreach, Health Communication/Public Information (HC/PI)	IDU MSM Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
Somerset County State Health Center HIV Clinic 651 South Center Avenue Somerset, PA 15501 814.445.7981	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Somerset County State Health Center Tuberculosis Clinic 651 South Center Avenue Somerset, PA 15501 814.445.7981	Counseling, Testing and Referral Services (CTR)	IDU MSM Heterosexual Emerging Risk Group - Homeless
Department of Health Westmoreland County Regional HIV Health Nurse Southwestern PA 233 West Otterman Street Greensburg, PA 15601 (724)-830-2701	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	General Public HIV+ IDU MSM Heterosexual
Somerset Planned Parenthood 118 South Kimberly Ave Somerset, PA 15501 814.443.6549	Counseling, Testing and Referral Services (CTR)	General Public Heterosexual
Windber Medical Center 600 Somerset Avenue Windber, PA 15963 814.467.6611 windbercare.com	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	General Public
WASHINGTON COUNTY Population—207,384 (Washington)		
Adagio Health 75 East Maiden Street Washington, PA 15301 724.228.7113	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
California University of	Counseling, Testing and	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
Pennsylvania 250 University Avenue California, PA 15419	Referral Services (CTR)	
Department of Health Westmoreland County Regional HIV Health Nurse Southwestern PA 233 West Otterman Street Greensburg, PA 15601 (724)-830-2701	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	General Public HIV+ IDU MSM Heterosexual
Planned Parenthood of Western PA 817 Franklin Street Johnstown, PA 15901 814.535.5545 www.ppwp.org	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Washington County Prison 29 West Cherry Avenue Washington, PA 15301 724.228.6845	Counseling, Testing and Referral Services (CTR), Partner Services (PS)	IDU MSM Heterosexual
Washington County State Health Center 167 North Main Street Suite 100 Washington, PA 15301 724.223.4540	Counseling, Testing and Referral Services (CTR), Partner Services (PS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI) HIV/STD Clinics Tuberculosis Clinic	General Public
WESTMORELAND COUNTY Population—362,251 (Greensburg)		
Adagio Health 3058 Leechburg Road Lower Burrell, PA 15068 724.337.3400	Counseling, Testing and Referral Services (CTR)	General Public
Community Health Clinic 422 Ninth Street New Kensington, PA 15068 724.335.3335	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	Black Heterosexual Hispanic Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
Conemaugh Health Systems Family Medical Center 1086 Franklin St, Johnstown, PA 15905 814-	Individual Level Intervention (ILI)	HIV+
Community Care Management Conemaugh Hospital, Lee Campus 320 Main Street, Room B111 Johnstown, PA 15901 (814)-534-6732	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI),Outreach, Health Communication/Public Information (HC/PI) Group Level Intervention (GLI)	HIV+ IDU MSM Heterosexual Emerging Risk Group-Youth
Comprehensive Substance Abuse Services 211 Huff Avenue Suite C Greensburg, PA 15601 724.853.8623	Counseling, Testing and Referral Services (CTR)	General Public
Department of Health Westmoreland County Regional HIV Health Nurse Southwestern PA 233 West Otterman Street Greensburg, PA 15601 724.830.2701	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI), Health Communication/Public Information (HC/PI)	General Public HIV+ IDU MSM Heterosexual
Mon Valley AIDS Task Force PO Box 416 Monessen, PA 15062 724.258.1270 724.258.2193 724.644.4436	Health Communication/Public Information (HC/PI)	HIV+ General Public
Southwest Behavioral Health Services Mon Valley Community Health Center Eastgate 8	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI)	Black IDU Hispanic IDU White IDU Black Heterosexual Hispanic Heterosexual

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
Monessen, PA 15062 724.682.9000 Alle-Kiski 2120 Freeport Road New Kensington, PA 15068 724.339.6860		White Heterosexual
Southwest Secure Treatment Unit State Route 1014 PO Box 94 Torrance, PA 15779 412.459.1100	Counseling, Testing and Referral Services (CTR)	General Public
Westmoreland County State Health Center HIV Clinic – Greensburg 233 West Otterman Street Greensburg, PA 15601 724.832.5315	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI)	General Public
Westmoreland County State Health Center, Monessen Eastgate #8, Room 140 Monessen, PA 15062 724.684.2945	Counseling, Testing and Referral Services (CTR), Partner Counseling and Referral Services (PCRS), Individual Level Intervention (ILI), Outreach, Health Communication/Public Information (HC/PI) **HIV Clinic** **STD Clinic** **Tuberculosis Clinic**	General Public
Westmoreland County State Health Center STD Clinic – Greensburg 120 Harrison Avenue Greensburg, PA 15601 724.832.5315	Counseling, Testing and Referral Services (CTR) **STD Clinic** **Tuberculosis Clinic**	Heterosexual
Westmoreland Regional Hospital 532 East Pittsburgh Street Greensburg, PA 15601 724.832.4000	Counseling, Testing and Referral Services (CTR), Individual Level Intervention (ILI), Health Communication/Public	General Public

PROVIDER	PREVENTION SERVICES	TARGET POPULATION(S)
	Information (HC/PI)	
Westmoreland Women's Health Center 626 North Main Street Greensburg, PA 15601 724.838.0980	Counseling, Testing and Referral Services (CTR)	General Public

4.12. Gap Analysis

The Intervention Subcommittee is exploring new technology to conduct gap analysis. *Geo Mapping* will provide geographical information on populations receiving HIV prevention interventions in Pennsylvania. The data generated will demonstrate HIV/AIDS cases by county to be compared to interventions by county.
Limitations:

- Every PA DOH funded agency reports their prevention intervention data, however, data for agencies not funded by PA DOH is not included. As the geo mapping technology is based on PaUDS data, the services delivered by those agencies not funded by the PA DOH may not be captured within the geo mapping process.
- Prevention services are often not delivered in the same area as HIV care services are received. This may result in what appears to be underserved areas.

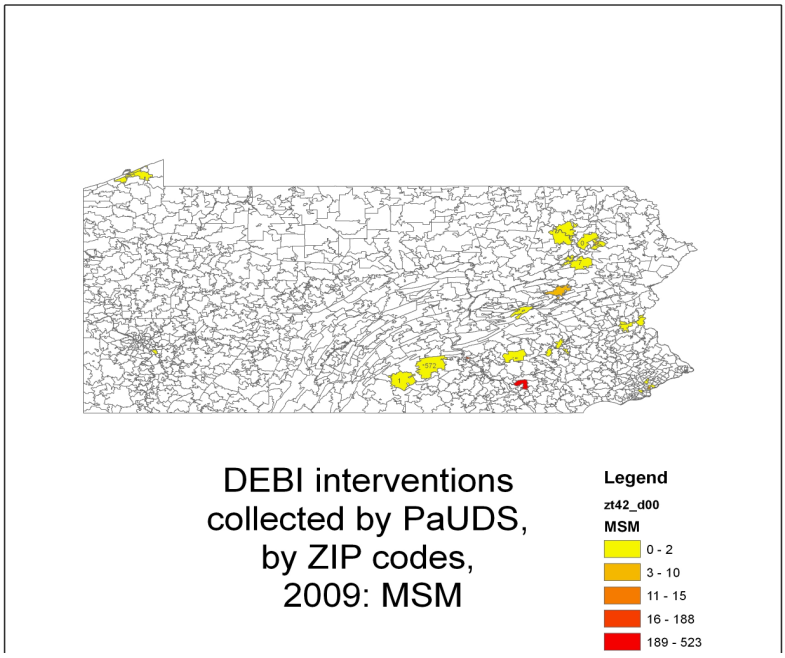

Figure 4.2 – Sample Geo Map showing number of evidenced-based interventions for MSM being conducted by zip code in 2009

5. Interventions—Appropriate Science-Based Prevention Activities

Table 5.1 Intervention Abbreviations

Intervention	Abbreviation
Counseling, Testing and Referral	CTR
Partner Services	PS
Interventions Delivered to Individuals	IDI
Interventions Delivered to Groups	IDG
Outreach	OR
Comprehensive Risk Counseling and Services	CRCS
Health Education/Risk Reduction	HE/RR
Community Level Interventions	CLI
Health Communication/Public Information	HC/PI

5.1. Interventions for Identifying Persons with Undiagnosed HIV

The PA Department of Health currently funds at least one strategy for reaching and providing CTR to persons with undiagnosed HIV infection: Social Networks Strategy (SNS). ***The primary goal of a program using a social network strategy is to identify persons with undiagnosed HIV infection within various networks and link them to medical care and prevention services.*** SNS enlists newly and previously diagnosed HIV-positive and high-risk HIV-negative *recruiters* on an ongoing basis to encourage people in their network (i.e., *network associates*) to be tested for HIV. This type of strategy facilitates expansion and penetration of testing within high-risk networks. SNS is a programmatic, peer-driven, recruitment strategy to reach the highest risk persons who may be infected but unaware of their status. Although similar in some ways, SNS is not partner services, partner notification, outreach, or health education/risk reduction and it is not intended to replace these services.

5.2. Behavioral Interventions

Evidence-based interventions (EBI) include, but are not limited to, interventions disseminated by the Diffusion of Effective Behavioral Interventions (DEBI) Project. The *DEBI Project* was designed to bring science-based HIV prevention interventions targeting individuals, groups and communities to community-based service providers and state and local health departments.

The DEBI Project is a Center for Disease Control and Prevention (CDC) initiative that conducted with the assistance of the Academy for Educational Development (AED). The goal is to enhance the capacity to implement effective interventions at the state and local levels, to reduce the spread of HIV and STDs, and to promote healthy behaviors.
The DEBI Project is meant to bridge the gap between research and practice. Under the project, high quality trainings, materials and technical assistance are provided to

community-based organizations and local health departments implementing the interventions.

In-depth descriptions, fact sheets, sample budgets and procedural guidance information regarding the DEBI Project can be found at www.effectiveinterventions.org
Also, the HIV/AIDS Prevention Research Synthesis (PRS) Project was initiated by the Prevention Research Branch, Division of HIV/AIDS Prevention (DHAP) at CDC in 1996 to systematically review and summarize HIV behavioral prevention research literature. The "2009 Compendium of Evidence-Based HIV Prevention Interventions" includes 69 evidence-based HIV behavioral interventions identified from the scientific literature published through June 2009. The Compendium can be accessed at http://www.cdc.gov/hiv/topics/research/prs/evidence-based-interventions.htm.

5.3. Tiers of Evidence: A Framework for Classifying HIV Behavioral Interventions

The CDC has developed a tiered framework for classifying HIV behavioral interventions based on their level of scientific evidence in reducing HIV risk. The framework identifies those interventions with the greatest chances of working in practice. The interventions with the strongest evidence are highlighted in the *Updated Compendium of Evidence-Based Interventions.*

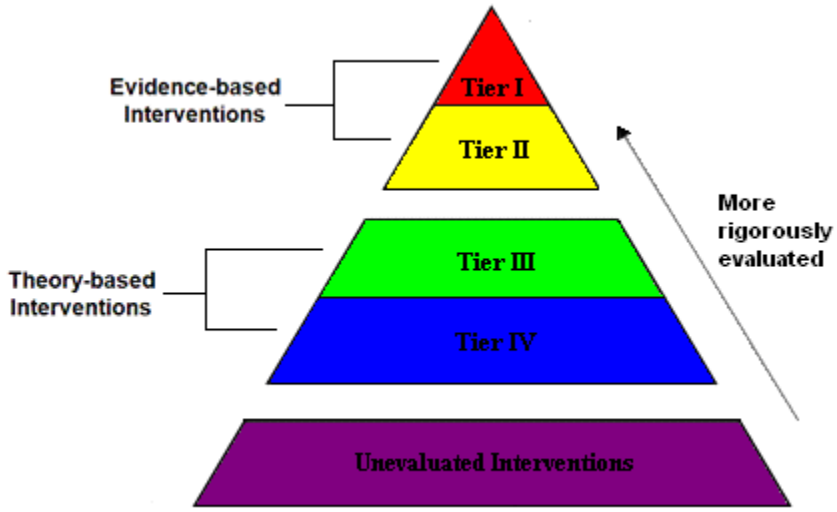

Figure 5.1 Tiers of Evidence

Currently, the PA Department of Health funds *any Evidence-based Intervention* within the framework, i.e. Tier I and Tier II interventions, including DEBI Project interventions.

5.4. Fidelity and Adaptation of Evidenced-based Interventions

The Pennsylvania Department of Health has clearly outlined rules for fidelity and adaptation in the "Policy Guidance on the Implementation of Evidence-Based HIV Prevention Interventions, Priority Populations and Incentives" document (9August2010).

As per the PA Department of Health *fidelity and adaptation* are defined as:

- **Fidelity** is conducting an intervention by exactly following the core elements, procedures, and content that determined its effectiveness.
- **Adaptation** is the change(s) to the ***Who (target population) and Where*** in the original intervention.

The *core elements* are those aspects of the intervention that the researchers believed made the difference within the target populations. Therefore, in order to assert that the intervention is effective, it is imperative that core elements not be altered.
When the core elements of an intervention are dropped or added, reinvention has occurred.

An agency should feel encouraged to adapt an intervention to reach populations, settings and risk behaviors for which there is not an appropriate EBI/DEBI to fill in the gap. However, the adaptation process needs to be evidence-based, that is, based on real information collected by the agency to help in the adaptation process. If an agency wants to change the target population of an intervention, the agency must *extensively* document:

- Any adaptation(s) and the justifications for the adaptation(s)
- The evidence-based process for the adaptation(s), including focus groups and piloting of activities.

5.5. Nuances of Evidenced-based Interventions

Effective implementation of any intervention depends on the capacity of the agency implementing the intervention. ***Minimal agency capacity building should strive for the following:***

- Systematic identification and selection of target population[1], e.g. Black MSM, based on the HIV epidemiological profile of a target region.
  - Knowledge and use of the "Integrated Epidemiologic Profile of HIV/AIDS in Pennsylvania" is recommended.
- Administrative and staff attendance at the following trainings:
  - The DEBI Project: An Overview
  - Selecting Evidenced-Based Interventions
  - Adaptation
- Selection of evidence-based intervention (EBI) that best meets the needs of the target population as well as the capacity of the agency.
- Agency capacity awareness (does the agency have the resources to implement *and maintain* the selected intervention for the specific target population).
- Training of facilitators' (TOF) course in the specific EBI intervention, e.g. Street Smart.

Once the target population is identified as well as the appropriate EBI for that population, it is recommended that **the budget be meticulously itemized**. It may cost an agency up

[1] Target population selection should be based on epidemiological data (see "Integrated Epidemiologic Profile of HIV/AIDS in Pennsylvania"; population accessibility; agency experience and expertise in delivering interventions; and agency credibility within the community.

to $100,000 per year to implement an evidenced-based intervention with fidelity. This cost can be impacted by current agency staffing; by the EBI selected and by the established community network and resources. There are several factors that need to be taken in consideration as they pertain to the cost per intervention:

1. The agency should have the capacity to maintain the intervention beyond the length of the funding stream
2. Number of program staff dedicated to intervention implementation (including salary and fringe benefits)
    - Facilitator skill-set may minimally require a foundational course in HIV/AIDS 101 to a Master's level education, possessing counseling skills. Also, knowledge of drug and alcohol issues, cultural sensitivity, group processes and motivational interviewing will enhance intervention facilitation.
    - Account for staff turnover – intervention training for more than primary facilitator(s).
3. Each budget should include a travel line as staff will need to attend the trainings, updates and conferences for the selected intervention.
    - While the PA Department of Health builds EBI capacity, trainings for interventions, updates and conferences may involve out-of-state travel. Therefore, travel and lodging expenses needed to attend the required training(s) need to be itemized.
    - In-state travel to location(s) where intervention session(s) are conducted
4. Program incentives – a crucial component of many of the EBI interventions. The CDC and PA Department of Health do permit the use of federal and state funds for the purchase *of incentives* – ***cash incentives are prohibited***.
5. Program supplies, e.g. cost of the implementation kit, handouts, etc.

5.6. Participant Retention Issues

Participant retention issues should be anticipated, therefore, it is recommended that an agency have a plan to assess participant retention issues for their specific target populations. One method is to network with other agencies to understand how they may have overcome retention issues within the same target population. Also, agencies might survey their target population to assess the reasons behind decreased attendance, e.g. lack of childcare, transportation, legal issues, etc. Understanding deeper or unrecognized issues could allow agencies to restructure incentives to meet participant needs. One example might be to reduce payments minimally and to provide bus tokens for transportation.

5.7. DEBI Project Interventions (Revised 7/2010)

1. **CLEAR** (Choosing Life: Empowerment! Action! Results!)
2. **Connect**
3. **Community PROMISE** (Peers Reaching Out and Modeling Intervention Strategies)
4. **d-up Defend Yourself!**
5. **Focus on Youth** (FOY)

6. **Healthy Relationships**
7. **The Holistic Health Recovery Program** (HHRP)
8. **Many Men, Many Voices** (3MV)
9. **MIP** (Modelo de Intervención Psychomédica) Psycho-Medical Intervention Model (PIM)
10. **MPowerment**
11. **Nia**
12. **Partnership for Health** (PfH)
13. **Popular Opinion Leader** (POL)
14. **Project START**
15. **Real AIDS Prevention Project** (RAPP)
16. **RESPECT**
17. **Safe in the City** (SITC)
18. **Safety Counts**
19. **SHIELD** (Self-Help in Eliminating Life-threatening Diseases)
20. **SIHLE** (Sisters Informing Healing Living and Empowering)
21. **SISTA** (Sisters Informing Sisters on Topics about AIDS)
22. **Sister to Sister**
23. **Street Smart**
24. **Together Learning Choices** (TLC)
25. **VOICES/*VOCES*** (Video Opportunities for Innovative Condom Education & Safer Sex)

WILLOW (Women Involved in Life Learning from Other Women)

5.8 DEBI Intervention Grids

Table 5.2 Health Education/Risk Reduction (HE/RR) Interventions for Persons with HIV

HIV Positive ***Ranked Population Target Group***	CLEAR	Community PROMISE	Healthy Relationships	Holistic Health Recovery Program (HHRP)	MPowerment	Partnership for Health (PfH)	Safe In The City (SITC)	Safety Counts	SHIELD (Self-Help in Eliminating Life-threatening Diseases)	Together Learning Choices (TLC)	VOICES/*VOCES*	WILLOW (Women Involved in Life Learning from Other Women)
1. White MSM	**X**	**X**	**X**		**X**	**X**	**X**					
2. Black IDU	**X**	**X**	**X**	**X**		**X**	**X**	**X**	**X**			
3. Black MSM/IDU	**X**	**X**	**X**	**X**		**X**	**X**		**X**			
4. White MSM/IDU	**X**	**X**	**X**	**X**		**X**	**X**		**X**			
5. Black Heterosexual	**X**	**X**	**X**			**X**	**X**				**X**	**X**
6. White IDU	**X**	**X**	**X**	**X**		**X**	**X**	**X**	**X**			
7. White Heterosexual	**X**	**X**	**X**			**X**	**X**					**X**
8. Hispanic IDU	**X**	**X**	**X**	**X**		**X**	**X**	**X**	**X**			
9. Black MSM	**X**	**X**	**X**		**X**	**X**	**X**					

10. Hispanic Heterosexual	**X**	**X**	**X**			**X**	**X**				**X**	**X**
11. Hispanic MSM/IDU	**X**	**X**	**X**	**X**		**X**	**X**		**X**			
12. Hispanic MSM	**X**	**X**	**X**		**X**	**X**	**X**					
13. Perinatal Transmission		**X**	**X**			**X**	**X**					
14. Emerging Risk Groups												
Youth	**X**	**X**	**X**		**X**	**X**	**X**			**X**		
Transgender		**X**	**X**			**X**	**X**					
Homeless		**X**	**X**			**X**	**X**					
Asian Pacific Islander		**X**	**X**			**X**	**X**					

Health Education/Risk Reduction (HE/RR) Interventions for Persons who are HIV Negative

HIV Negative ***Ranked Population Target Group***	CLEAR	Community PROMISE	Connect	d-up: Defend Yourself!	Focus on Youth (FOY)	Holistic Health Recovery Program (HHRP)	Many Men, Many Voices (3MV)	MIP (Modelo de Intervención Psychomédica)	MPowerment	Nia	Popular Opinion Leader	Real AIDS Prevention Project (RAPP)	Project START	RESPECT	Safe In The City (SITC)	Safety Counts	SHIELD (Self-Help in Eliminating Life-threatening Diseases)	SIHLE	SISTA Project	Sister to Sister	Street Smart	VOICES/*VOCES*
1. White MSM	X	X							X		X		X	X	X							
2. Black IDU	X	X				X		X			X		X	X	X	X	X					
3. Black MSM/IDU	X	X				X					X		X	X	X	X	X					
4. White MSM/IDU	X	X				X					X		X	X	X	X	X					
5. Black Heterosexual	X	X	X							X	X	X	X	X	X			X	X			X
6. White IDU	X	X				X		X			X		X	X	X	X	X					
7. White Heterosexual	X	X	X								X	X	X	X	X							
8. Hispanic IDU	X	X				X		X			X		X	X	X	X	X					
9. Black MSM	X	X		X			X		X		X		X	X	X							
10. Hispanic Heterosexual	X	X	X								X	X	X	X	X							X
11. Hispanic MSM/IDU	X	X				X					X		X	X	X	X	X					
12. Hispanic MSM	X	X							X		X		X	X	X							
13. Perinatal Transmission		X									X	X	X	X	X							
14. Emerging Risk Groups																						
Youth	X	X			X				X		X	X	X	X	X			X			X	
Transgender		X									X		X	X	X							
Homeless		X									X		X	X	X						X	
Asian Pacific Islander		X									X		X	X	X							

CLEAR

CLEAR (Choosing Life: Empowerment! Action! Results!) is an **individual level** health promotion intervention for males and females ages 16 and older living with HIV/AIDS and high-risk HIV-negative individuals. CLEAR is a client-centered program delivered using cognitive behavioral techniques to change behavior. The intervention provides clients with the skills necessary to be able to make healthy choices for their lives. The CDC's guidelines on Comprehensive Risk Counseling and Services (CRCS) identify CLEAR as a structured intervention that may be integrated into CRCS programs.

HIV Positive								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
1. White MSM			**X**					
2. Black IDU			**X**					
3. Black MSM/IDU			**X**					
4. White MSM/IDU			**X**					
5. Black Heterosexual			**X**					
6. White IDU			**X**					
7. White Heterosexual			**X**					
8. Hispanic IDU			**X**					
9. Black MSM			**X**					
10. Hispanic Heterosexual			**X**					
11. Hispanic MSM/IDU			**X**					
12. Hispanic MSM			**X**					
13. Perinatal Transmission								
14. Emerging Risk Groups								
Youth			**X**					
Transgender								
Homeless								
Asian Pacific Islander								

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
White MSM			**X**					
Black IDU			**X**					
Black MSM/IDU			**X**					
White MSM/IDU			**X**					
Black Heterosexual			**X**					
White IDU			**X**					
White Heterosexual			**X**					
Hispanic IDU			**X**					
Black MSM			**X**					
Hispanic Heterosexual			**X**					
Hispanic MSM/IDU			**X**					
Hispanic MSM			**X**					
Perinatal Transmission								
Emerging Risk Groups								
Youth			**X**					
Transgender								
Homeless								
Asian Pacific Islander								

Connect

Connect is a **six session,** relationship-based intervention that teaches couples techniques and skills to enhance the quality of their relationship, communication, and shared commitment to safer behaviors. The program is based on the AIDS Risk Reduction Model, which organizes behavior change into three phases-recognizes risk, commit to change, and act on strategies-and on the Ecological Perspective which emphasizes the personal, relational, and societal influences on behavior. Connect integrates techniques commonly used in family therapy, which will allow couples to work together to solve shared problems. This **couple-level intervention** for heterosexual couples targets women or men, 18 and over and their main sexual partners.

HIV Positive								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
1. White MSM								
2. Black IDU								
3. Black MSM/IDU								
4. White MSM/IDU								
5. Black Heterosexual				**X**				
6. White IDU								
7. White Heterosexual				**X**				
8. Hispanic IDU								
9. Black MSM								
10. Hispanic Heterosexual				**X**				
11. Hispanic MSM/IDU								
12. Hispanic MSM								
13. Perinatal Transmission								
14. Emerging Risk Groups								
Youth								
Transgender								
Homeless								
Asian Pacific Islander								

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
White MSM								
Black IDU								
Black MSM/IDU								
White MSM/IDU								
Black Heterosexual				**X**				
White IDU								
White Heterosexual				**X**				
Hispanic IDU								
Black MSM								
Hispanic Heterosexual				**X**				
Hispanic MSM/IDU								
Hispanic MSM								
Perinatal Transmission								
Emerging Risk Groups								
Youth								
Transgender								
Homeless								
Asian Pacific Islander								

Community PROMISE

Community PROMISE (Peers Reaching Out and Modeling Intervention Strategies) is a **community-level**, HIV/STD prevention intervention that relies on role model stories and peer advocates from the community. Members of the target population who have made positive HIV/STD behavior change are interviewed and role models stories are written based upon the interviews. Peers advocates from the target populations are recruited and trained to distribute the role model stories and prevention materials within their social networks to help people move toward safer sex or risk reduction practices. Community PROMISE **can serve any population**.

HIV Positive								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
1. White MSM								**X**
2. Black IDU								**X**
3. Black MSM/IDU								**X**
4. White MSM/IDU								**X**
5. Black Heterosexual								**X**
6. White IDU								**X**
7. White Heterosexual								**X**
8. Hispanic IDU								**X**
9. Black MSM								**X**
10. Hispanic Heterosexual								**X**
11. Hispanic MSM/IDU								**X**
12. Hispanic MSM								**X**
13. Perinatal Transmission								**X**
14. Emerging Risk Groups								**X**
Youth								**X**
Transgender								**X**
Homeless								**X**
Asian Pacific Islander								**X**

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
White MSM								**X**
Black IDU								**X**
Black MSM/IDU								**X**
White MSM/IDU								**X**
Black Heterosexual								**X**
White IDU								**X**
White Heterosexual								**X**
Hispanic IDU								**X**
Black MSM								**X**
Hispanic Heterosexual								**X**
Hispanic MSM/IDU								**X**
Hispanic MSM								**X**
Perinatal Transmission								**X**
Emerging Risk Groups								**X**
Youth								**X**
Transgender								**X**
Homeless								**X**
Asian Pacific Islander								**X**

d-up: Defend Yourself!

d-up: Defend Yourself! is a **community-level** intervention designed for and developed by **Black men who have sex with men (MSM)**. d-up! is a cultural adaptation of the POL intervention and is designed to promote social norms of condom use and assist Black MSM to recognize and handle risk related racial and sexual bias. d-up! finds and enlists opinion leaders whose advice is respected and trusted by their peers. These opinion leaders are trained to change risky sexual norms in their own social networks. Opinion leaders participate in a four session training and endorse condom use in conversations with their friends and acquaintances.

HIV Positive								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
1. White MSM								
2. Black IDU								
3. Black MSM/IDU								
4. White MSM/IDU								
5. Black Heterosexual								
6. White IDU								
7. White Heterosexual								
8. Hispanic IDU								
9. Black MSM								**X**
10. Hispanic Heterosexual								
11. Hispanic MSM/IDU								
12. Hispanic MSM								
13. Perinatal Transmission								
14. Emerging Risk Groups								
Youth								
Transgender								
Homeless								
Asian Pacific Islander								

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
White MSM								
Black IDU								
Black MSM/IDU								
White MSM/IDU								
Black Heterosexual								
White IDU								
White Heterosexual								
Hispanic IDU								
Black MSM								**X**
Hispanic Heterosexual								
Hispanic MSM/IDU								
Hispanic MSM								
Perinatal Transmission								
Emerging Risk Groups								
Youth								
Transgender								
Homeless								
Asian Pacific Islander								

Focus on Youth (FOY)

Focus on Youth (FOY) is a community-based, **8 session** group intervention that provides youth with the skills and knowledge they need to protect themselves from HIV and other STDs. The curriculum, founded on the Protection Motivation Theory, uses fun, interactive activities such as games, role plays and discussions to convey prevention knowledge and skills. FOY targets **African American youth, ages 12-15**. **There is also a short component for parents, Informed Parents and Children Together (ImPACT), that assists them in areas such as parental monitoring and effective communication.**

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IGI	OR	CRCS	HC/PI	Other (CLI)
1. White MSM								
2. Black IDU								
3. Black MSM/IDU								
4. White MSM/IDU								
5. Black Heterosexual								
6. White IDU								
7. White Heterosexual								
8. Hispanic IDU								
9. Black MSM								
10. Hispanic Heterosexual								
11. Hispanic MSM/IDU								
12. Hispanic MSM								
13. Perinatal Transmission								
14. Emerging Risk Groups								
Youth				**X**				
Transgender								
Homeless								
Asian Pacific Islander								

Healthy Relationships

Healthy Relationships is a **five session**, small-group intervention for **men and women living with HIV/AIDS**. It is based on Social Cognitive Theory and focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills. Decision-making and problem-solving skills are developed to enable participants to make informed and safe decisions about disclosure and behavior.

HIV Positive								
Ranked Population Target Group	CTR	PS	IDI	IGI	OR	CRCS	HC/PI	Other (CLI)
1. White MSM				**X**				
2. Black IDU				**X**				
3. Black MSM/IDU				**X**				
4. White MSM/IDU				**X**				
5. Black Heterosexual				**X**				
6. White IDU				**X**				
7. White Heterosexual				**X**				
8. Hispanic IDU				**X**				
9. Black MSM				**X**				
10. Hispanic Heterosexual				**X**				
11. Hispanic MSM/IDU				**X**				
12. Hispanic MSM				**X**				
13. Perinatal Transmission				**X**				
14. Emerging Risk Groups				**X**				
Youth				**X**				
Transgender				**X**				
Homeless				**X**				
Asian Pacific Islander				**X**				

Holistic Health Recovery Program (HHRP)

The Holistic Health Recovery Program (HHRP) is a **12 session**, manual-guided, **group-level** program for **HIV-positive and HIV negative injection drug users**. The primary goals of HHRP are health promotion and improved quality of life. More specific goals are abstinence from illicit drug use or from sexual risk behaviors; reduced drug use; reduced risk for HIV transmission; and improved medical, psychological, and social functioning. In HHRP, there are three steps to changing behavior: Providing HIV prevention information, motivation to engage in HIV prevention and opportunities to practice behavior skills for HIV prevention.

HIV Positive								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
1. White MSM								
2. Black IDU				**X**				
3. Black MSM/IDU				**X**				
4. White MSM/IDU				**X**				
5. Black Heterosexual								
6. White IDU				**X**				
7. White Heterosexual								
8. Hispanic IDU				**X**				
9. Black MSM								
10. Hispanic Heterosexual								
11. Hispanic MSM/IDU				**X**				
12. Hispanic MSM								
13. Perinatal Transmission								
14. Emerging Risk Groups								
Youth								
Transgender								
Homeless								
Asian Pacific Islander								

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
White MSM								
Black IDU				**X**				
Black MSM/IDU				**X**				
White MSM/IDU				**X**				
Black Heterosexual								
White IDU				**X**				
White Heterosexual								
Hispanic IDU				**X**				
Black MSM								
Hispanic Heterosexual								
Hispanic MSM/IDU				**X**				
Hispanic MSM								
Perinatal Transmission								
Emerging Risk Groups								
Youth								
Transgender								
Homeless								
Asian Pacific Islander								

Many Men, Many Voices (3MV)

Many Men, Many Voices (3MV) is a **seven session**, group-level intervention program to prevent HIV and sexually transmitted diseases among **African American men who have sex with men** (MSM) who may or may not identify themselves as gay. The intervention addresses factors that influence the behavior of Black MSM: cultural, social, and religious norms; interactions between HIV and other sexually transmitted diseases; sexual relationship dynamics; and the social influences that racism and homophobia have on HIV risk behaviors. 3MV is designed to be facilitated by a peer in groups of 6-12 clients.

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IGI	OR	CRCS	HC/PI	Other (CLI)
1. White MSM								
2. Black IDU								
3. Black MSM/IDU								
4. White MSM/IDU								
5. Black Heterosexual								
6. White IDU								
7. White Heterosexual								
8. Hispanic IDU								
9. Black MSM				**X**				
10. Hispanic Heterosexual								
11. Hispanic MSM/IDU								
12. Hispanic MSM				**X**				
13. Perinatal Transmission								
14. Emerging Risk Groups								
Youth								
Transgender								
Homeless								
Asian Pacific Islander								

MIP (Modelo de Intervención Psychomédica)

A Psycho-Medical Intervention Model (PIM), **MIP** is a holistic behavioral intervention for reducing high-risk behaviors for infection and transmission of HIV among **injection drug users (IDUs)**. The intervention is theory-driven and intensive, combining individualized counseling and comprehensive case management **over a 3-6-month period**. The strategies of motivational counseling, self efficacy, and role induction are used. The target population is **injection-drug users who are 18 years of age** and older recruited from the community; however the program can be adapted for other drug users, including IDUs in methadone treatment for the past year.

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IGI	OR	CRCS	HC/PI	Other (CLI)
1. White MSM								
2. Black IDU			**X**					
3. Black MSM/IDU								
4. White MSM/IDU								
5. Black Heterosexual								
6. White IDU			**X**					
7. White Heterosexual								
8. Hispanic IDU			**X**					
9. Black MSM								
10. Hispanic Heterosexual								
11. Hispanic MSM/IDU								
12. Hispanic MSM								
13. Perinatal Transmission								
14. Emerging Risk Groups								
Youth								
Transgender								
Homeless								
Asian Pacific Islander								

MPowerment

MPowerment is a **community-level intervention** designed for young **gay and bisexual men, ages 18-29**. MPowerment uses a combination of informal and formal outreach, discussion groups, creation of safe spaces, social opportunities, and social marketing to reach a broad range of young gay men with HIV prevention, safer sex, and risk reduction messages. The intervention is run by a core group of 10-15 young gay men from the community and paid staff. M-groups are peer-led, 2-3 hour meetings of 8-10 young gay men to discuss factors contributing to unsafe sex among the men.

HIV Positive								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
1. White MSM				**X**	**X**			**X**
2. Black IDU								
3. Black MSM/IDU								
4. White MSM/IDU								
5. Black Heterosexual								
6. White IDU								
7. White Heterosexual								
8. Hispanic IDU								
9. Black MSM				**X**	**X**			**X**
10. Hispanic Heterosexual								
11. Hispanic MSM/IDU								
12. Hispanic MSM				**X**	**X**			**X**
13. Perinatal Transmission								
14. Emerging Risk Groups								
Youth				**X**	**X**			**X**
Transgender								
Homeless								
Asian Pacific Islander								

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
White MSM				**X**	**X**			**X**
Black IDU								
Black MSM/IDU								
White MSM/IDU								
Black Heterosexual								
White IDU								
White Heterosexual								
Hispanic IDU								
Black MSM				**X**	**X**			**X**
Hispanic Heterosexual								
Hispanic MSM/IDU								
Hispanic MSM				**X**	**X**			**X**
Perinatal Transmission								
Emerging Risk Groups								
Youth				**X**	**X**			**X**
Transgender								
Homeless								
Asian Pacific Islander								

Nia

Nia is a six hour, two to four session, video-based, small group level intervention. The goals of this intervention are to educate African American men about HIV/AIDS and its effect on their community, bring groups of men together, increase motivation to reduce risks, and help men learn new skills to protect themselves and others by promoting condom use and increasing intentions to use condoms. Nia is based on the Information-Motivational-Behavioral Skills (IMB). The IMB model assumes that people need information, motivation, and behavioral skills to adopt preventive behaviors. The target population for Nia is African American men (ages 18 and over) who have sex with women.

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IGI	OR	CRCS	HC/PI	Other (CLI)
1. White MSM								
2. Black IDU			**X**					
3. Black MSM/IDU								
4. White MSM/IDU								
5. Black Heterosexual								
6. White IDU			**X**					
7. White Heterosexual								
8. Hispanic IDU			**X**					
9. Black MSM								
10. Hispanic Heterosexual								
11. Hispanic MSM/IDU								
12. Hispanic MSM								
13. Perinatal Transmission								
14. Emerging Risk Groups								
Youth								
Transgender								
Homeless								
Asian Pacific Islander								

Partnership for Health (PfH)

Partnership for Health (PfH) is a **brief** safer sex intervention in HIV clinics that targets **HIV-positive patients**. Partnership for Health uses message framing, repetition, and reinforcement during patient visits to increase HIV positive patients' knowledge, skills, and motivations to practice safer sex. The program is designed to improve patient-provider communication about safer sex, disclosure of HIV serostatus, and HIV prevention. Implementation of PfH includes development of clinic and staff "buy-in" and training.

HIV Positive								
Ranked Population Target Group	CTR	PS	IDI	IGI	OR	CRCS	HC/PI	Other (CLI)
1. White MSM			**X**					
2. Black IDU			**X**					
3. Black MSM/IDU			**X**					
4. White MSM/IDU			**X**					
5. Black Heterosexual			**X**					
6. White IDU			**X**					
7. White Heterosexual			**X**					
8. Hispanic IDU			**X**					
9. Black MSM			**X**					
10. Hispanic Heterosexual			**X**					
11. Hispanic MSM/IDU			**X**					
12. Hispanic MSM			**X**					
13. Perinatal Transmission			**X**					
14. Emerging Risk Groups			**X**					
Youth			**X**					
Transgender			**X**					
Homeless			**X**					
Asian Pacific Islander			**X**					

Popular Opinion Leader (POL)

Popular Opinion Leader (POL) is a **community-level** intervention designed to identify, enlist, and train opinion leaders to encourage safer sexual norms and behaviors within their social networks of friends and acquaintances through risk reduction conversations. POL can be used with **various at-risk populations** in a variety of venues. POL has been tested with gay men in bars, African American women in low-income housing settings, and male commercial sex workers.

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IGI	OR	CRCS	HC/PI	Other (CLI)
1. White MSM								**X**
2. Black IDU								**X**
3. Black MSM/IDU								**X**
4. White MSM/IDU								**X**
5. Black Heterosexual								**X**
6. White IDU								**X**
7. White Heterosexual								**X**
8. Hispanic IDU								**X**
9. Black MSM								**X**
10. Hispanic Heterosexual								**X**
11. Hispanic MSM/IDU								**X**
12. Hispanic MSM								**X**
13. Perinatal Transmission								**X**
14. EmergingRisk Groups								**X**
Youth								**X**
Transgender								**X**
Homeless								**X**
Asian Pacific Islander								**X**

Project START

Project START is an individual-level, multi-session intervention for people being released from a correctional facility and returning to the community. It is based on the conceptual framework of Incremental Risk Reduction, and focuses on increasing clients' awareness of their HIV, STI, and Hepatitis risk behaviors after release and providing them with tools and resources to reduce their risk.

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IGI	OR	CRCS	HC/PI	Other (CLI)
1. White MSM			**X**					
2. Black IDU			**X**					
3. Black MSM/IDU			**X**					
4. White MSM/IDU			**X**					
5. Black Heterosexual			**X**					
6. White IDU			**X**					
7. White Heterosexual			**X**					
8. Hispanic IDU			**X**					
9. Black MSM			**X**					
10. Hispanic Heterosexual			**X**					
11. Hispanic MSM/IDU			**X**					
12. Hispanic MSM			**X**					
13. Perinatal Transmission			**X**					
14. Emerging Risk Groups								
Youth			**X**					
Transgender			**X**					
Homeless			**X**					
Asian Pacific Islander			**X**					

Real AIDS Prevention Project (RAPP)

Real AIDS Prevention Project (RAPP) is a **community mobilization program**, designed to reduce risk for HIV and unintended pregnancy among women in communities at high risk by increasing condom use. This intervention relies on peer-led activities, including: outreach/one-on-one brief conversations with brochures, referrals, and condom distribution; small group safer sex discussions and presentations. RAPP is for **sexually active women of reproductive age and their male partners**.

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IGI	OR	CRCS	HC/PI	Other (CLI)
1. White MSM								
2. Black IDU								
3. Black MSM/IDU								
4. White MSM/IDU								
5. Black Heterosexual				**X**	**X**		**X**	**X**
6. White IDU								
7. White Heterosexual				**X**	**X**		**X**	**X**
8. Hispanic IDU								
9. Black MSM								
10. Hispanic Heterosexual				**X**	**X**		**X**	**X**
11. Hispanic MSM/IDU								
12. Hispanic MSM								
13. Perinatal Transmission				**X**	**X**		**X**	**X**
14. Emerging Risk Groups								
Youth				**X**	**X**		**X**	**X**
Transgender								
Homeless								
Asian Pacific Islander								

RESPECT

RESPECT is an **individual-level**, client-focused, HIV prevention intervention, consisting of **two brief interactive counseling sessions**. This intervention can be easily incorporated into an HIV counseling/testing program; essentially it can be incorporated wherever discussion of client risk and risk reduction strategies occur. The provider follows a structured protocol to guide delivery of the intervention, using or creating a "teachable moment" to enhance a client's perception of their risk and level of concern for HIV infection. It can be **implemented for any population at increased risk for HIV/STD**.

HIV Positive								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
1. White MSM			**X**					
2. Black IDU			**X**					
3. Black MSM/IDU			**X**					
4. White MSM/IDU			**X**					
5. Black Heterosexual			**X**					
6. White IDU			**X**					
7. White Heterosexual			**X**					
8. Hispanic IDU			**X**					
9. Black MSM			**X**					
10. Hispanic Heterosexual			**X**					
11. Hispanic MSM/IDU			**X**					
12. Hispanic MSM			**X**					
13. Perinatal Transmission			**X**					
14. Emerging Risk Groups			**X**					
Youth			**X**					
Transgender			**X**					
Homeless			**X**					
Asian Pacific Islander			**X**					

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
White MSM			**X**					
Black IDU			**X**					
Black MSM/IDU			**X**					
White MSM/IDU			**X**					
Black Heterosexual			**X**					
White IDU			**X**					
White Heterosexual			**X**					
Hispanic IDU			**X**					
Black MSM			**X**					
Hispanic Heterosexual			**X**					
Hispanic MSM/IDU			**X**					
Hispanic MSM			**X**					
Perinatal Transmission			**X**					
Emerging Risk Groups			**X**					
Youth			**X**					
Transgender			**X**					
Homeless			**X**					
Asian Pacific Islander			**X**					

Safe In The City (SITC)

Safe in the City (SITC) is a 23-minute HIV/STD prevention video for STD clinic waiting rooms. This video has been shown to be effective in reducing sexually transmitted diseases (STDs) **among diverse groups of STD clinic patients**. Safe in the City aims to increase condom use and other safer sex behaviors, and thereby reduce infections among patients who view the video in the clinic waiting room.

HIV Positive								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
1. White MSM							**X**	
2. Black IDU							**X**	
3. Black MSM/IDU							**X**	
4. White MSM/IDU							**X**	
5. Black Heterosexual							**X**	
6. White IDU							**X**	
7. White Heterosexual							**X**	
8. Hispanic IDU							**X**	
9. Black MSM							**X**	
10. Hispanic Heterosexual							**X**	
11. Hispanic MSM/IDU							**X**	
12. Hispanic MSM							**X**	
13. Perinatal Transmission							**X**	
14. Emerging Risk Groups							**X**	
Youth							**X**	
Transgender							**X**	
Homeless							**X**	
Asian Pacific Islander							**X**	

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
White MSM								**X**
Black IDU								**X**
Black MSM/IDU								**X**
White MSM/IDU								**X**
Black Heterosexual								**X**
White IDU								**X**
White Heterosexual								**X**
Hispanic IDU								**X**
Black MSM								**X**
Hispanic Heterosexual								**X**
Hispanic MSM/IDU								**X**
Hispanic MSM								**X**
Perinatal Transmission								**X**
Emerging Risk Groups								**X**
Youth								**X**
Transgender								**X**
Homeless								**X**
Asian Pacific Islander								**X**

Safety Counts

Safety Counts is an HIV prevention intervention for out-of-treatment active **injection and non-injection drug users** aimed at reducing both high-risk drug use and sexual behaviors. It is a behaviorally focused, **seven session** intervention, which includes both structured and unstructured psycho-educational activities in group and individual settings.

HIV Positive								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
1. White MSM								
2. Black IDU			**X**	**X**				
3. Black MSM/IDU								
4. White MSM/IDU								
5. Black Heterosexual								
6. White IDU			**X**	**X**				
7. White Heterosexual								
8. Hispanic IDU			**X**	**X**				
9. Black MSM								
10. Hispanic Heterosexual								
11. Hispanic MSM/IDU								
12. Hispanic MSM								
13. Perinatal Transmission								
14. Emerging Risk Groups								
Youth								
Transgender								
Homeless								
Asian Pacific Islander								

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
White MSM								
Black IDU			**X**	**X**				
Black MSM/IDU								
White MSM/IDU								
Black Heterosexual								
White IDU			**X**	**X**				
White Heterosexual								
Hispanic IDU			**X**	**X**				
Black MSM								
Hispanic Heterosexual								
Hispanic MSM/IDU								
Hispanic MSM								
Perinatal Transmission								
Emerging Risk Groups								
Youth								
Transgender								
Homeless								
Asian Pacific Islander								

SHIELD

SHIELD (Self-Help in Eliminating Life-threatening Diseases) intervention is based on several theories; Social Cognitive Theory, Social Identity Theory, Cognitive Dissonance (or inconsistency) Theory, and Social Influence Theory. In SHIELD, a Peer Educator is taught strategies to reduce HIV risk associated with drug use and sex behavior. In addition, Peer Educators are taught effective communication skills in order to talk with people in their social networks about HIV prevention information. Peer Educators are trained to be leaders within their social networks and communities; they use their communication skills to have conversations about prevention to help stop the spread of HIV. SHIELD targets male and female adults (18 years older) who are current or former "hard" drug users (heroin, cocaine, and crack) who interact with other drug users; it can be delivered with clients who are HIV positive and HIV negative.

HIV Positive								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
1. White MSM								
2. Black IDU			**X**					
3. Black MSM/IDU								
4. White MSM/IDU								
5. Black Heterosexual								
6. White IDU			**X**					
7. White Heterosexual								
8. Hispanic IDU			**X**					
9. Black MSM								
10. Hispanic Heterosexual								
11. Hispanic MSM/IDU								
12. Hispanic MSM								
13. Perinatal Transmission								
14. Emerging Risk Groups								
Youth								
Transgender								
Homeless								
Asian Pacific Islander								

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
White MSM								
Black IDU			**X**					
Black MSM/IDU								
White MSM/IDU								
Black Heterosexual								
White IDU			**X**					
White Heterosexual								
Hispanic IDU			**X**					
Black MSM								
Hispanic Heterosexual								
Hispanic MSM/IDU								
Hispanic MSM								
Perinatal Transmission								
Emerging Risk Groups								
Youth								
Transgender								
Homeless								
Asian Pacific Islander								

SIHLE

SIHLE (Sisters Informing Healing Living and Empowering) is a peer-led, social-skills training intervention aimed at reducing HIV sexual risk behavior among sexually active, African American teenage females, ages 14-18. It consists of four 3-hour sessions, delivered by two peer facilitators (ages 18-21) and one adult facilitator in a community-based setting. The sessions are designed for 10-12 African American teenage females. The sessions are gender-specific, culturally relevant and include behavioral skills practice, group discussions, lectures, role-playing, and take-home exercises.

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IGI	OR	CRCS	HC/PI	Other (CLI)
1. White MSM								
2. Black IDU								
3. Black MSM/IDU								
4. White MSM/IDU								
5. Black Heterosexual				**X**				
6. White IDU								
7. White Heterosexual								
8. Hispanic IDU								
9. Black MSM								
10. Hispanic Heterosexual								
11. Hispanic MSM/IDU								
12. Hispanic MSM								
13. Perinatal Transmission								
14. Emerging Risk Groups								
Youth				**X**				
Transgender								
Homeless								
Asian Pacific Islander								

SISTA Project

SISTA (Sisters Informing Sisters on Topics about AIDS) is a group-level, gender- and culturally- relevant intervention, is designed to increase condom use with **heterosexually active African American women**. The **five peer-led group sessions** focus on ethnic and gender pride, HIV knowledge, and skills training around sexual risk reduction behaviors and decision making. The intervention is based on Social Learning theory as well as the theory of Gender and Power. The sessions include behavioral skills practice, group discussions, lectures, role-playing, prevention video viewing, and take-home exercises.

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IGI	OR	CRCS	HC/PI	Other (CLI)
1. White MSM								
2. Black IDU								
3. Black MSM/IDU								
4. White MSM/IDU								
5. Black Heterosexual				**X**				
6. White IDU								
7. White Heterosexual								
8. Hispanic IDU								
9. Black MSM								
10. Hispanic Heterosexual								
11. Hispanic MSM/IDU								
12. Hispanic MSM								
13. Perinatal Transmission								
14. Emerging Risk Groups								
Youth								
Transgender								
Homeless								
Asian Pacific Islander								

Sister to Sister

Sister to Sister is a **brief (20-minute)**, **one-on-one**, skill-based HIV/sexually transmitted disease (STD) risk-reduction behavioral intervention for sexually active African American women 18 to 45 years old that is delivered during the course of a routine medical visit. The target population for Sister to Sister is sexually active African American women 18-45 years old who have male partners and are attending primary health care clinics (e.g., family planning, women's health reproductive care, etc.).

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IGI	OR	CRCS	HC/PI	Other (CLI)
1. White MSM								
2. Black IDU								
3. Black MSM/IDU								
4. White MSM/IDU								
5. Black Heterosexual			**X**					
6. White IDU								
7. White Heterosexual								
8. Hispanic IDU								
9. Black MSM								
10. Hispanic Heterosexual								
11. Hispanic MSM/IDU								
12. Hispanic MSM								
13. Perinatal Transmission								
14. Emerging Risk Groups								
Youth								
Transgender								
Homeless								
Asian Pacific Islander								

Street Smart

Street Smart is a skills-building program to help **runaway and homeless youth**, **ages 11 to 18**, practice safer sexual behaviors and reduce substance use. Street Smart is conducted over a six- to eight-week period with 10-12 youth. The program consists of **eight 1.5 to 2 hour group sessions**, one individual counseling session, and one visit to a community-based organization that provides healthcare. The sessions address improving youths' social skills, assertiveness and coping through exercises on problem solving, identifying triggers, and reducing harmful behaviors. Agency staff provides individual counseling and trips to community health providers.

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IGI	OR	CRCS	HC/PI	Other (CLI)
1. White MSM								
2. Black IDU								
3. Black MSM/IDU								
4. White MSM/IDU								
5. Black Heterosexual								
6. White IDU								
7. White Heterosexual								
8. Hispanic IDU								
9. Black MSM								
10. Hispanic Heterosexual								
11. Hispanic MSM/IDU								
12. Hispanic MSM								
13. Perinatal Transmission								
14. Emerging Risk Groups								
Youth				**X**				
Transgender								
Homeless				**X**				
Asian Pacific Islander								

Together Learning Choices (TLC)

Together Learning Choices (TLC) is an intervention for **young people ages 13-29 living with HIV**. This program helps young people living with HIV identify ways to increase use of health care, decrease risky sexual behavior and drug and alcohol use, and improve quality of life. It emphasizes how contextual factors influence ability to respond effectively to stressful situations, solve problems, and act effectively to reach goals.

HIV Positive								
Ranked Population Target Group	CTR	PS	IDI	IGI	OR	CRCS	HC/PI	Other (CLI)
1. White MSM								
2. Black IDU								
3. Black MSM/IDU								
4. White MSM/IDU								
5. Black Heterosexual								
6. White IDU								
7. White Heterosexual								
8. Hispanic IDU								
9. Black MSM								
10. Hispanic Heterosexual								
11. Hispanic MSM/IDU								
12. Hispanic MSM								
13. Perinatal Transmission								
14. Emerging Risk Groups								
Youth				**X**				
Transgender								
Homeless								
Asian Pacific Islander								

VOICES/*VOCES*

VOICES/*VOCES* (Video Opportunities for Innovative Condom Education & Safer Sex) A group-level, **single-session** video-based intervention designed to increase the intention of condom use among heterosexual African American and Latino men and women who visit **STD clinics**.

HIV Positive								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
1. White MSM								
2. Black IDU								
3. Black MSM/IDU								
4. White MSM/IDU								
5. Black Heterosexual				**X**				
6. White IDU								
7. White Heterosexual								
8. Hispanic IDU								
9. Black MSM								
10. Hispanic Heterosexual				**X**				
11. Hispanic MSM/IDU								
12. Hispanic MSM								
13. Perinatal Transmission								
14. Emerging Risk Groups								
Youth								
Transgender								
Homeless								
Asian Pacific Islander								

HIV Negative								
Ranked Population Target Group	CTR	PS	IDI	IDG	OR	CRCS	HC/PI	Other (CLI)
White MSM								
Black IDU								
Black MSM/IDU								
White MSM/IDU								
Black Heterosexual				**X**				
White IDU								
White Heterosexual								
Hispanic IDU								
Black MSM								
Hispanic Heterosexual				**X**				
Hispanic MSM/IDU								
Hispanic MSM								
Perinatal Transmission								
Emerging Risk Groups								
Youth								
Transgender								
Homeless								
Asian Pacific Islander								

WILLOW

WILLOW (Women Involved in Life Learning from Other Women) intervention is a social-skills building and educational intervention for adult women living with HIV. The small group sessions consist of 8-10 women living with HIV and are conducted in a community-based setting. It consists of **4 four-hour sessions** which are delivered by two trained adult female facilitators, one of whom is a woman living with HIV. The target population for WILLOW is heterosexual women, regardless of race or ethnicity, living with HIV/AIDS who are 18-50 years of age and who have known their HIV serostatus for at least 6 months.

HIV Positive								
Ranked Population Target Group	CTR	PS	IDI	IGI	OR	CRCS	HC/PI	Other (CLI)
1. White MSM								
2. Black IDU								
3. Black MSM/IDU								
4. White MSM/IDU								
5. Black Heterosexual				**X**				
6. White IDU								
7. White Heterosexual				**X**				
8. Hispanic IDU								
9. Black MSM								
10. Hispanic Heterosexual				**X**				
11. Hispanic MSM/IDU								
12. Hispanic MSM								
13. Perinatal Transmission								
14. Emerging Risk Groups								
Youth								
Transgender								
Homeless								
Asian Pacific Islander								

5.9 HIV & Hepatitis C Virus (HCV) Interventions

Although CDC Grant funds cannot be used for the provision of HCV prevention services, the Department's Division of HIV/AIDS encourages the appropriate use of evidence-based interventions that address the prevention issues for HIV and HCV among injection-drug users. The Interventions subcommittee identified the following evidence-based interventions that address both HIV and HCV:

1. **Drug Users Intervention Trial** (DUIT) targets young HIV-negative and hepatitis C virus (HCV)-negative injection drug users (Promising Evidence).
2. **Safety Counts** (disseminated as a DEBI)
3. **Study to Reduce Intravenous Exposures** (STRIVE) targets HIV-negative injection drug users with hepatitis C virus (HCV) infection (Best Evidence).
4. **Project Start** (disseminated as a DEBI)

5.10 Rural Work Group

The Pennsylvania CPG has established a rural work group to address the unique and often not well-understood concerns of rural areas within our state. The Rural Work Group consists of volunteer committee members who are applying their efforts outside of regular committee meeting time. The express purpose of the rural work group is to present the special demographic, geographic and social/cultural conditions that impact the HIV prevention needs of non-metropolitan populations in Pennsylvania to the Centers for Disease Control and Prevention.

The Rural Work Group recognizes the impact of the unaddressed risk behaviors, and lack of appropriate HIV/AIDS prevention education adaptations, in our non-metropolitan communities. The group feels that the CPG must address these deficiencies throughout Pennsylvania's non-urban areas. Although rural areas are significant sources of the State's natural resources, and are of primary importance to the economy of Pennsylvania, the needs of rural people are often overlooked because of population dispersion and inadequate political infrastructures (Willits, et al, 2004). As information about rural needs and interventions of proven effectiveness are located, they will be included in our plan as a means of assisting non-metropolitan prevention groups adapt recommended procedures within each of their unique rural areas.

5.10.1. Characteristics of Rural Pennsylvania

The Rural Work Group recognizes the quality and expertise of the Co-Editors, CDC researchers, authors and educators whose work we have so extensively added into our 2011 Plan Update. Further, we believe that we have clearly indentified our kinship with rural issues of other states as being our issues as well. Our plea is that our need for finding expertise and training in adaptations of the DEBIs is met with the vigor that is exposed in the literature we have reviewed and often quoted.

"What does rural mean? In 2000, non-metropolitan counties in the United States outnumbered metropolitan counties by two to one. Does this mean that the majority of the country is rural? That depends on how rural is defined. Currently, there is no national consensus on how and where to draw the line between rural and urban. Federal and state agencies, researchers and policy makers apply different definitions for different purposes.

"Many agencies define "urban" and everything outside of that definition is labeled 'rural' by default. For example, the U.S. Census Bureau defines urban areas as continuously built up areas with a population nucleus of 50,000 or more and a population density greater than 1,000 people per square mile. Based on this definition, the Census Bureau reported in 2000 that 59 million people (21% of the population) were living in rural settings.

"In contrast, the White House's Office of Management and Budget (OMB) concluded from the same Census 2000 data that 55.9 million people (20% of the total population) should be considered rural. Then, in 2003 the OMB revised the definitions to reflect today's economic and social ties between rural and urban communities. OMB currently defines metro counties as those with one or more urbanized area of 50,000 or more. Metro areas may include outlying counties that show economic and social ties to the central county indicated by frequent commuting between the two. Non-metro areas are subdivided into micropolitan areas, those with a population center of 10,000 to 50,000, and noncore counties with smaller or no population centers. Using this newest definition, the OMB reports that in 2005, micropolitan areas and noncore counties covered 75% of America's land area and were home to nearly 49 million people, just over 17% of the country's population." (Rural HIV/STD Prevention Workgroup, *Tearing Down Fences: HIV/STD Prevention in Rural America,* Rural Center for AIDS/HIV Prevention, pp 3-4)

According to the Rural Center for AIDS/STD Prevention (2009) "life in rural America is as varied as the men, women, and children who live there. For some, rural life comes with the freedom to enjoy a slower-paced life style, a small supportive community, and wide-open spaces. For others, rural life traps them in a web of inadequate education, limited job opportunities, limited access to health care and social services, and isolation due to social stigma and a lack of public transportation.

"Challenges like these make HIV/AIDS prevention and care difficult in rural setting. Wide-open spaces create long distances to travel for HIV/AIDS care. Close knit social networks may make it hard to get an HIV/STD test or even buy condoms without friends, relatives or acquaintances noticing. Freedom from big city congestions may also mean living with fewer local resources for health care, mental health care, substance abuse treatment, housing and jobs. And traditional values embraced by many rural communities may contribute to stigma toward those who engage in risky behaviors or have been diagnosed with HIV or AIDS. Traditional values and stigma account for some obstacles that keep people from talking about sexuality and learning how to prevent HIV/AIDS. Fear of stigma also stops people from getting tested, learning their results, and disclosing their HIV status.

"Despite these challenges, many rural communities have created innovative and promising strategies to HIV prevention and care that take advantage of the diverse people and strengths of their communities. Promising strategies that address HIV in rural areas are not one-size-fits-all solutions, but are strategies that rural communities can adopt and adapt to meet their own unique needs and build on their own strengths.

"The U.S. Centers for Disease Control and Prevention (CDC) reports that since the early 1990s, 5% to 8% of the new AIDS cases each year have been diagnosed among those who live in non-metropolitan areas (counties with fewer than 50,000 residents). By the end of 2007, 56,209 rural people had been diagnosed with AIDS. This number does not include those whose HIV infection has not progressed to AIDS, who are unaware of being infected with HIV, who have migrated to rural areas after diagnosis or those who are diagnosed in urban areas and do not provide their rural home address to avoid hometown stigma." (Fact Sheet, Rural Center for AIDS/STD Prevention, number 23, 2009, HIV/AIDS in rural America: challenges and promising strategies.)

Twenty-five percent or about 3 million Pennsylvanians live in rural areas of the state. Of the 67 counties in Pennsylvania, 48 are classified as rural based on population density. Moreover, of the 19 counties designated as urban, approximately 17 contain rural municipalities (boroughs or townships). These also have extensive rural characteristics. Also of note is the fact that there is more landmass in Pennsylvania designated as part of Appalachia than any other state with the exception of West Virginia. (Appalachia is a rugged swath of America hugging the mountains from Georgia to New York that has for generations been a symbol of

poverty). Of the 48 rural counties depicted in Table V.1, 25 (60%) report poverty levels that are below that of Pennsylvania (10.5%) (Center for Rural PA 2007).

Issues in addition to poverty that impact rural areas include lack of medical care, increased cost and availability of local community services, restricted access to urban centers of specialty due to distance and transportation problems, and limited telecommunication access. According to the Pennsylvania Office of Rural Health, rural areas have fewer hospital beds and fewer primary care physicians, dentists, and other health care providers than do urban areas. In addition, although the population of rural non-whites increased from 2 percent to 4 percent between 1990 and 2000, most rural counties have extremely low percentages of ethnic and racial minorities. However, youth under 18 years of age account for 23% of the population, which is comparable to urban areas. Figure V.1 depicts rural and urban counties of Pennsylvania. Table V.1 lists the rural counties of Pennsylvania by population density, percentage of Black and Hispanic residents and percentage of residents living with AIDS. Population density is calculated by dividing the total population of an area by the total number of square miles. Thus, the population density of Pennsylvania is 274 persons per square mile. Rural counties are those with population densities of less than 274 (Center for Rural Pennsylvania 2007).

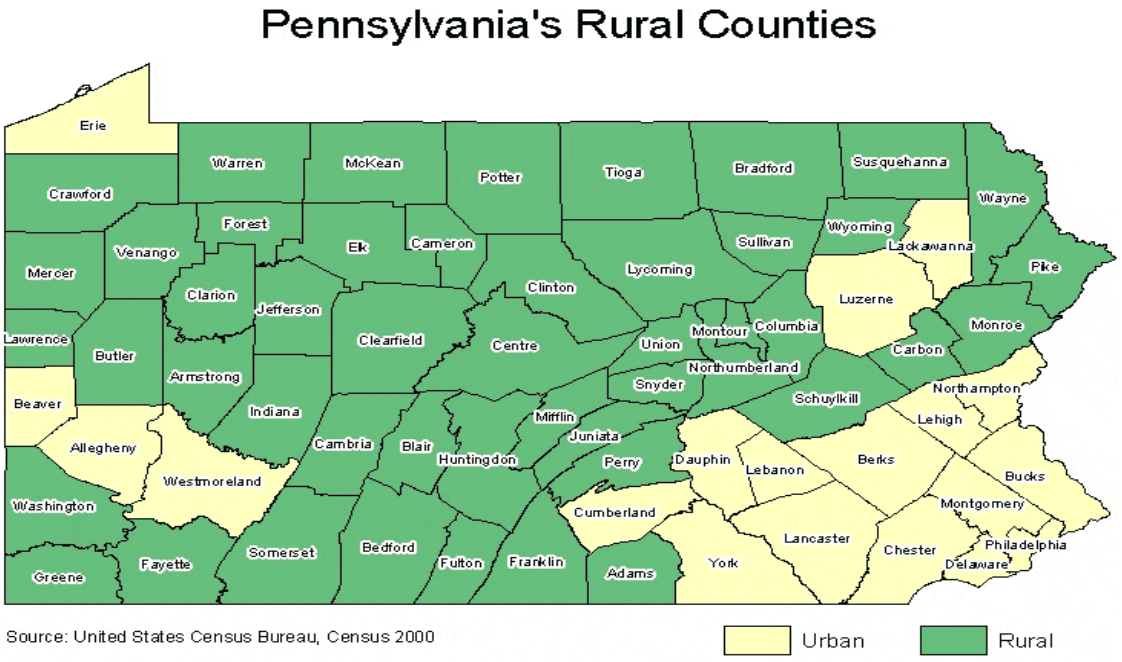

Figure 5.2 Pennsylvania Rural & Urban Counties

Table 5.3 Rural Counties in Pennsylvania with Greater than 40 Percent Rural Population

Rural County	Population Density *	Total Population *	Percent Rural Municipality **	Percent Black ***	Percent Hispanic ***	Living HIV Cases ****	Living AIDS Cases ****
Adams	176	101,119	82.0	2.1	5.3	**17**	31
Armstrong	111	68,790	93.0	1.0	0.5	**9**	20
Bedford	49	49,727	97.0	0.5	0.7	**9**	11
Blair	246	125,174	58.0	1.6	0.7	**29**	46

Rural County	Population Density *	Total Population *	Percent Rural Municipality **	Percent Black ***	Percent Hispanic ***	Living HIV Cases ****	Living AIDS Cases ****
Bradford	55	61.233	94.0	0.5	0.7	**21**	15
Butler	221	182,902	81.0	1.1	.8	**31**	30
Cambria	222	144,319	65.0	3.4	1.1	**48**	78
Cameron	15	5,266	86.0	0.6	0.8	**1**	0
Carbon	154	63,558	48.0	1.6	2.6	**17**	20
Centre	123	144,779	80.0	3.1	2.1	**57**	62
Clarion	69	39,989	97.0	1.0	0.5	**2**	6
Clearfield	73	82,896	94.0	2.1	0.8	**25**	43
Clinton	43	37,038	97.0	0.8	0.8	**7**	3
Columbia	132	65,004	91.0	1.2	1.5	**19**	21
Crawford	89	88,411	94.0	1.9	0.8	**32**	29
Elk	42	32,268	83.0	0.2	0.5	**2**	4
Fayette	188	143,925	57.0	4.1	0.5	**31**	**38**
Forest	12	6,825	100.0	17.6	4.4	**9**	**4**
Franklin	168	143,495	81.0	3.1	3.0	**50**	63
Fulton	33	14,935	100.0	1.1	0.4	**3**	3
Greene	71	39,344	96.0	3.9	1.0	**9**	14
Huntingdon	52	45,543	94.0	5.6	1.3	**22**	57
Indiana	108	87,479	92.0	1.9	0.6	**20**	16
Jefferson	70	45,105	91.0	0.3	0.6	**8**	7
Juniata	58	23,146	100.0	0.6	2.0	**5**	7
Lawrence	263	90,272	78.0	4.0	0.8	**16**	26
Lycoming	97	116,670	85.0	4.6	0.9	**113**	143
McKean	47	43,537	91.0	2.5	1.4	**2**	9
Mercer	179	116,652	83.0	5.4	0.8	**28**	41
Mifflin	113	46,062	94.0	0.7	0.7	**7**	7
Monroe	228	165,058	70.0	11.3	11.6	**99**	121
Montour	139	17,705	82.0	1.5	1.3	**4**	9
Northumberland	206	91,091	81.0	2.1	1.7	**26**	54
Perry	79	45,185	97,0	0.7	1.0	**16**	17
Pike	85	59,664	100.0	5.6	8.1	**27**	37
Potter	17	16,720	97.0	0.8	0.8	**1**	2
Schuylkill	193	147,254	81.0	2.9	1.9	**39**	86
Snyder	113	38,074	95.0	1.1	1.3	**8**	11
Somerset	74	77,454	94.0	2.4	0.9	**26**	44
Sullivan	15	6,124	100.0	2.9	1.3	**3**	2
Susquehanna	51	40,831	90.0	0.5	1.0	**7**	11
Tioga	36	40,574	95.0	0.9	0.7	**10**	9
Union	131	43,640	71.0	8.2	4.4	**48**	76
Venango	85	54,423	94.0	1.3	0.7	**9**	11
Warren	50	40,728	96.0	0.3	0.5	**11**	13
Washington	237	206,407	51.0	3.5	0.9	**46**	61
Wayne	65	52,016	93.0	2.9	2.9	**30**	53

Rural County	Population Density *	Total Population *	Percent Rural Municipality **	Percent Black ***	Percent Hispanic ***	Living HIV Cases ****	Living AIDS Cases ****
Wyoming	71	27,759	96.0	0.8	1.0	**7**	10

* Population statistics are from The Center for Rural PA website as of July 2008
** Percentage of Rural Municipalities in a County is calculated using data found on The Center for Rural PA website based from 2008
*** Race Statistics are as of 2007 and were found on The Center for Rural PA website
**** Number of AIDS cases are taken from the Commonwealth of Pennsylvania's, HIV and AIDS Surveillance Summary Report dated December 2008

Table 5.1 illustrates the low percentages of Black and Hispanic residents in Pennsylvania's rural counties. However, it must be noted that migrant populations who work in some of the north and southeastern counties of the state and are known to be at risk for HIV are not accounted for in Census data. Programming for these populations is in place. It is also noted that since the 1990 US Census the Hispanic population in rural counties has steadily increased and at times exceeded the rural Black population in several counties.

Table 5.4 Counties in Pennsylvania with Less than 40 Percent Rural Population

Urban County	Population Density *	Total Population *	Percent Rural Muni-cipality **	Percent Black ***	Percent Hispanic ***	Living HIV Cases ****	Living AIDS Cases ****
Allegheny	1,755	1,281,666	5.0	13.2	1.4	1,050	1,183
Beaver	417	172,476	34.0	6.3	1.0	31	69
Berks	435	621,643	53.0	3.7	3.3	387	477
Bucks	984	403,595	23.0	5.1	13.3	260	344
Chester	573	591,489	27.0	6.5	4.7	197	233
Cumberland	388	229,361	55.0	3.3	2.0	161	197
Dauphine	479	256,562	58.0	17.8	5.4	394	461
Delaware	2,990	553,619	0.0	18.5	5.7	607	718
Erie	350	279,175	68.0	6.7	2.6	114	167
Lackawanna	465	209,408	43.0	2.1	2.9	97	127
Lancaster	496	302,370	40.0	3.6	6.9	330	403
Lebanon	333	128,934	54.0	2.0	6.8	52	70
Lehigh	900	339,989	21.0	5.5	15.1	339	460
Luzerne	358	311,983	39.0	2.8	3.8	150	151
Montgomery	1,553	778,048	5.0	8.6	3.1	469	442
Northampton	714	294,787	16.0	4.4	8.8	188	226
Philadelphia	11,230	1,447,395	0.0	45.0	10.7	7,013	10,271
Westmoreland	362	361,744	43.0	2.4	0.7	61	94

Urban County	Population Density *	Total Population *	Percent Rural Muni-cipality **	Percent Black ***	Percent Hispanic ***	Living HIV Cases ****	Living AIDS Cases ****
York	422	424,997	47.0	5.1	4.2	276	395

* Population statistics are from The Center for Rural PA website as of July 2008

** Percentage of Rural Municipalities in a County is calculated using data found on The Center for Rural PA website based from 2008

*** Race Statistics are as of 2007 and were found on The Center for Rural PA website

**** Number of AIDS cases is taken from the Commonwealth of Pennsylvania's, HIV and AIDS Surveillance Summary Report dated December 2008

Table 5.5 Percent of Pennsylvania County population with HIV/AIDS

County	HIV Cases	AIDS Cases	Total	Population	% of Pop
Dauphin	**394**	**461**	**855**	**256,562**	**.033332%**
Philadelphia	**7,013**	**10,271**	**17,284**	**1,447,395**	**.011941%**
Union	**48**	**76**	**124**	**43,640**	**.002841%**
Lancaster	**330**	**403**	**733**	**302,370**	**.002424%**
Delaware	**607**	**718**	**1325**	**553,619**	**.002393%**
Lehigh	**339**	**460**	**799**	**339,989**	**.002350%**
Lycoming	**113**	**143**	**256**	**116,670**	**.002194%**
Forest	**9**	**4**	**13**	**6,825**	**.001905%**
Allegheny	**1,050**	**1,183**	**2,233**	**1,281,666**	**.001742%**
Huntingdon	**22**	**57**	**79**	**45,543**	**.001735%**
Wayne	**30**	**53**	**83**	**52,016**	**.001596%**
York	**276**	**395**	**671**	**424,997**	**.001579%**
Cumberland	**161**	**197**	**358**	**229,361**	**.001561%**
Bucks	**260**	**344**	**604**	**403,595**	**.001497%**
Northampton	**188**	**226**	**414**	**294,787**	**.001404%**
Berks	**387**	**477**	**864**	**621,643**	**.001390%**
Monroe	**99**	**121**	**220**	**165,058**	**.001333%**
Montgomery	**469**	**442**	**911**	**778,048**	**.001171%**
Pike	**27**	**37**	**64**	**59,664**	**.001073%**

County	HIV Cases	AIDS Cases	Total	Population	% of Pop
Lackawanna	97	127	224	209,408	.001070%
Erie	114	167	281	279,175	.001007%
Luzerne	150	151	301	311,983	.000965%
Lebanon	52	70	122	128,934	.000946%
Somerset	26	44	70	77,454	.000904%
Northumberland	26	54	80	91,091	.000878%
Cambria	48	78	126	144,319	.000873%
Schuylkill	39	86	125	147,254	.000849%
Centre	57	62	119	144,779	.000822%
Clearfield	25	43	68	82,896	.000820%
Sullivan	3	2	5	6,124	.000816%
Franklin	50	63	113	143,495	.000787%
Montour	4	9	13	17,705	.000734%
Perry	16	17	33	45,185	.000730%
Chester	197	233	430	591,489	.000727%
Crawford	32	29	61	88,411	.000690%
Columbia	19	21	40	65,004	.000615%
Wyoming	7	10	17	27,759	.000612%
Blair	29	46	75	125,174	.000599%
Mercer	28	41	69	116,652	.000592%
Warren	11	13	24	40,728	.000589%
Greene	9	14	23	39,344	.000585%
Carbon	17	20	37	63,558	.000582%
Beaver	31	69	100	172,476	.000580%
Juniata	5	7	12	23,146	.000518%
Washington	46	61	107	206,407	.000518%
Snyder	8	11	19	38,074	.000499%
Fayette	31	38	69	143,925	.000479%

County	HIV Cases	AIDS Cases	Total	Population	% of Pop
Adams	17	31	48	101,119	.000475%
Tioga	10	9	19	40,574	.000468%
Lawrence	16	26	42	90,272	.000465%
Susquehanna	7	11	18	40,831	.000441%
Westmoreland	61	94	155	361,744	.000428%
Armstrong	9	20	29	68,790	.000422%
Indiana	20	16	36	87,479	.000412%
Bedford	9	11	20	49,727	.000402%
Fulton	3	3	6	14,935	.000402%
Venango	9	11	20	54,423	.000367%
Butler	31	30	61	182,902	.000334%
Jefferson	8	7	15	45,105	.000333%
Mifflin	7	7	14	46,062	.000304%
Bradford	21	15	36	125,174	.000288%
Clinton	7	3	10	37,038	.000270%
McKean	2	9	11	43,537	.000253%
Clarion	2	6	8	39,989	.000200%
Cameron	1	0	1	5,266	.000190%
Elk	2	4	6	32,268	.000186%
Potter	1	2	3	16,720	.000018%
Totals		31,211		12,479,352	.002501%

5.10.2. Characteristics of Rural People in Pennsylvania

"Just as rural urban variations exist, so do variations among rural people. The issues of rural diversity are related to demography, economics, culture and geographical differences. In general, rural populations have more elderly, higher unemployment and under-employment and higher percentages of underinsured and uninsured individuals," (Hart, Larson & Lishner 2005). "In addition, rural Pennsylvanians hold more conservative values and are less tolerant of diverse populations. Strong religious beliefs play a major role in dictating and shaping the values, attitudes and social norms of rural communities. Moreover, because of the

small town 'grapevine' it is difficult to maintain privacy, making confidentiality a problem" (Preston et al. 2004)."

The transgender populations in rural Pennsylvania are at greater risk of poverty as a result of unemployment, homelessness, family and social rejection, stigma, and the bias of strong religious beliefs. The need for transgender specific DEBIs, and training for HIV prevention providers for this emerging high-risk group, cannot be overstated.

"The number of rural people living with HIV/AIDS (PLWHA) continues to grow due to new infections, extended life expectancies for those living with HIV or AIDS, and people moving to or returning to rural areas after being diagnosed. With early detection and anti-retroviral therapy infected with HIV can expect to live productive lives with appropriate and consistent health care. A recent report suggests, however, that certain medical conditions are prematurely striking those who are aging and living with AIDS. These age-related health problems can complicate the medical management for older HIV+ individuals and increase their need for medical and support services. Regardless of age or whether they are living in urban or rural settings, people living with HIV/AIDS need high-level medical services and case management. However, many HIV-infected people in rural America have inconsistent or nonexistent relationships with primary care providers despite the Ryan White CARE Act that provides health care and social services for those living with HIV/AIDS. As one rural health provider put it, 'Their needs are immense and all encompassing – yet rural areas do not have this capacity.'

"Receiving a diagnosis of HIV/AIDS is daunting under any circumstances, but when it occurs in a rural setting it carries extra burdens. Rural residents are less likely to have health insurance, making it difficult for them to access both car and expensive essential medications. There are too few rural health care providers trained to manage the complex care for a patient with HIV/AIDS. Basic health services may be more than an hour away and specialized care may entail a ride of several hours. This barrier to care is compounded by the lack of public transportation in most rural areas. Other significant gaps in care for those living with HIV in rural areas is include a lack of adequate mental health services, support groups, and substance abuse treatment programs even though the need for these services in rural areas meets or exceeds the need in urban areas.

"A lack of stable housing can also be a barrier to care. Stable housing has been shown to increase access to consistent medical care, increase adherence to drug therapy, and decrease HIV-related risk behaviors. However, rural residents living with HIV/AIDS risk losing their housing due to discrimination. They also face limited housing options in some rural areas, unaffordable medical expenses, or an inability to work due to AIDS and related illnesses. Requesting or receiving housing assistance may unintentionally disclose a person's HIV status in a small community. And people in more remote areas may be less aware of how to access services available through Housing Options for Persons with AIDS (HOPWA).

"The burden that is perhaps hardest on rural people diagnosed with AIDS is fear of stigma and discrimination. It is not that these negative social reactions are unique to rural areas but they are often more severe and readily observed, leading to loss of jobs, housing, and estrangement from family and friends. Some rural people living with HIV/AIDS have voiced concern for their personal safety as well. This may be one of the most important areas of care that rural communities need to confront. Although it is a slow process, shifting social attitudes to be more tolerant of those with HIV is possible through increasing public awareness and giving HIV a rural 'face'.

"The important ethical issue of unintentional disclosure deserves consideration. Well intended services and interventions can put PLWHA at risk for disclosure of their HIV status to other program participants, extraneous clinic or program staff, drivers, and even people merely walking by the program site. Successful programs need to put a lot of thought into ways to protect the privacy and safety of participants." (*Tearing Down Fences: HIV/STD Prevention in Rural America,* Rural HIV/STD Prevention Workgroup, Rural Center for AIDS/STD Prevention, pp58-59.)"

5.10.3. Rural HIV/AIDS

Although estimating HIV infection in rural areas is complicated because many residents seek diagnosis in urban centers, evidence suggests that the infection is increasing in rural areas of Pennsylvania. Several trends have been noted continued in-migration of HIV infected individuals from metropolitan areas (some through the prison systems), increases in heterosexual infections, increases in infections due to intravenous drug use, increased infection in the MSM community and an increase in survival rates due to drug therapy (PA Department of Health, 2006). These trends place a significant burden on rural health care systems that are not always prepared to offer HIV education, counseling, care and treatment. In fact, relative to their urban counterparts, rural people with HIV infection experience more difficulty accessing health and social services, less access to transportation, more stigma and greater fear that others will know their HIV serostatus. In addition, rural HIV infected persons experience more depressive symptoms and more thoughts of suicide than their urban counterparts (Heckman et al, 2007).

"In the U.S., the largest proportion of people with HIV/AIDS is men exposed to the virus by having sex with men. This is true for both rural and urban areas. Consequently, MSM are a primary focus for HIV Prevention interventions. Successfully implementing programs to reduce HIV and STD transmission among MSM is a particular challenge in rural areas in part due to discrimination and homophobia. This seems to apply regardless of whether men identify as gay or bisexual, and whether they are open or secretive about their behavior. Although there are few if any venues for men to socialize with other men in rural areas, social networks may provide a good way to recruit men into interventions. Some MSM are fearful of disclosing their behavior to avoid stigma, discrimination, and potential violence so they may be reluctant to openly participate in interventions. The following interventions begin to address some of these challenges. (*Because most of the programs have not been rigorously evaluated in the rural context, they are described here as programs that **may** work for rural HIV prevention.)* However, the firs step in any rural HIV/STD behavioral intervention is to assess the community and identify local social networks. This requires gathering information about the accessibility of the target audience, their stage of readiness to change, the assets they bring, the social and sexual networks in which risk behaviors occur, and cultural as well as structural influences that might hinder or support the implementation of a program." Rural adaptations of MPowerment, Community PROMISE, and VOICES/VOCES are described in Chapter 7 of Tearing Down Fences: HIV/STD Prevention in Rural America, Rural Center for AIDS/STD Prevention, p 81 (www.indiana.edu/~aids)

5.10.4. Summary of Findings Related to Rural Areas from CPG Poster Sessions

In the 2011 update of the HIV Prevention Plan the Rural Work Group completed an extensive literature review. Published research papers and HIV prevention plans from other rural and/or Appalachian states were examined. Particular attention was paid to descriptive analyses which most clearly define the impact of HIV/AIDS on rural populations. To that end, the following germane excerpts from the literature review are included in the rural portions of the 2011 HIV Prevention Plan Update.

5.10.4.1. Results of 2004 Poster Presentation—Contracted Providers

In May 2004 the CPG organized a program evaluation of 15 funded agencies doing HIV prevention programming in Pennsylvania. The evaluation was done in poster presentation format. The purpose of the presentation was to initiate dialogue between funded agencies/organizations and the CPG, to elicit information for program evaluation, and to provide an opportunity for networking among presenters and CPG members. (See the Program Evaluation section for details on methodology, etc.) Data collected from the poster presentations related to rural HIV prevention issues are listed below:

- not enough resources, very rural; transportation a problem; not enough service providers, especially rural; many people in this area don't think HIV is a problem
- the mobility of the migrant population; access to MSM populations
- difficult in rural areas; stigma a problem
- lack of staffing for prevention; large area to cover; lack of money for incentives; recruitment most difficult
- continued stigma in rural PA; lack of skilled staff; lack of cultural competencies; (staff) unaware of how to access target populations; lack of funding to do the job right
- rural areas underserved (medically)
- Wayne & Pike counties most difficult to provide resources. (note: Pike fastest growing county in state. Large urban transplant populations; the northeast is such a rural difficult area, especially in my county
- targeting rural youth is a challenge; we need to get into the schools
- barriers – not enough resources, very rural; transportation a problem; not enough service providers, especially rural; many people in this area don't think HIV is a problem; only one HEP C provider
- external validity issues . . . what works at one location may not work elsewhere . . . "canned programs" that require lots of staff don't work in agencies with one staff member
- limited services to school age populations; in Clarion County they have reached only 2 of 7 school districts; does not provide services to school age, gay lesbian, transgender, questioning youth; does address IDU
- Stigma from "stoic German population" ; unable to go into the high school (York county)
- outreach – finding at risk populations - hard to reach, homeless, IVDUs, married MSM in rural areas, married Hispanic men;
- stigma, conservatism, access to programs, fewer providers; providers who need education in presenting programs (what works, especially in rural areas); many providers in rural areas said that "canned" programs developed in metro areas are hard to apply in rural (takes time and more providers); hard to specialize in rural areas
- all planning coalitions listed rural issues as a major barrier, whether because of transportation, the large geographic (service) area, or access to targeted populations; many sub-grantees have one paid prevention worker to do outreach and not enough resources to maintain a dependable trained volunteer pool; other barriers: lack of interest in peer education; lack of access to training of volunteers lack of co-operation of other resource groups; liability/safety issues for Public Sex Environment (PSE) outreach workers

All of the Planning Coalitions listed rural issues as major challenges, whether because of transportation, the large geographic service areas, or access to targeted populations; many sub-grantees have one paid prevention worker to do outreach and not enough resources to maintain a dependable trained volunteer pool; other barriers identified were the lack of interest in peer education; lack of access to training of volunteers; lack of co-operation of other resource groups; and liability/safety issues for PSE outreach workers.

5.10.4.2. Results of 2005 Poster Presentation—Pa Department of Health Field Staff

In May 2005, a second poster presentation was held. PA DOH field staff made presentations. Presenters highlighted a variety of issues related to the special needs of rural areas. These included transportation but also access to care and language barriers. It was stated that in rural areas many people do not know where to get tested and often do not know that testing is free. Lack of confidentiality, real or imagined, was rated by three presenters as a major barrier to HIV prevention as was methadone use among youth, and high school drug use in general. Two presenters rated several other issues as barriers. These include entry barriers to notifying a contact when conducting partner services the mindset of corrections staff and policies of prisons (including the inability to distribute condoms): general community attitudes (both complacency about HIV and negative attitudes about "those people"): cultural barriers beyond language: and accessing MSM, including the inability to conduct outreach in parks in rural areas due to police activities.

5.10.4.3. Results of 2006 Poster Presentation—Agencies Utilizing DEBI Interventions

In May 2006, 14 agencies that were implementing DEBI interventions presented posters to the CPG. Issues related to utilizing these programs in rural areas were addressed.
Practically speaking, the narrowly focused target populations for many of the interventions, combined with the strong emphasis upon implementing them precisely as proscribed, are problematic in rural areas. Such rigid guidelines do not permit Community Based Organizations (CBO) to respond to local community needs. Cost is also prohibitive when implementing DEBIs precisely as proscribed. The degree of staff turnover in HIV prevention programs was stated as a major barrier.

In addition, no program specifically addresses the unique challenges of rural prevention such as low staffing and hard-to-find rural gay youth or other rural youth at risk. For example, it is difficult to recruit MSM for Group Level Interventions (GLI) because it is perceived in rural communities to be dangerous to be out as gay or bisexual and dangerous to be associated with an AIDS service organization. In addition, the MSM population in rural areas was perceived to be so small (most are hidden) that people know each other too well to want to be in a group together.

5.10.4.4. Results of 2007 Poster Presentations – Evidence Based HIV Prevention Projects – County and Municipal Health Departments

Since none of the seven health departments and sub-contractors participating in this poster session represented efforts in rural communities, none of the presenters found it necessary to adapt their interventions to address the unique barriers to prevention education in non-metropolitan areas, However, it is the consensus of the Rural Work Group that the majority of the barriers identified, and the strategies for overcoming stated barriers, would also be applicable in adaptations of interventions in a rural setting.

5.10.4.5. Results of 2008 Poster Presentations – Evidence Based HIV Prevention Projects—State and Local Prisons and Jails

During the May 2008 Pennsylvania Community Planning Group meeting, a poster session was held to review six HIV/AIDS interventions that had been implemented across the Commonwealth of Pennsylvania. The evaluation included six posters of four CDC DEBI (Diffusion of Effective Behavioral Interventions) and one non-DEBI intervention (based on social and behavioral theory) which had been implemented.

5.10.4.6 Results of 2009 Poster Presentation-- Evidence Based HIV Prevention Projects--Immigrants and Refugees

During the May 2009 Pennsylvania Community Planning Group meeting, the Evaluation Subcommittee facilitated the sixth consecutive poster session to review HIV prevention interventions. This year's focus area was immigrants and refugees. The evaluation included eight posters of existing programs, home grown interventions that may or may not have been evidence-based (DEBI or EBI).

5.10.4.7 Results of 2010 Poster Presentation-- Evidence Based HIV Prevention Projects--Rural Populations

During the May 2010 Pennsylvania CPG meeting, the Evaluation Subcommittee facilitated the sixth consecutive poster session to review HIV prevention interventions. This year's focus area was rural service delivery. The evaluation included six posters of existing programs that may or may not have based on an evidence based intervention (DEBI or EBI).

5.11. Results of the Rural Men's Study

Deborah Bray Preston, PhD, RN, Principal Investigator
Anthony R. D'Augelli, PhD. Co-Investigator
Funded 2001 to 2005 by NIMH: RO1-MH 62981

This study was undertaken to describe the life experiences regarding health and social issues related to sexual risk taking behavior of gay and bisexual men living in the most rural counties or parts of counties in Pennsylvania. We were able to access 414 men through their social, political and health care networks. Each completed a questionnaire. The findings were aggregated by Pennsylvania HIV/AIDS coalitions and are presented here. However, care must be taken in their interpretation because of the difficulties in reaching those that are hidden. The sample may not be representative of all rural men.

The men ranged in age from 18 to 76, 95% were Caucasian, 70% were employed and 6% were on disability. Overall, 8.6% were HIV positive and 57% reported having receptive anal sex (RAS) in past 6 months. Of those, 44% reported they did not use condoms consistently during RAS. In terms of relationships, 34% monogamous, 56% had multiple partners, and 33% stated they met partners on the Internet.

The following tables depict the findings of the study by Pennsylvania Ryan White HIV/AIDS Regional Planning Coalitions. Most numbers are percentages. Numbers listed under "Variable" are percentages and means for the entire study. M is the symbol for the mean or the average score while R is the symbol for range of scores.

Table 5.6

Age, Education, Race and Ethnicity

Variable	North West % N=29	North Central % N=101	North East % N=68	South West % N=48	South Central % N=130	AIDS NET % N=37
Age	R = 27-54	R = 18-76	R = 20-70	R =22-69	R =18-75	R = 18-62
18-24 10	0	8	15	2	11	22
25-34 17	15	14	15	15	22	17
35-44 37	59	32	33	44	36	33
45-60 31	26	41	31	33	26	25
60+ 5	0	5	6	6	5	3
M =40 years	M = 40	M = 42	M = 40	M=42	M = 39	M = 37
Education						
High School 21	7	21	22	23	22	19
Post High School 39	38	26	46	48	39	41
College 24	31	20	19	21	27	25
Post Grad 17	24	33	13	8	11	14
Race/Ethnicity						
White	97	95	94	92	92	94
Black	3	2	1	4	1	3
Hispanic	0	4	4	4	7	3

Table 5.7

Sexual Orientation and Victimization

Variable N=414 %	North West % N=29	North Central % N=101	North East % N=68	South West % N=48	South Central % N=130	AIDS NET % N=37
Identity						
Mostly Gay 5	0	7	8	2	6	3
Almost Gay 21	18	16	16	25	13	28
Totally Gay 74	82	77	76	73	81	69
Openness						
Hidden 14	17	21	15	11	7	17
Somewhat Open 60	55	52	51	65	70	66
Completely Open 26	28	27	34	24	23	17
Mean Openness 2.87	3.07	2.85	2.80	2.82	2.92	2.85
Harassment						
Scale=1-4						
Verbal 2.33	2.50	2.31	2.28	2.51	2.21	2.58
Physical 1.38	1.48	1.31	1.34	1.56	1.31	1.64

Table 5.8

Sexual Risk Behaviors

Variable	North West % 29	North Central % 101	North East % 68	South West % 48	South Central % 130	AIDS NET % 37
RAS						
No 42	41	50	47	39	40	37
With Condom 13	7	16	8	11	16	14
W/out Condom 42	52	34	45	50	45	49
Partners						
No 9	7	18	12	6	4	8
One 39	38	42	33	33	43	35
Multiple 52	55	42	55	61	53	57
Risk (M) (1-4) 2.52	2.60	2.26	2.50	2.70	2.60	2.65
Sensation Seeking (M)(1-4) 1.94	1.79	1.79	1.95	2.04	2.04	1.96

Table 5.9

More Sexual Risks

Variable	North West % N=29	North Central % N=101	North East % N=68	South West % N=48	South Central % N=130	AIDS NET % N=37
Go for Sex						
Philadelphia	14	18	22	9	25	43
Pittsburgh	34	8	3	49	15	11
Harrisburg	7	24	13	17	44	26
New Hope	0	2	19	4	7	23
New York City	14	10	28	13	18	34
Drugs with Sex in Past 6 Months 34	28	14	43	52	38	50
Alcohol with Sex in Past 6 Months 57	48	57	40	77	74	74

Table 5.10

Mental Health and Stigma

Variable	North West M	North Central M	North East M	South West M	South Central M	AIDS NET M
Self-Esteem (1-4) 3.37	3.19	3.44	3.26	3.38	3.40	3.40
Internalized Homophobia (1-4) 1.73	1.88	1.72	1.70	1.82	1.67	1.76
Depression (1-4) 1.59	1.67	1.54	1.57	1.71	1.58	1.51
Family Stigma (1-5) *High=Tolerant* 3.52	3.68	3.49	3.42	3.67	3.49	3.51
Health Care Providers Stigma (1-5) 3.51	3.46	3.54	3.41	3.46	3.56	3.56
Community Stigma (1-5) 2.88	2.81	2.98	2.81	2.79	2.89	2.79

Note: Internalized Homophobia measures a man's feelings about being gay or bisexual. Low scores mean good feelings.

Figure 5.3 Relationship of Stigma to Sexual Risk

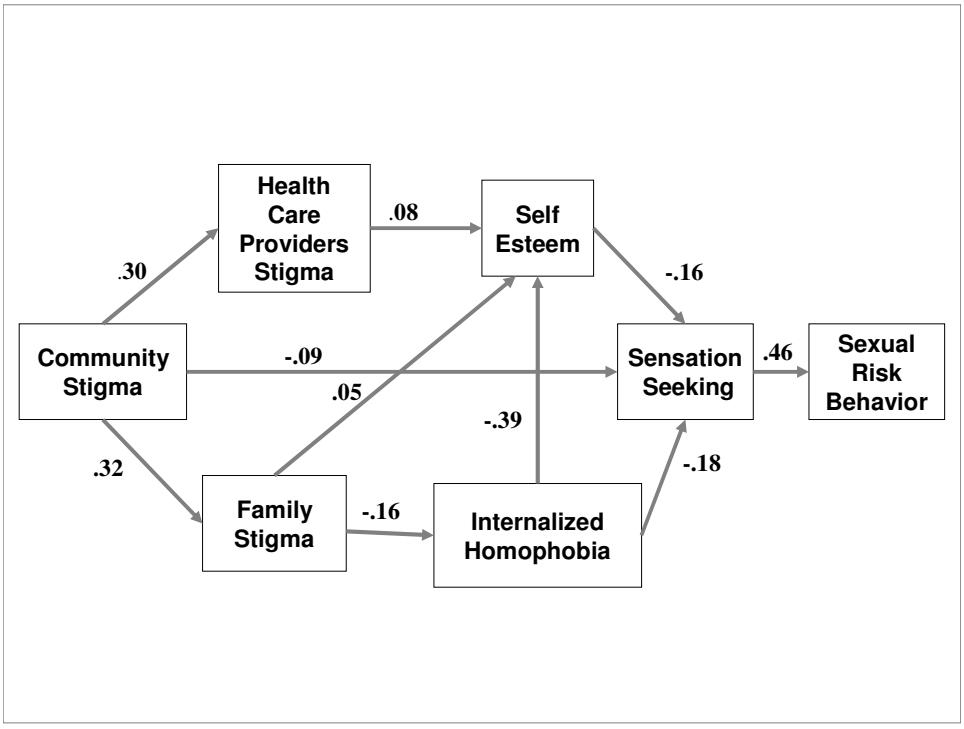

Figure 5.3 shows that the stigma experienced by rural men is indirectly related to their sexual risk behavior through sensation seeking, self esteem and internalized homophobia.

In addition, community stigma (intolerance) was the highest form of stigma reported by the men. Moreover, the men's experience of being gay, their sexual health, degree of sexual harassment, experience of stigma and sexual risk taking behavior differed by the area in which they live.

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5.12. Decisions For Life

Decisions For Life (DFL) is a peer-based, group-level intervention designed by and for sexually active young people (ages 16-24). DFL is rooted in behavioral science and targets universal risk behaviors through a comprehensive, interactive and skills-based, risk reduction program that focuses on HIV/STI counseling and testing, treatment, risk reduction skills and informed decision-making.

Table 5.11 INTERVENTION MODULES

	Title	Sample Learning Objectives
SESSION ONE	Personal Risk Assessment	• identify personal risk factors for HIV infection/re-infection
MODULE ONE	HIV Transmission	• understand levels of risk of common modes of HIV transmission • identify importance of STI and HIV treatment
MODULE TWO	HIV Risk Reduction Skills & Strategies	• communication skills • demonstrate male condom use efficacy
MODULE THREE	HIV Counseling & Testing and Treatment	• understand HIV counseling and testing experience and results • identify local, accessible test sites
MODULE FOUR	Decision-Making & Social Norms and Personal Values	• identify social forces that impact risk reduction behaviors • understand personal sexual values
FINAL SESSION	Personal Risk Re-Assessment and Wrap Up	• update personal risk reduction plan • complete Intervention evaluation

DFL is rooted in community planning. Begun in 2000, DFL is being designed, implemented and evaluated by members of a Young Adult Advisory Team (YAAT) – a planning group of eighteen diverse and high-risk young people – in partnership with University of Pittsburgh staff. Three external reviews by members of the Pennsylvania HIV Prevention Community Planning Committee and process evaluation data from DFL pilot group participants have all provided invaluable insights and recommendations used to improve the Decisions For Life curriculum.

Currently in the final phase of a formative process, the DFL curriculum is being piloted among targeted populations of young people in locations throughout Pennsylvania. Members of the PA HIV Community Planning Committee have assisted in identifying local recruiters, young peer educators and guest speakers for the pilot groups:

Table 5. 12 Decisions For Life Pilot Groups (2006-2010)

Target Population	n	Participant Age Range	Racial Distribution	Location	Attendance Rate*	Retention Rate**	Satisfaction Scores^
Gay/ Bisexual Males	10	16-20	40% (4) White 40% (4) Afr Am 20% (2) Latino	Pittsburgh	6.5	60%	3.82
Latinas	13	16-19	84% (11) Latina 15% (2) multiracial	Bethlehem	6.6	46%	3.18
Females from a Rural Community	15	18-21	80% (12) White 6% (1) API 6% (1) Latina 6% (1) multiracial	Honesdale	12.3	66%	3.62

Target Population	n	Participant Age Range	Racial Distribution	Location	Attendance Rate*	Retention Rate**	Satisfaction Scores^
African American females	21	14-17	77% (16) Afr Am 23% (5) multiracial	Reading	6.6	85%	3.64
Gay/Bisexual Males	16	17-20	68% (11) White 19% (3) Afr Am 13% (2) multiracial	Pittsburgh	6.4	57%	3.74
Gay/Bisexual Males	20	16-20	65% (13) Latino; 15% (3) multiracial; 10% White; 5% (1) Afr Am; 5% (1) other	Reading	in process		

* group size averaged over ten sessions
** comparison of attendance rates at first and last sessions
^ based on group average of 11, Likert-type items (scaled 1= very dissatisfied to 4= very satisfied) rated by participants in confidential session evaluations.

In order to enhance the aggregated qualitative and quantitative data from confidential evaluation forms, YAAT members personally interviewed members of each pilot group following final sessions and have used this information to modify and update the DFL curriculum by integrating topics from modules, eliminating topics or activities that were repeatedly cited as poor or unnecessary, and adding topics or activities that were repeatedly identified as lacking. As a result, after eleven revisions the DFL curriculum has been reduced from 40 hours to fewer than 29 hours.

Initial outcome data suggests that DFL may, in fact, be effective in reducing rates of HIV risk behaviors:

- rate of sexual activity (oral, anal or vaginal) decreased 18%
- rate of unprotected receptive vaginal sex decreased 16%
- rate of receptive anal sex decreased 5% (although only two individuals reported having unprotected RAS, they provided explanations that suggest they are, in fact, utilizing risk reduction strategies**)
- rate of drug use during sex decreased 14%

One of the primary DFL objectives is to encourage at-risk participants (and their partners) to "GET TESTED." 12% of DFL participants received their first HIV test during the intervention period. Additional data are needed to support these initial outcomes.

DFL pilot group members provided the following comments about the DFL curriculum in confidential written evaluations completed during the final session:

*Young gay/bisexual males***:**

- I have lots of helpful information and tools! They will help me make risk reducing decisions and safer sex.
- Educated me totally about HIV, taught me the correct way to test a condom before opening it. Discussing risk levels is important also.
- It taught me a lot about safer sex and other ways to be intimate without putting myself at risk.
- Knowing the information helps tremendously, and now having my own risk reduction plan and my goal to continue to follow it helps a lot.
- THIS PROGRAM IS NEEDED. Should be available as soon as possible. Young people can greatly benefit from this information.

- Thank you for creating a program where other gay/bisexual people can discuss about life issues and ways to protect our community from the HIV virus. It's been an honor being a part of it and I hope you continue to alert other young men about the epidemic so that we can live happier and longer.
- They actually made it so we can connect with the program and retain the information.
- AWESOME!

Young Latinas:
- This program is a very big help to young adults like me!!
- I learned a lot of things about HIV that I never knew about.
- They have helped me change the way I was and made me think now before I act.
- Thanks! The information really helped a lot.
- I really liked the program.
- You did a good job to teach others how to protect themselves.
- It gave me information I can use in my sexual life to protect myself.
- It really helped me change my life and made me think of risks of HIV.
- It made me realize that it's important to take care of yourself.
- I liked the parts that really got me thinking about myself… they get to you.

Young Females from Rural Community:
- I think this is an awesome thing you've done. It is very important for young people to be fully informed with all of this. I really hope that this is available to everyone in the near future. Thank you.
- Before this "class" I had little to no understanding of what HIV is and how you can get it.
- I think it will definitely help me in the future because I will think twice now before I act. The facts about HIV were shocking and had an effect on me. I will definitely protect myself!
- I'm not concerned w/myself currently, but if my relationship ends I will use what I learned in other interactions.
- I learned so much about protecting myself and skills to have a healthy relationship(s).
- There were a lot of things about HIV + AIDS that I didn't know, or that I had the wrong info about it, so getting all the facts straight and learning more about it has made me really evaluate my behavior and I plan to reduce my risk.
- The meetings have really made me re-think behavior (past/ present/ future) and decisions.
- I think the curriculum we talked about were all very relevant to our age group and I think it made a lot of people think about their own behaviors.
- It has helped me and changed my way of life for the better. THANKS!! ☺

Young African American Females:
- It's a great program to be involved in even if you are not sexually active because it gives great information about the different aspects of sex, and where to get tested, etc. It can prepare you for your future when you are ready to have sex.
- It's a very good program, great idea. It's very much information. I've learned a lot of new things and if it weren't for this class I would not know half the things I know now. I think they should open groups like this all around the world.
- Thank you. It was a wonderful learning experience. Now I get to share the info I learned with peers, friends and family, and to keep the program alive because it really helps people be more aware of HIV/AIDS.

- Thank you for helping me understand HIV. It gave me the opportunity to see that it is a serious matter and by me protecting myself from unprotected sex I'm doing a wonderful thing.
- I think this was a Great Idea. I really honestly didn't get info like this anywhere else. I loved coming and now I'm informed about what is out there & what I can do. Those that put this together, it was helpful to me and can be helpful to others. So, thank you and I hope it will become a permanent program.
- That it was a fun and informative program. It was also useful, but at times long.
- To be sure to strap up, use a condom.
- Thanks. I've learned way more about AIDS then I ever could imagine.

6. EVALUATION

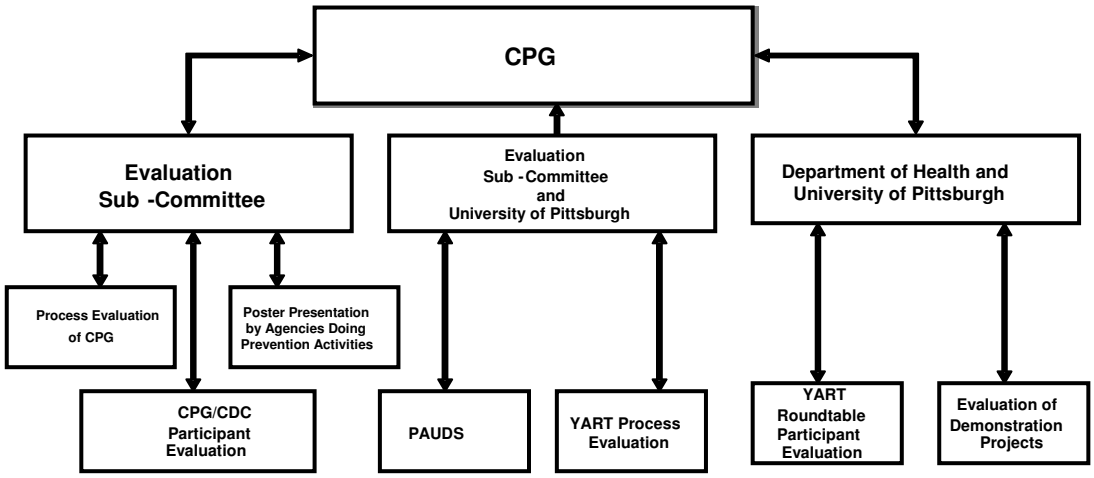


Figure 6.1 Evaluation Flow Chart

6.1. Introduction

At the first meeting of the HIV Community Planning Group (CPG) in 1994, the members clearly identified evaluation as a critical function of the CPG. Over time, CPG members working with professional evaluators developed a number of mechanisms for evaluating important CPG functions. These mechanisms were a three arm evaluation of the state's counseling and testing program; a process evaluation of the CPG's and the Young Adult Roundtables' planning processes; evaluations of CPG initiated prevention interventions; and an evaluation of all CDC funded interventions including local Departments of Health and local agency prevention activities.

The Committee highly values its evaluation activities and has integrated them into all phases of its work. Committee evaluations have been designed and implemented to ensure that they are valued as useful tools that will promote better programming rather than as surveillance activities that can be used punitively. As a result, they continue to produce recommendations that lead to valuable changes in Committee, Department, and agencies' HIV-related activities.

6.2. Activities Conducted by the Evaluation Subcommittee

The Evaluation Subcommittee conducts three evaluations. The first is a process evaluation of the CPG, the second is an evaluation of the efficacy of the HIV Prevention Plan/Update by means of a poster presentation of HIV prevention activities, and the third is a CPG participant evaluation (see Figure VI.1).

The process evaluation was designed to evaluate the CPG's internal functions, its relationship with the Pennsylvania Department of Health and the University of Pittsburgh staff, and to identify strengths and weaknesses of the CPG. The results of the process evaluation are presented to the CPG and recommendations for change emerge and are implemented. This evaluation occurs every year at the November meeting after the annual plan is submitted.

The poster presentation is designed to evaluate the impact of the Prevention Plan on statewide prevention interventions. It is an evaluation activity using poster presentations by local Departments of Health, the seven Ryan White Coalitions and interventions carried out by other related agencies. Agencies are asked to create posters describing their work. The Evaluation Subcommittee members develop a series of questions to identify all of the issues that CPG members want evaluated. The CPG members collect the data for each question during the poster presentations. These data are then analyzed and recommendations developed. This innovative program also promotes communication and networking between the CPG members and providers of prevention programming.

The CPG participant evaluation identifies the demographic characteristics of the CPG members in order to determine whether they reflect the demographic characteristics of the HIV epidemic in Pennsylvania. In addition, the survey gathers data on eight objectives identified by the CDC related to CPG functions.

6.3. Process Evaluation of the 2009 CPG - Findings from the Nominal Group Process
Submitted the consulting firm: By The Numbers

The CPG by-laws, section 3.3.4, state that "the Evaluation Subcommittee is charged with evaluating the CPG planning process, which leads to the development of the Plan, which is submitted to the CDC." The committee chose to process CPG concerns by having trained non-CPG members gather data through open-ended questions posed to small groups of CPG members. It was felt that this method provided greater objectivity and a lack of conflict of interest. The results are presented at a subsequent CPG meeting. Results are then used to support changes in the CPG. For example, the 2005 process evaluation results cited that improvements needed to be made in the CPG orientation process; the level of commitment of CPG members; the member recruitment process, and the reading material provided to members.

As part of the Pennsylvania HIV Prevention Community Planning Committee's overall evaluation process, the Pennsylvania Department of Health contracted with By The Numbers to perform an evaluation of the Community Planning Group (CPG) planning process. By The Numbers is a consulting firm in State College, Pennsylvania specializing in program evaluation.

CPG Planning Evaluation Focus Group Report
The evaluation is based on the results of three focus groups held with CPG members from 1:00-3:00 pm on Wednesday, November 18, 2009, during a meeting of the Pennsylvania HIV Prevention Community Planning Committee. The meeting and focus groups were held at the Holiday Inn Harrisburg West. The goal of the focus groups was to determine the strengths and weaknesses of the 2009 planning process and identify recommendations to improve the planning process in 2010.

Focus Group Questions

Three questions were covered in each focus group:

1. What have been the strengths of the CPG planning process this past year?

2. What have been the weaknesses of the CPG planning process this past year?

3. What recommendations would you make to improve the CPG planning process?

Methodology:

The focus groups were conducted using a nominal group process technique, which is more structured and quantitative than the typical method for carrying out focus groups. In the nominal group process technique as implemented here, the moderator of each focus group began by explaining three rules. First, participants were asked to refrain from all discussion as each person's response to a question was written on a flipchart. Participants were asked to listen carefully to each response and think about whether the nominated response triggered another response. Second, participants were asked to offer their best response when it was their turn. Third, participants were asked to nominate only one response statement at a time (in order to balance nominations around the group).

Following this, the moderator read the first question aloud twice and gave participants a couple of minutes to think about it. The moderator went around the room in a clockwise direction, asking each person for their best response to the question. This continued until there were no more responses by any participant. Participants then had an open group discussion on two questions for each response statement: (1) Do we understand the statement as written? (2) Do we agree that the statement is a good response to the question? Participants had the option to eliminate, modify, and combine responses at this stage of the process.

Two rounds of voting were then held. In the first round, each participant voted for up to two themes (i.e., responses) they felt were the best. The second round was limited to the three themes receiving the most votes in the first round, with each person voting for the theme (out of the three in the second round) which they felt was the best. If multiple themes were tied for second or third place in the first round, the second round was limited to the two themes receiving the most votes in the first round.

After the conclusion of this process for the first question, the entire process was repeated for questions two and three, with the moderator moving around the room in a counterclockwise direction for the second question and back to a clockwise direction for the third question. Each focus group had a moderator, who led the group, and a recorder, who wrote responses on a flip chart and tallied votes. The moderators and recorders were By The Numbers employees.

Focus group participants consisted of the meeting attendees who were CPG members in 2009. (New CPG members participated in an orientation session while the focus groups were being held.) Meeting attendees who were employees of the Pennsylvania Department of Health or the University of Pittsburgh did not participate in the focus groups. Participants were assigned at random to the three focus groups, labeled A, B and C. A similar nominal group process technique and the same set of questions were used in focus groups held annually since 2005 to evaluate the CPG planning process.

There were a total of 26 participants across the three focus groups. Focus group A had nine participants, focus group B had seven participants, and focus group C had ten participants.

Results for Focus Group A:

The themes emerging in focus group A in response to the first question, "What have been the strengths of the CPG planning process this past year?" are shown in Table 1. The three themes receiving the most votes in the second round were all tied for most votes in the first round. The theme receiving the most votes in the second round was "The clarity and variety of information presented to CPG." The second-highest vote recipient in the second round was "Statewide representation, dedication and diversity of membership." The third-highest in the second round was "The leadership."

Three themes receiving two votes each in the first round were "Roundtables improved interactions between subcommittees," "YART," and "DOH and University of Pittsburgh support staff." Another three themes received one vote each in the first round: "Poster presentation in May," "The meeting site"and"The overall plan produced." Three additional themes were mentioned by participants that did not receive any votes in the first round, these being "Improved member attendance," "Enforcement of rules of engagement," and "The specificity of the work plan and the agendas."

Table 1 Strengths of the CPG Planning Process (Focus Group A)

Strength	**1st Round Vote**	**2nd Round Vote**
The clarity and variety of information presented to CPG	3	4
Statewide representation, dedication and diversity of membership	3	3
The leadership	3	2
Roundtables improved interactions between subcommittees	2	—
YART	2	—
DOH and University of Pittsburgh support staff	2	—
Poster presentation in May	1	—
The meeting site	1	—
The overall plan produced	1	—
Improved member attendance	0	—
Enforcement of rules of engagement	0	—
The specificity of the work plan and the agendas	0	—

The themes emerging in focus group A in response to the second question, "What have been the weaknesses of the CPG planning process this past year?" are shown in Table 2. The theme receiving the most votes in the second round, and tied for the most number of votes in the first round, was "Gaps in representation in CPG membership." The theme receiving the second-highest number of votes in the first and second rounds was "Insufficient time for poster presentation dialog." The third highest number of votes in the second round, and tied for the most number of votes in the first round, was "Verbal confrontation towards presenters."

Table 2 Weaknesses of the CPG Planning Process (Focus Group A)

Weakness	1st Round Vote	2nd Round Vote
Gaps in representation in CPG membership	5	6
Insufficient time for poster presentation dialog	4	2
Verbal confrontation towards presenters	5	1
Sidebar communication	2	—
Not keeping to the time	2	—
Lack of full participation by members	0	—

Other themes receiving votes in the first round were "Sidebar communication" and "Not keeping to the time." One them mentioned by participants that did not receive any votes in the first round was "Lack of full participation by members."

The themes emerging in focus group A in response to the third question, "What recommendations would you make to improve the CPG planning process this coming year?," are shown in Table 3. The theme receiving the most votes in the first and second rounds was "Increase recruitment efforts to fill membership gaps." The other theme making it to the second round of voting was "Another training exercise on the interaction between subcommittees."

Table 3 Recommendations for Improvement (Focus Group A)

Recommendation	1st Round Vote	2nd Round Vote
Increase recruitment efforts to fill membership gaps	7	6
Another training exercise on the interaction between subcommittees	4	3
Continued capacity building from the state DOH and University of Pittsburgh	3	—
More use of the gavel	3	—
Dig deeper in data sets for better pictures of the epidemic and processes	1	—

Two themes received three votes each in the first round: "Continued capacity building from the state DOH and University of Pittsburgh" and "More use of the gavel." Another theme that received one vote in the first round was "Dig deeper in data sets for better pictures of the epidemic and processes."

Results for Focus Group B:

The themes emerging in focus group B in response to the first question, "What have been the strengths of the CPG planning process this past year?," are shown in Table 4. The theme receiving the most votes in the second round, and the second-most number of votes in the first round, was "Strong leadership to organize, facilitate and make difficult decisions." The theme receiving the most number of votes in the first round, and

the second-highest vote total in the second round, was "Development of group cohesiveness." Also making it to the second round of voting was "Work of the subcommittees including edits of the plan."

Two themes were mentioned by participants that received one vote each in the first round: "Dr. Ben is a valuable resource" and "Informative presentations." One additional theme, "Good networking opportunities," was mentioned by participants but did not receive any votes in the first round.

Focus group B combined several themes in the open discussion part of the process in arriving at the two top themes shown in Table 4. The "strong leadership" theme was a combination of "Getting information and feedback to members on time before meetings via email or mail," "Well-organized meetings," "Ken, Steve, and Roger are good facilitators," "Ability of leadership to facilitate bylaw changes," and "Organization for new members." The "group cohesiveness" theme was a combination of "Increased commitment in attendance by members," "Well-developed membership able to reach consensus amicably," "Longevity of CPG membership and support staff cohesiveness," "Fostering a sense of community," and "Group diversity and acceptance."

Table Strengths of the CPG Planning Process (Focus Group B)

Strength	**1st Round Vote**	**2nd Round Vote**
Strong leadership to organize, facilitate and make difficult decisio	4	5
Development of group cohesiveness	5	2
Work of the subcommittees including edits of the plan	3	0
Dr. Ben is a valuable resource	1	—
Informative presentations	1	—
Good networking opportunities	0	—

The themes emerging in focus group B in response to the second question, "What have been the weaknesses of the CPG planning process this past year?" are shown in Table 5. The theme receiving all the most votes in the first round was "Disregarding respectful engagement at times (has occurred in all sessions); leadership needs to enforce Bob's Rules" (i.e. Robert's Rules of Order). Because this theme received all the votes in the first round, no second round of voting was necessary. Two other themes mentioned in the first round were "Enforcement of subcommittee start times" and "Inefficient use of time."

Table 5 Weaknesses of the CPG Planning Process (Focus Group B)

Weakness	**1st Round Vote**	**2nd Round Vote**
Disregarding respectful engagement at times (has occurred in all sessions); leadership needs to enforce Bob's Rules	7	—
Enforcement of subcommittee start times	0	—
Inefficient use of time	0	—

The themes emerging in focus group B in response to the third question, "What recommendations would you make to improve the CPG planning process this coming year?" are shown in Table 6. The theme receiving the most votes in the first and second rounds was "Access to a hard copy of presentations and a larger format PowerPoint projector." The theme with the second-highest number of votes in both rounds was "Clarification

of CDC guidance before we do the Plan." Two other themes receiving votes in the first round were "Enforce Bob's rules on an individual basis" and "More effective use of downtime in subcommittees."

Table 6 Recommendations for Improvement (Focus Group B)

Recommendation	1st Round Vote	2nd Round Vote
Access to a hard copy of presentations and a larger format PowerPoint projector	5	6
Clarification of CDC guidance before we do the plan	4	1
Enforce Bob's rules on an individual basis	3	—
More effective use of downtime in subcommittees	2	—
Hold all questions on the presentation until prompted by the presenter	0	—
Be able to give suggestions for future presentation topics	0	—
Have a representative from an out-of-state CPG explain how they've modified Debi's for at-risk minority populations	0	—
Keep room at a comfortable temperature	0	—

Four additional themes were mentioned by participants that did not receive any votes in the first round, these being "Hold all questions on the presentation until prompted by the presenter," "Be able to give suggestions for future presentation topics," "Have a representative from an out-of-state CPG explain how they've modified DEBI's for at-risk minority populations," and "Keep room at a comfortable temperature."

Results for Focus Group C:

The themes emerging in focus group C in response to the first question, "What have been the strengths of the CPG planning process this past year?" are shown in Table 7. The theme receiving the most number of votes in both rounds of voting was "Structured leadership." The theme receiving the next-most number of votes in the second round of voting was "Wealth of knowledge." The other theme making into the second round of voting was "Diverse presentations/excellent presenters with visible slides."

Table 7 Strengths of the CPG Planning Process (Focus Group C)

Strength	1st Round Vote	2nd Round Vote
Structured leadership	7	6
Wealth of knowledge	3	3
Diverse presentations/excellent presenters with visible slides	4	1
Up-to-date Epi info	2	—
Diversity	1	—
Commitment (inclusive)	1	—
Roundtable clarifications	1	—
Committee members' identifying and addressing needs	1	—
Vested interest	0	—
Networking	0	—
Openness	0	—

Schedule change	0	—
Representation from other state offices	0	—
Food!	0	—

Other themes receiving votes in the first round were "Up-to-date Epi info," "Diversity," "Commitment (inclusive)," "Roundtable clarifications," and "Committee members' identifying and addressing needs." Themes mentioned by participants that did not receive any votes in the first round were "Vested interest," "Networking," "Openness," "Schedule change," "Representation from other state offices," and "Food!"

The themes emerging in focus group C in response to the second question, "What have been the weaknesses of the CPG planning process this past year?" are shown in Table 8. The theme receiving the most number of votes in both the first and second rounds was "Lack of connection between care and prevention." The theme receiving the next-most number of votes in the second round was "Disconnect between plan and implementation/lack of plan marketing." The other theme making it into the second round of voting was "Lack of load-sharing of committee responsibilities."

Table 8 Weaknesses of the CPG Planning Process (Focus Group C)

Weakness	**1st Round Vote**	**2nd Round Vote**
Lack of connection between care and prevention	7	7
Disconnect between plan and implementation/lack of plan marketing	3	2
Lack of load-sharing of committee responsibilities	6	1
Cell phones	1	—
Overuse of acronyms	1	—
Lack of use of YART consensus statement	1	—
Ineffective communication between Philadelphia and CPG	1	—
Process gets stale	0	—
Cross-talking	0	—
Lack of microphones	0	—
Distance	0	—

Other themes receiving one vote each in the first round were "Cell phones," "Overuse of acronyms," "Lack of use of YART consensus statement," and "Ineffective communication between Philadelphia and CPG." Themes mentioned that did not receive any votes were "Process gets stale," "Cross-talking," "Lack of microphones," and "Distance" (a reference to the distance some participants had to travel to the meeting site).

The themes emerging in focus group C in response to the third question, "What recommendations would you make to improve the CPG planning process this coming year?," are shown in Table 9. The theme receiving the most votes in the second round, and tied for the most votes in the first round, was "Improve connection between care and prevention." Tied with this theme in the first round was "Leadership development."

Five themes were tied for third place in the first round, and so were excluded from the second round of voting. These themes, which received two votes each, were "Utilize Philadelphia expertise," "Subcommittee chairs/workgroup chairs should have limited terms," "Target population representation at table," "More

information on heterosexual risks," and "Improve access, implementation and marketing of plan to subcontractors."

Themes receiving one vote each in the first round were "New member inclusiveness" and "Mentors for agency representatives." Themes that did not receive any votes were "Continuous clarification of University of Pittsburgh's role," "Continue commitment to group diversification," "More effort to make Epi info accessible and understandable to all members," and "Increase term lengths for CPG members to utilize gained knowledge."

Table 9 Recommendations for Improvement (Focus Group C)

Recommendation	**1st Round Vote**	**2nd Round Vote**
Improve connection between care and prevention	4	6
Leadership development	4	4
Utilize Philadelphia expertise	2	—
Subcommittee chairs/workgroup chairs should have limited terms	2	—
Target population representation at table	2	—
More information on heterosexual risks	2	—
Improve access, implementation and marketing of plan to subcontractors	2	—
New member inclusiveness	1	—
Mentors for agency representatives	1	—
Continuous clarification of University of Pittsburgh's role	0	—
Continue commitment to group diversification	0	—
More effort to make Epi info accessible and understandable to all members	0	—
Increase term lengths for CPG members to utilize gained knowledge	0	—

Cross-Cutting Themes among the Three Focus Groups:

Three cross-cutting themes emerged from the three focus groups with respect to the strengths of the CPG planning process in 2009:

- **Information Sharing**
  Participants in all three focus groups indicated that information sharing is a strength of the CPG planning process. Focus group A mentioned the clarity and variety of information presented to the CPG. Group A also mentioned that roundtables improved interactions between subcommittees, and the poster presentation in May. Group B mentioned informative presentations as a strength. Group C mentioned "Wealth of knowledge," "Up-to-date Epi info," and "Diverse presentations/excellent presenters with visible slides."
- **Leadership**
  Participants in all three focus groups also identified leadership as a strength. Focus group A mentioned simply "The leadership," group C mentioned "Structured leadership." Group B

indicated that the strength of CPG's leadership helps with organizing, facilitating, and making difficult decisions.

- **Membership**
  In different ways, participants in all three focus groups identified the CPG membership as one of its strengths. Focus group A mentioned the "Statewide representation, dedication and diversity of membership." Group B mentioned "Work of the subcommittees including edits of the plan." Group C mentioned the diversity of the membership and "Committee members' identifying and addressing needs."

Cross-cutting themes with respect to the weaknesses of the CPG planning process in 2009 were more difficult t identify because each focus group tended to emphasize different issues. However, there appear to be two cross cutting themes:

- **Lack of Respectful Engagement**
  Participants in focus group A mentioned "Verbal confrontation towards presenters" and "Sidebar communication." Participants in focus group B indicated "Disregarding respectful engagement at times (has occurred in all sessions); leadership needs to enforce Bob's Rules" (i.e. Robert's Rules of Order). Participants in focus group C mentioned "Cell phones" and "Cross-talking."

- **Inefficient Use of Time at CPG Meetings**
  Participants in focus group A mentioned "Insufficient time for poster presentation dialog" and "Not keeping to the time." Participants in focus group B indicated "Enforcement of subcommittee start times" and "Inefficient use of time."

Cross-cutting themes with respect to recommendations for improving the CPG planning process in 2009 were also difficult to identify. There appear to be three cross-cutting themes:

- **More Respectful Engagement**
  Participants in focus group A mentioned "More use of the gavel." Participants in focus group B mentioned "Enforce Bob's rules on an individual basis" and "Hold all questions on the presentation until prompted by the presenter."

- **More and Better Use of the University of Pittsburgh**
  Participants in focus group A mentioned "Continuous capacity building from the state DOH and University of Pittsburgh." Participants in focus group C mentioned "Continuous clarification of University of Pittsburgh's role."

- **More Diversity in Membership**
  Participants in focus group A mentioned "Increase recruitment to fill membership gaps." Participants in focus group C mentioned "Continue commitment to group diversification" and "New member inclusiveness."

6.4. Results of the CPG Participant Evaluation (2009)

The results of the CPG participant evaluation mandated by the CDC are reported in the Pennsylvania Commonwealth Department of Health's grant application to the CDC. The Evaluation Subcommittee

presented the data to the Committee and the CPG Nominations and Recruitment Work Group uses these results in screening prospective Committee members.

6.5. Results of the HIV Prevention Provider's Poster Sessions

Section 3.3.4 of the CPG by-laws further state that "this subcommittee is also responsible for designing frameworks for evaluation, establishing standards and benchmarks, assessing capacity, and planning for the allocation of resources for outcome evaluation in prevention/intervention programs. This subcommittee is responsible for identifying best evaluation practices, reviewing and recommending resources and infrastructure needed for evaluation to be conducted within government agencies and Community-Based AIDS Service Organizations.

6.5.1. Results of the 2004 Poster Session – Funded Agencies in Pennsylvania

The following is a report compiled by the evaluation subcommittee of the Community Planning group (CPG) of a poster presentation made by funded agencies doing HIV prevention programming in Pennsylvania. The presentation took place in Harrisburg, PA on May 18th, 2004. Committee members were: Steve Godin, Chair; Marilyn Bergt, Co-Chair; Charles Christen, Deborah Preston, David Spring, and Belinda Williams.

Purpose:

The purpose of the presentation was to elicit initial dialogue between funded agencies/organizations and the CPG, to elicit information for program evaluation, and to provide an opportunity for networking among presenters and CPG members.

Procedure:

Letters were sent to funded organizations inviting them to present a poster about their projects at the May, 2004 CPG meeting. The letter included guidelines for the presentation. A second letter was sent to confirm the invitation and further clarify guidelines and procedures. Follow-up telephone calls were made by evaluation subcommittee members for any additional clarification and to confirm attendance. Presenters representing 15 organizations/agencies attended the session. CPG members interviewed presenters during the session. A set of five questions were formulated to guide the interviews (see results section).

Upon completion of the interviews, the CPG members wrote their summaries of the answers to the five questions on a prepared summary sheet. In addition, presenters submitted a summary handout to the evaluation subcommittee. The subcommittee summarized and collated the raw data from the interviews according to the five questions. In addition, the presenter's handouts were analyzed and additional information related to the five questions was compiled and summarized. The summaries were listed by agency in bullet format. Finally, a thematic analysis was conducted. Common themes were extracted from the data and summarized for each question. In addition, themes that were particular to non-metropolitan areas of Pennsylvania were extracted and summarized.

Results:

The letters were received by the organizations and although the purpose of the presentation was clear to the CPG members, it was not so clear to those invited. There seemed to be an overwhelming feeling that the CPG evaluation committee was evaluating the work that direct providers did, and therefore there would be consequences associated with their presentations. This caused a great deal of stress among service providers,

as well as a lot of questions about what to do. However, during the presentations it became obvious that the CPG members were not there to penalize the agencies but to gain an understanding of what those charged with doing prevention in the State of Pennsylvania were doing. The atmosphere thus became more congenial and productive. During this time CPG members learned what types of prevention activities were being initiated in the state while direct service providers gained a better understanding of what the CPG does. The meeting allowed service providers and the CPG to learn of different programs and initiatives throughout the region, the efficacy of these programs and to establish networks with previously unknown organizations. The experience was found to be positive by both the CPG and service providers and served to strengthen existing relationships between direct service providers and the CPG to a new level.

The following are the summaries related to the five questions followed by results of the thematic analysis for each question (except for Question 1).

Question 1
Do your organization/subcontractors use the CPG plan in developing the fiscal year goals and objectives? If not, why?

Of the 15 organizations/agencies, 6 said they used the CPG Plan, 5 used it for target and priority populations only and 4 did not respond to the question. Several cited difficulties with using the plan because they found it cumbersome. One agency presenter found it overwhelming and three suggested the plan be made more "user friendly".

Question 2
Regarding your target population, which interventions do you feel are working and why?

- Networking for the purpose of accessing risk groups through outreach
- Programming works best if it is location-based and group/culturally sensitive
- Programming must be innovative and comprehensive
- Anonymity/ confidentiality supports interventions – i.e. telephone and/or Internet education programs
- Websites can provide education materials for providers
- ILI's help gain trust – GLI's work best in groups with common risks e.g. prisons

Question 3
Out of all the HIV prevention work your organization/subcontractors do what types of prevention /education do you think are the most difficult to implement and why? Which are the easiest, and why?

Programs most difficult to implement:
- Outreach to at-risk populations: homeless, IVDUs, married MSM in rural areas, married Hispanic men.
- Transgender issues/education
- School age populations if access is denied.
- "Canned" programs - developed in metro areas are hard to apply in rural areas (takes time and trained providers), hard to specialize in rural areas
- Abstinence programs (don't work well)
- Condom distribution and education – especially in schools and prisons

Programs easiest to implement:

- Outreach (if there are strong community networks and collaborations)
- Outreach in metropolitan areas. Rural areas more difficult
- Outreach through churches
- Outreach that is culturally sensitive – e.g. to Latino populations by Spanish speaking educators
- Mandatory prevention with groups – e.g. drug and alcohol rehab
- Clinics – if staff are well trained and if clinics are accessible.
- Websites (in some areas only) – works well with HIV positives who have access to computers – helps them find services

Question 4
What do you feel are the biggest barriers to doing effective HIV prevention in your community or region?

Barriers:

- Stigma/conservatism about HIV and about at-risk groups
- Lack of community support and trust
- Abstinence only programs
- Inability to access schools because of school boards etc.
- Restrictions on distribution of condoms and bleach kits
- Restrictions on subject matter
- Makes it difficult to find at-risk populations
- HIV is not a priority anymore in many communities
- Transportation problems
- Fewer providers
- Difficulty with staff training
- Cultural barriers – because of lack of language training and understanding of cultural issues
- Movement of at-risk populations in and out of counties
- Conflict within and between agencies – makes networking and collaboration difficult
- Lack of funding - many sub-grantees have one paid. Prevention worker to do outreach and not enough resources to maintain a dependable trained volunteer pool
- Lack of trained staff – staff turnover – keeping staff current
- Adapting boilerplate evidence based programs to different populations and with limited staff and resources.

Question 5
Is there any need for HIV prevention training for staff in your organization or your subcontractors, and if so, what areas?

Of the 15 agencies, 9 stated a need for HIV prevention training of staff because of:

- Staff turnover
- Lack of administrative support
- Need for training updates in accessing populations, cultural issues, and networking
- Need to adapt boilerplate efforts to specific targeted populations
- Need to operate evidence-based programs with limited staff and resources

6.5.2. Results of the 2005 Poster Session – Department of Health Field Staff

Analysis by Mark S. Friedman, PhD, University of Pittsburgh

In May 2005, the evaluation subcommittee of the CPG sponsored a second poster session. Field staff from the Pennsylvania Department of Health were invited to present. Lessons learned from the poster session of May 2004 were incorporated into the guidelines and procedures. The following is an analysis of the results:

Purpose:

The purpose of the second annual CPG HIV prevention poster session was to open a dialogue between CPG members and Pennsylvania Department of Health HIV Prevention Field Staff to determine if the statewide plan developed by the CPG is being carried out. A second purpose was to evaluate prevention programs and "best practices" that worked out with priority populations. A final goal was to provide an opportunity for networking among presenters and CPG members.

Overview and General Analytic Approach:

Members of the HIV Prevention Community Planning Committee met with State Health District Office staff (covering regions across Pennsylvania not covered by local county and municipal health departments) on March 18, 2005 at the Best Western and Union Suites of Harrisburg. Representatives of the State Department of Health, Division of HIV/AIDS and the Pennsylvania Prevention Project also attended. The purpose of this meeting was to learn about interventions that these staff perceive of as being effective, those with less effectiveness, barriers to providing effective HIV interventions, and their training needs. To accomplish this, DOH staff presented poster sessions that answered the four following questions:

1. What interventions are effective and why?
2. What interventions are less effective and why?
3. What are the presenters' biggest barriers in doing effective HIV prevention?
4. What is the presenters' HIV prevention training needs?

The HIV Prevention Community Planning Committee was divided into 6 subgroups. The presenters (State Health District Office staff) from each of six Pennsylvania regions rotated approximately every 15 minutes from subgroup to subgroup to present their posters.

This report summarizes the data from this meeting. The general analytic approach is to present data as objectively as possible and to triangulate the data. With respect to objectivity, the data analyst has attempted to refrain from interpreting data and instead simply presents and summarizes it. With respect to triangulation of data, several analyses of what is basically the same data were implemented to informally assess validity.

After presenting a summary of findings, poster session data are presented in tabular form and are summarized by region. These data are then analyzed by comparing findings across regions. Next, general reviews of the poster-sessions (i.e., reviewers took notes related to each question above rather than by region) are presented. The information about the Decisions for Life intervention is included in a separate section because this presentation consisted of a *plan for* an intervention as opposed to evaluating previously implemented interventions. Finally, evaluations of the workshop process are presented.

It should be noted that while a summary of findings is provided, it is recommended that readers examine the data contained throughout the report, especially in sections three and four. Qualitative data analysis is both science and art, objective and subjective. While the data analyst believes that the major themes of the workshop have been captured in the summary, it is always the case that different readers will, to a certain degree, identify themes differently.

Summary of Findings:
This section summarizes the data from the poster sessions. It does not interpret the data. For a richer understanding of the issues presented below, the reader is directed to section three.

Effective Interventions

Two types of interventions were judged by presenters to be effective and possess a high level of consensus among staff from the different offices. The first is counseling and testing at various sites (i.e., drug and alcohol, WIC, STD, PPA, and prisons). It should be noted that presenters from all regions identified counseling and testing as an effective intervention for either one or two of these sites, except for outreach in prisons. Counseling and testing within prisons was thought to be an effective intervention by all six of the presenters. It was however acknowledged that not all prisons allow HIV prevention professionals sufficient access. Partner Counseling Referral Services (PCRS) was thought to be an effective intervention by four of the six presenters. It is important to note however that two of these four (who identified PCRS as effective) also considered it to be an intervention with less effectiveness. The notes from the workshop do not permit the analyst to determine why this inconsistency exists. Nevertheless, these two presenters noted the time constraints and distance to reach individuals and that a significant proportion of people who are offered services do not respond affirmatively.

There are two interventions for which there was a lower level of consensus with respect to judging them as effective (i.e., two of the six regions deemed these to be effective). These are outreach to gay individuals (e.g., in parks, bars, campgrounds) and outreach to schools. It is noted that one of the two presenters that deemed outreach to gay individuals as effective also considered it to be an intervention with less effectiveness. While it is not totally clear why this is the case, it appears that the presenter was discussing different types of interventions to gay men with respect to one being effective and the other not. It is also important to note that one of the two presenters who rated schools as an effective intervention site also rated schools as an intervention with less effectiveness due to restrictions related to the types of interventions permissible. The other presenter who rated schools as an effective intervention also rated the inability to access schools as a barrier to the delivery of effective HIV prevention interventions. Finally, there are several interventions that were rated as effective by one of the presenters. These are noted in section four with greater description in section three.

Less Effective Interventions

Presenters differed greatly in their description of interventions with less effectiveness. The following "interventions" were rated by one of six presenters as being less effective: 1) interventions involving populations other than MSM, 2) interventions involving treatment facilities, 3) interventions not targeting specific populations, 4) interventions lacking peer outreach, 5) outreach in certain prisons, and, 6) outreach in outlying areas. Outreach to MSMs was deemed as lacking effectiveness by two of the presenters while three thought of outreach to schools as less effective. Two of the three presenters did not rate schools as an intervention lacking effectiveness. These two presenters did however rate lack of access to schools as a barrier to the implementation of effective preventions. In summary, five of six presenters either described

interventions in schools as lacking effectiveness, and/or lack of access to schools as a barrier with respect to implementing effective interventions.

Major Barriers to Effective Interventions

Three barriers were highlighted by nearly all of the presenters. Five of six of the presenters stated that lack of funding (for staff, vehicles to do outreach, materials and other needs) was a major barrier. In fact, based on the amount of notes taken describing this barrier, there appears to have been greater emphasis in this area than in any other. Similarly, the lack of staff, staff being overworked, and staff having to focus on much more than three presenters highlighted simply HIV as a barrier. Problems with implementing prevention in schools were rated by five presenters as a major barrier. These presenters stated that it is often difficult to access schools and to implement the types of interventions that are needed, especially with respect to the distribution of condoms. Among many other issues, school boards are reported to be controlled by conservative individuals who often stand in the way of effective prevention. Four presenters rated language barriers, often mentioned in relation to Latino individuals, as a barrier. Three presenters highlighted transportation barriers. Three presenters highlighted a variety of issues related to the special needs of rural areas. These included transportation but also access to care and language barriers. It was stated that in rural areas many people do not know where to get tested and often do not know that testing is free. Lack of confidentiality, real or imagined, was rated by three presenters as a major barrier as was methadone use among youth and high school drug use in general. Two presenters as barriers rated several other issues. These include entry barriers to notifying a contact, the mindset of corrections staff and policies of prisons (including the inability to distribute condoms), general community attitudes (both complacency about HIV and negative attitudes about "those people"), cultural barriers beyond language, and accessing MSM including the inability to outreach in parks in rural areas due to police activities. Individual presenters rated several other barriers as being significant. These are noted in section four and described in more depth in section three.

Training Needs:

Three presenters identified co-infections (HIV/Hep C and other STIs) as an important training need while three highlighted the need for training in counseling related to HIV. Two presenters requested training in HIV and the elderly; how to deal with schools; current and emerging issues in HIV; and how to acquire funding. Other training needs are outreach to MSM; treatment updates; lesbians and HIV; and pediatric HIV.

Consistency of Findings between Regional and General Reviews:

The above data comes from the notes of the presenters and from the notes of reviewers. One group of reviewers recorded the information in relation to individual regions. Other reviewers recorded the information in a general manner. Specifically, they described effective interventions, interventions lacking effectiveness, major barriers, and training needs in general rather than by region. Section five presents a summary of the general reviews. It is noted here that the findings of these general reviews are very consistent with the findings as presented above.

Evaluation of Process:

Most evaluators stated that important information was presented. Some found their ability to identify common themes as interesting.

There was significant consensus that there were too many presentations and that time constraints decreased the quality of presentations. Several evaluators said that it was difficult to hear presenters and those presentations should take place in separate rooms. In summary, it appears that valuable information was presented but that the overall process needs to be improved (Note: This is an interpretation by the data analyst). Finally, one evaluator stated that it should be remembered that this is a process and that much can be learned from it to improve the process in the future.

Comparison of Regional Data:

This table summaries the data from Section 3 above and describes the level of consensus between regions of Pennsylvania: South West, South Central, North Central, North East, North West and South East. **Content**	SW	SC	NC	NE	NW	SE
Effective Interventions						
Internet has expanded the ability to implement partner notification.	X					
C&T				X	X	
C&T (and sometimes other HIV services) at methadone sites	X				X	
Rapid testing sites						X
C&T at D&A clinics	X	X				X
C&T at WIC sites			X			
C&T at STD clinics		X				
C&T at PPA clinics		X				
C&T in prisons			X	X	X	X
Outreach to prisoners			X		X	
Outreach by providers, peer-based, community-based		X				
PCRS outreach		X	X	X		X
ILI					X	
D&A treatment				X		
Providing transportation				X		
Outreach to gay clients (e.g., parks, bars, campgrounds)			X	X		
National testing days			X			
Community-based youth programs					X	
Faith based D&A programs						X
Face to face talks with doctors			X			
Home-based services – give HIV+ test results and referral and CD4					X	
Building relationship with clients					X	
Accommodate clients' needs and schedules.					X	
Interagency collaborations						X
All interventions are effective				X		
"Positive result notify nurse consultant once every 3 months/3,000 miles per month, more frequent if"					X	
Condoms					X	
Outreach to schools (stated as effective but also stated that condoms can not be distributed)				X		X

Interventions With Less Effectiveness						
No other connections established other than with than MSM	X					
PCRS – time constraints, distance to reach individuals may be quite far, information on co-infections, many people being offered services and many not responding affirmatively				X	X	
Lack of effort with treatment facilities	X					
Those not targeting specific populations		X				
In schools – lack of testing sites		X				
Lack of peer outreach		X				
Grade School			X			
Schools in general						X
College students			X			
Outreach in general					X	
Some prisons						X
In outlying areas						X
Outreach to MSM, hard to reach them (e.g., state parks)			X		X	
Major Barriers						
Caring	X					
Weather – Makes seasonal travel difficult	X					
Funding (for staff, vehicles to do outreach, materials, other)	X	X	X	X	X	
Religion					X	
Entry barriers such as “Beware of Dog” when trying to notify a contact	X					
Lack of staff, staff being overworked	X	X				X
Methadone is a youth emerging problem. High school age drug use.					X	
Mindset of corrections staff and policies of prisons (including inability to distribute condoms)	X		X			
Staff attitudes	X					
Illiteracy			X			
Surveillance inaccurate			X			
Lack of ability to test of HEP C					X	
General Community Attitudes (both complacency and negative attitudes about “those people”	X					X
Access to schools and ability to implement effective interventions within schools, especially not being able to distribute condoms. Among many other issues, school boards are often controlled by very conservative/religious individuals.	X	X	X		X	X
Reaching adolescents		X				
People go out of their own counties to get tested often					X	
Language barriers	X	X	X			X
Other cultural barriers (NE referred to Asians)		X		X		
HIPPA			X			
Transportation – Distance to clinics makes them difficult for clients to reach and distance to do outreach is a problem	X	X		X		
Special needs of rural areas including transportation but also beyond (access to care, language barriers). In rural areas many people do not know where to get tested and do not know it is free.		X		X	X	

Lack of staff, especially someone of color	X					
Communication between agencies		X				
"Allegheny County-centric environment" (though better than in the past)	X					
Lack of participation by clients		X				
Access to care including limited care for co-infected individuals		X				
Lack of confidentiality (real or imagined)		X			X	X
Problems associated with prioritization process, did not allot time for C&T		X				
Access to MSM including inability to outreach in parks in rural areas due to police		X	X			
Training Needs						
HIV/Hep/other STIs co-infections (co-morbidity)	X	X		X		
Hep C		X				
Approaching MSM				X		
HIV in elderly			X			X
How to deal with schools			X		X	
Treatment updates						X
Lesbians						X
Pediatric HIV						X
Training for counselors				X	X	X
None, all is effective				X		
Current and emerging issues	X			X		
How to acquire funding	X		X			

6.5.3. Results of the 2006 Poster Session—Community-Based Diffusion of Effective Interventions and Science-based HIV Prevention Implementations

Prepared by Mark S. Friedman, PhD, University of Pittsburgh

On Wednesday, 17 May 2006, members of the PA Department of Health, Division of HIV /AIDS and the PA HIV Prevention Community Planning Group met (at the Holiday Inn Harrisburg West) for a poster session, during which representatives of various organizations presented information about their experiences with Diffusion of Effective Behavioral Interventions (DEBIs) as well as other interventions of proven effectiveness. The content of these posters provided brief description of the original interventions followed by description of how the organization implemented it (i.e., nature of the target population, content of the intervention and why specific interventions were more or less effective including barriers to implementation). Each organization also presented information about their training needs and if they utilized the PA HIV Prevention Community Plan. This report summarizes the content of the poster sessions and incorporates data provided by CPG members (i.e., each member's summary of the posters). The seven topics covered were:

1. Target Population(s) of Focus
2. Descriptions of DEBI and Science-Based Interventions Provided
3. Information that Describes What Interventions are Effective & Why
4. Information that Describes What Interventions are Less Effective and Why
5. Information that Describes the Biggest Barriers in Implementing Your Intervention
6. Descriptions of HIV Prevention Training Needs (if any)
7. Whether or not they use the State's Prevention Plan

Methods:

CPG members were divided into six groups. Three groups were be assigned to listen to half the presentations while the other three groups listened to the other half. Everyone was asked to collect written information regarding the above-mentioned points on the datasheets provided. Presenters were asked to provide handouts addressing the same points. Following the presentations, there was time for presenters and CPG members to network and share ideas and information. Data collected by the CPG members and those contained in the handouts were compiled and analyzed.

Results:

General themes/observations related to DEBIs

1. Factors that facilitate effectiveness across many if not most DEBIs include: A) use of incentives; B) group interventions that allow members of a target population to relate to other members of that population and build trust with the provider of the intervention; C) interventions that include HIV testing; D) interventions that specifically address the culture of the target population; E) interventions that are peer driven; F) interventions that publicly recognize positive attributes and achievements of participants; G) interventions that are interactive; H) interventions that build pride about one's culture; and I) interventions that allow for some modification based on local needs.
2. Factors that inhibit effectiveness across many if not most DEBIs include: A) the ability to retain participants; B) participants under the influence during intervention implementation; C) insufficient resources (possible the greatest barrier mentioned); D) difficulty of reaching rural youth and, generally, the difficulty of applying the DEBIs to rural areas; E) stigma (that people with HIV feel and that gay/MSM feel); F) difficulty adapting DEBI to local conditions (see #5 below); G) difficulty of adapting DEBI to other racial/ethnic groups (see #5 below) (also described as the need for longer pre-implementation stage to adapt materials for other racial/ethnic groups given that funders demand immediate results); H) staff turnover; I) community resistance to harm reduction; J) 1 to 1 discussion of readiness to change or intensive case management sometimes ineffective with certain targets; and K) identifying and accessing young MSM.
3. There is a tension among some agencies concerning the emphasis on implementing the DEBI as closely as possible to what is prescribed versus being able to adapt the DEBI to local conditions. Similarly, there is also a tension between what some representatives feel is a narrow focus on target populations (with prescribed intervention characteristics for that population) versus the need to implement the DEBI in such a way so as to target other racial and ethnic groups.
4. Representatives generally stated a need for more training on the implementation of the DEBIs, on tailoring a DEBI to other target populations, and on implementing the DEBIs in rural areas. It appears that nearly all of the agencies utilize the PA HIV Prevention Community Plan, although the exact manner in which it is used was generally not described.

Relative effectiveness of specific DEBI and possible contributory factors:

Adolescents Living Safely – An AIDS Services Organization (ASO) reports serving both urban and rural areas. It utilizes a program targeting LGBT youth. It is very difficult to determine the effectiveness of this intervention because the provider and CPG members provide so little data about it. The difficulty of identifying/accessing LGBT youth in rural areas is a significant barrier.

Mpowerment is another DEBI that targets gay youth. This DEBI is being implemented by both a mental health center with an AIDS program in a large urban area, and by an ASO in a rural area. It appears that Mpowerment in the large urban area has substantial effectiveness as demonstrated by the process evaluation data provided by the agency. Outcome data was also provided, but it cannot be determined if a decrease in high-risk behavior is attributable to this intervention. Over 200 youth were trained as peer outreach educators since 1995; over 500 outreach events occurred; and 3,000 to 4,000 annual individual encounters were completed. In 2004-2005, 25 individuals were trained; attended over 55 community events; and 3,300 individual encounters were completed. The project increased youth referrals to counseling and other services by 25%. The peer educators did a youth regional survey and found that high-risk behavior decreased from 16% to 12% (no details about research methods were provided. It is not clear if the decrease can be attributed to this project). Strong management of this program has helped make it successful, along with the fact that it is mostly peer driven. The DEBI has been modified to include straight young women and transgender youth. Excellent training was provided to volunteers. Nevertheless, insufficient resources limit peer educators from reaching many at-risk youth; including rural young MSM.

The **Mpowerment** intervention implemented by an ASO in rural areas appears to be less effective. It was reported that the group of local lesbian, gay, bisexual and transgender (LGBT) teens and young adults was too small to be effective. Most of the teens in the program are individuals affiliated with Penn State University groups. They did not have sufficient funding to implement this program effectively. No DEBI specifically addresses the challenges of rural prevention making the effective implementation of Mpowerment in this area difficult. Also, stigma is a major barrier (i.e., dangerous to be gay or to be associated with ASOs in these areas).

Teens for AIDS Prevention (TAP) also targets youth, though not LGBT youth, and is being implemented by the same ASO as the **Mpowerment** intervention above. It appears that it is somewhat effective, though little evaluative data is provided. The target population of the DEBI resembles youth in the service area. The DEBI can be modified without changing the program's core elements. The CPG questions when the modification of a DEBI render it no longer scientifically rigorous.

Healthy Relationships, implemented by a hospital in a large urban area, appears to be the only DEBI exclusively focusing on HIV positive individuals. Its effectiveness cannot be determined because they have had only had 2 of 5 sessions thus far. Intensive case management (which does not appear to be part of this DEBI) feels like therapy to many participants, and according to their reports, which causes many of them to drop out. Stigma is a problem, patients feel singled out. Some HIV positive people do not feel like they need the intervention**.**

Holistic Health Recovery Program is being implemented by an ASO that serves both urban and rural areas. It focuses on IDUs and other substance abusers who are willing to commit to recovery. The level of effectiveness of this DEBI cannot be determined because no outcome data was provided. The DEBI combines small group and individual sessions. Recruitment is labor intensive. Client retention is challenging. The program is reported to be costly to implement, and there is community resistance to the harm reduction approach.

The **Popular Opinion Leader** DEBI is being implemented by two agencies: An ASO in a major urban area (ASO #1) and by another ASO (ASO #2) in a separate major urban area. The ASO #1 intervention targets MSM while the ASO #2 targets Asian MSM. It is difficult to determine the effectiveness of the ASO #1 program. They have recruited and trained 120 MSM since 2005 throughout various social venues. Leaders are

willing to access CTR services. They do not indicate how many contacts the leaders made, or what exactly the leaders did with respect to prevention activities. The POL's have self-reported likeliness to reduce the number of sexual partners and to practice safer sex. The effectiveness of the POL intervention by ASO #2 appears to be at least somewhat effective as presenters stated that because API individuals tend to model perceived leaders generally; this DEBI takes advantage of the cultural identity of the target populations. It was also reported that the DEBI was not tested on other ethnic communities. For example, the DEBI sometimes does not take language and culture into account if venues contain groups that ascribe to different cultures and speak different languages. ASO #2 also stated that there is a need for a much longer pre-implementation stage to plan for diversity of cultures, values, and backgrounds. If not, the message becomes culturally insensitive. Lack of resources is a major barrier.

The Real AIDS Prevention Project (RAPP), which targets heterosexually active men and women, has been implemented by a University Health Services Department. The implementation appears to adhere to the prescribed DEBI (content of the small groups, peer networks, one to one outreach). Evaluations indicated that the women gained new information, and intended to be tested for HIV; and to use condoms with their sexual partners. The University will measure behavioral outcomes in 2008. Presenters stated that safer sex parties gave women a comfortable environment to discuss issues. Peer network and outreach appear to work effectively. The educators develop a web-site that asked participants questions, and then The stage based encounters that were provided were inappropriate for college students. Students did not want to be identified as influential peers with participants. The University stated that facilitators and outreach workers need more training than what is recommended in the packet; and the Volunteer coordinator would benefit from training in volunteer coordination.

The Safety Counts intervention is being implemented by three agencies. A Health Department in a smaller urban area also serves rural clients. Their program also targets heroin addicts. The program appears to be effective, though limited. About on-half drop out before completing the program. Helpful attributes of the program include incentives; social events "keeping it honest; respectful; staff who keep it real." A big challenge is also that people participate under the influence. The cost of the program is a problem. Parents and boyfriends sometimes interfere with participants. Staffing is limited, thus reducing the effectiveness of the study.

An ASO in a smaller urban area that also serves rural populations is also implementing this DEBI targeting **Latino active drug users**, IDU and non-IDU. Only anecdotal data was provided with respect to outcomes. The number of individuals involved is not clear. Presenters claim that retention is much better in groups than in individual follow-up sessions. Factors that facilitate effectiveness include setting expectations in the beginning; using "steps" of change; social events that recognize participants' efforts; and positive participant attributes. A focus on sex and drugs, videos of success stories and the bilingual nature of the intervention were also utilized. Attendance is affected by addiction and some individuals participate while under the influence. It is difficult to follow-up with participants.

The third agency was non-HIV specific and non-profit in a mostly rural area. They targeted active IDU and crack cocaine users. Effectiveness has been demonstrated through pre and post-test evaluations. Questionnaires identified modes of behavioral change and how to create a plan to make these changes. Post-test knowledge increased by 12%; 57% made solid behavioral change commitments; 62% came in for testing. Insufficient funding limits implementation of the program and paying for required personnel. This agency also offers a modified version of **Safety Counts**, in treatment facilities**,** but can not provide incentives.

There are five separate implementations of the **Sisters Informing Sisters about Topics on AIDS (SISTA)** DEBI with what appear to be varying levels of effectiveness. First, an ASO that serves both urban and rural areas is targeting African American women in heterosexual relationships. The agency appears to have had limited effectiveness with this DEBI. Consistently structured sessions have been implemented. Materials do address culturally relevant issues, and the program is appealing to target populations. Sessions make it easy to develop relationships with participants. It was reported that a barrier to effectiveness is the narrowness of the target population. Adapting materials for other racial/ethnic groups is labor intensive and requires great expertise. Retention of participants in the program is a challenge. Staff turnover is also a major barrier to fully implementing this DEBI.

The other non-HIV specific, non-profit organization is a mostly rural area also targeting African American women. This appears to be effective with respect to the number of women participating; improving retention; and participant's ability to follow the DEBI content and procedures. About 1,000 African American females participate annually. They are changing behaviors and using condom negotiation skills. When adding formal and public acknowledgement such as a garden party graduation and luncheon the retention level increased by 60%. Follow-up becomes less difficult as this is a good place for structured follow-up. Each graduate is requested to meet two hours before the beginning of the event to complete updated surveys and additional evaluative questions. The positive effect is attributed to the intervention being culturally specific. The cost of the incentive is a challenge, but they seem to have gotten most of what is needed donated. The lack of resources limits what can be accomplished.

An ASO in a smaller urban area with outreach to rural clients implements **SISTA** targeting African American women, ages 18-52. The program instills pride, and has young black women talking to other young black women. Retention is a challenge. Lack of funding is a major problem. Some participants do not feel a sense of community or of family in general, which stands in the way to their participation.

An ASO in a major urban area implements **SISTA** targeting African American female adults. They state that over 75% of the participants have reported an increase in their likelihood to negotiate safer practices with their sexual or drug partners, and an improvement in self-esteem and the decisions they make. Two hundred and ninety-one women have been recruited and trained in the SISTA project since January 2005. Recruiting individuals in the community is more difficult, therefore, the ASO's approach is to recruiting individuals from existing groups (i.e., jails, D&A treatment, clients at PATF)..

The office of health services at a rural University implements **SISTA** targeting heterosexually active African American college women. The group was able to develop trust and discuss sensitive information. SISTA is offered as an academic course, and so people who sign up for this can adapt it into their schedule. Homework allows participants a chance to apply what they learn in class, and to share experiences with their partners.

Finally, an ASO which serves both urban and rural areas implements **VOICES/*VOCES*** targeting heterosexual African Americans, ages 18 and over, who are at high risk of infection. This is a single session intervention that is easy to implement; bilingual; and one that can be utilized in a variety of settings by a small staff.

Presenter Evaluations (note that bullets are quotations):

What prompted you to participate in the session?

- Impressed that state was requesting feedback. A chance to contribute to the possibility of productive change.

- We welcomed the opportunity to discuss the good and the bad with people in a position to facilitate change.
- Our coalition asked us to.
- A CPG member asked two.
- I was delighted to share my knowledge on the efficacy of the two interventions my agency is currently using.
- I was filling in for my coworker

What do you think went well?
- Process of providing information in a focused and succinct manner. Information presented was outstanding.
- Some questionnaires asked excellent questions
- The method of having smaller groups rotate through gave the opportunity to reach a larger number of people quickly.
- The form participants had to fill out – they seemed to focus on getting those answers and this limited the conversation.
- The instructions concerning what exactly to present. Information provided prior to the presentation day could have been a little more in depth and detailed. I felt confused about where to meet, whom to meet, etc. as well as how the presentations were going to run.
- Do see what others are doing and how we compare with respect to effectiveness
- Questioners validated my experiences and concerns, that other organizations were having similar issues. I especially enjoyed talking with other groups that were using the other DEBIs, but in different ways.
- It was remarkable, that given similar barriers, that everyone was provide effective prevention to their individual target populations.
- People were very interested and attentive.
- The set up and floor plan worked well. It gave the audience a smooth flow, less confusion.
- The overall poster presentation was excellent. Good set up and concept.

What problems did you encounter?
- None (2)
- The room was very loud and it was difficult to hear the CPG members as well as them hearing me.
- Nothing major except not enough time for presenters.
- Direct care staff did not have experience or technology to present in “poster session” format

What suggestions do you have for change?
- Nothing about presentations. Would love to have a clearer approach to rural prevention efforts.
- Provide more detailed information prior to the presentations about what to expect.
- Rooms with less noise.
- I would suggest that out of the 11 posters, split them into 3 groups of 3 (one with 2) and split the CPG members into 3 groups also, have each of the 3 groups of presenters in separate rooms and have each one present their information then have questions last. Then the CPG members would rotate to another room for another set of presentations. Then, of course, time at the end for networking.
- Have presenters meet with each other an hour before the poster presentations; that would be very interesting and informative.
- The need for revision in the evaluation form.

- None
- Continue to do these on a yearly basis.

Additional Comments:

There was lots of information to address problems we have that had nothing to do with DEBI programs (e.g., interventions with gay men in chat rooms; hiring rural gay men to reach rural get men). It felt like evidence that there are no DEBIs that include this type of intervention, the type that would probably work best.

*Evaluations by CPG members***:**

What went well?
- Liked small groups.
- Set up worked well. Much more organized; we got to pay more attention to each presentation.
- Feedback sheets were a great tool.
- Presentations very thorough.
- DEBI interventions are well represented in presentations but training is essential and not being available in our area.
- Event ran so smoothly. People seemed to appreciate not having to listen to 10 or 11 presentations.
- Very well structured. Movement was also better than last year.
- Presenters very informative.
- Strict adherence to time.
- Time allotted for presentations was adequate.
- Adequate amount of time.
- Great networking opportunity.
- Projects were enlightening.

What didn't work so well?
- Couldn't hear all the presenters.
  Back problems made standing for so long hard. Also, background noise from other groups made hearing presenters hard.
- Evaluation tool was horrible.
- The wording on some questions such as which interventions are less and more effective. Some interventions were confused because they see themselves as one intervention. Maybe what methods.
- Space limited so distractions were hard to avoid.
- Evaluation forms. I don't like taking notes in long hand.
- Process very tiring.
- Too long without a break.
- Too many posters, too little time.
- Process was too long.
- Posters didn't have outcomes information.
- Projects did not show effectiveness.
- Questions on our forms weren't always a good fit.

Changes for next time

- Nothing.
- How about YART filling out the feedback sheets as well.
- Place chairs and maybe a five-minute break halfway through so people can use the restroom and generally decompress without missing out on important information.
- Please use a simpler evaluation tool like met or unmet needs. Scoring or good or bad.
- Make sure that you make the groups (2) have a variety of presenters. My group had 3 SISTA interventions. So it would have been nice to see the others. Also, maybe time in the end so if people had more questions they could have gone back instead of holding up time.
- Recommend no more than 4 posters per group to review.
- Perhaps a way for CPG members to hear every presentation.
- Give us chairs. My back started to hurt.
- More air conditioning.
- Possibly smaller groups of CPG members so not to place anyone too far from posted information.
- Some CPG's displays were of small type set and thus difficult to read.
- Don't withhold desserts.
- Long time to stand and my back started hurting.
- We needed something to write on if we are going to stand and collect (write down) information.
- Might combine all similar projects (SISTA) and compare what was effective and not so effective.
- Add Young Adult Roundtable.
- Add a faith based organization.
- Build in breaks!
- Rethink the questions.
- Difficult to hear.
- Difficult to write on sheets.

Methodological Issues:

Criteria used to assess effectiveness in this report are: A) to what degree did the organization's implementation of the DEBI match the prescription of how the DEBI was to be implemented (fidelity)? B) Process evaluative data (e.g., qualitative, number of individuals who begin and complete the intervention). C) Outcome evaluative data (e.g., pre- and post-test data about intentions to use condoms). D) The nature of the intervention (i.e., single contact versus multi-contact (e.g., ongoing groups) interventions.

Note: Based on #1, it is difficult to assess the effectiveness of approximately one third of the 19 interventions (i.e., unable to determine the fidelity of the intervention to the DEBI, little or no process or outcome evaluative data), about a third are clearly effective though probably to a limited degree, and about a third probably possess substantial effectiveness.

6.5.4. Results of the 2007 Poster Session: Evidence-Based HIV Prevention Projects - County and Municipal Health Departments

Prepared by Grace Kizzie, LACSW

Overview of Poster Sessions

On Wednesday, May 16, 2007, representatives of various organizations presented information about their experiences with Diffusion of Effective Behavioral Interventions (DEBIs), as well as, other interventions of proven effectiveness at a CPG sponsored poster session in Harrisburg. The purpose of the CPG HIV prevention poster session was to create a dialogue between funded agencies/organizations and the CPG, to elicit information for program evaluation, to explore if and how the Prevention Plan is being used, and to provide opportunities for networking among presenters and CPG members.

Methods:

Letters were sent to the nine local county and municipal health departments inviting them to present a poster about their evidence-based HIV prevention projects. The letter included guidelines for the presentation. A second letter was sent by evaluation subcommittee members to confirm the invitation and further clarified the poster session's guidelines and procedures. People representing seven health departments and subcontractors attended the poster session.

Attendees:

- Allentown Health Bureau (VOICES/*VOCES*)
- Bethlehem Health Bureau AIDS Program (VOICES/*VOCES*)
- Booker T. Washington Center-Subcontractor of Erie Dept. of Health (SISTA)
- Bucks County Department of Health (SISTA)
- Montgomery County Health Dept. (VOICES/*VOCES*)
- York City Bureau of Health (SISTA)
- Wilkes-Barre Health Dept (VOICES/*VOCES* pending until July 2007)

CPG members interviewed health department representatives during the session. The twelve topics covered by the poster session were:

1. Identification of target populations
2. Description of DEBI or other science-based interventions provided.
3. Information about the process used to select this intervention.
4. Information regarding adaptations of DEBI or science-based intervention.
5. Specific information detailing how the program was adapted.
6. A description of what is being done regarding non-science-based interventions.
7. An explanation as to why providers did not apply for health education and risk reduction funding.
8. Information regarding identified barriers associated with interventions.
9. Information about dealing with identified barriers.
10. Information regarding HIV prevention training needs.
11. Information regarding the use of the State's HIV Prevention Plan.
12. Information regarding how the plan is used, or the rationale for those <u>not</u> using the Plan.

Criteria used to assess program effectiveness were:

To what degree did the organization's implementation of the DEBI match the description of how the DEBI was to be implemented (fidelity)?
Process evaluative data (e.g. qualitative, number of individuals who began and completed the intervention).
Outcome evaluative data.
The nature of the intervention (i.e.: single contact versus multi-contact ongoing group interventions)

Data Analysis and Limitations:

Information for this analysis was obtained from the poster session presenters and CPG members. Data obtained from CPG members, proved more difficult to score. Several members failed to identify the interventions they were assigned to critique; others failed to identify the presenting agency; and a few failed to provide specific responses to several items on the questionnaire. Two members used the questionnaire as a system for rating the presenters' responses (e.g..: "Great."). The data was analyzed using the general themes that were generated and scored by response frequencies.

DEBI Interventions as described by Centers for Disease Control & Prevention:

1. Sistas Informing Sistas on Topics of AIDS **(SISTA)** – a group level, gender & culturally relevant intervention designed to increase condom use among sexually active African American women. Five peer-led group sessions are conducted that focus on ethnic and gender pride, HIV knowledge, and skills training around sexual risk reduction behaviors and decision-making. The intervention is based on Social Learning theory, as well as, the theory of Gender and Power.
2. Video Opportunities for Innovative Condom Education & Safer Sex: **(VOICES / *VOCES*)** – a group level, single-session video-based intervention designed to increase condom use among heterosexual African American and Latino men and women who visit STD clinics. Participants are grouped by gender and ethnicity, view English or Spanish video on HIV risk behaviors and condom use and take part in a facilitated discussion.

DEBI Adaptations:

All of the six agencies that actively provided a DEBI intervention (VOICES/*VOCES* and SISTA) reported the need to adapt their interventions to support their inability to locate and/or recruit the populations that these interventions were originally designed. For example: The agencies that provided a SISTA intervention reported difficulty locating and recruiting African American females. Additionally, some agencies reported a need to address the misperception that SISTA was intended for HIV-positive African American females. As a result, this intervention was adapted to accommodate mixed-racial and ethnic groups. One agency expressed their desire to extend SISTA to all age groups.

Agencies that provided VOICES/*VOCES* adapted their interventions to accommodate youth, inmates in prison settings, and small groups. Additionally, program facilitators were instructed to preface the videos with dialogue that encouraged mixed racial and ethnic group participants to focus on the prevention messages verses the race or ethnicity of the actor.

Summary of strategies for overcoming barriers:

Staffing and funding needs were consistent themes identified by most presenters. Representatives reported the need for additional funding for local DEBI trainings to implement their intervention in schools and/or other community-based settings. For example, agencies acknowledged the importance for DEBI trainings, but one agency found it most economical to "host" the trainings versus attempting to secure funding for trainings and related costs (travel, lodging, etc.)

Recruitment and retention proved most challenging for all of the providers. The barriers associated with their identified recruitment failures involved the lack of childcare; the lack of transportation; the lack of incentives; and limited access to the target populations. Issues that involved incentives remained problematic; however creative programming addressed many of the remaining barriers. Strategies for overcoming many of the barriers involved agencies collaborating with other community-based agencies, organizations, prisons, and schools. Other strategies involved combining prevention programs with outreach activities to the target populations. Reportedly, those outreaching efforts have helped increase programming access to the intended target populations. Other agencies expanded the target populations to include other races, ages, and ethnic groups.

General themes/observations related to DEBIs

Factors that facilitated effectiveness across many if not most DEBIs included:

- Group interventions that allowed members of a target population to relate to other
- Members of that population and assisted with building trust with the provider of the Intervention (however establishing trusting relationships is an ongoing process).
- Interventions that included HIV testing.
- Interventions that specifically addressed the culture of the target population.
- Interventions that were peer driven.
- Interventions that publicly recognized positive attributes and achievements of participants.
- Interventions that are interactive.
- Interventions that built pride about one's culture.
- Interventions that allowed for some modification based on local needs.

Factors that inhibited the effectiveness across many if not most DEBIs included:

- The lack of incentives.
- The inability to retain participants.
- Insufficient resources (the most often identified barrier).
- Difficulty of reaching high risk targeted populations.
- Stigma (that people with HIV felt and partner disclosure issues).
- Staff turnover, staff language limitations (difficulty securing Spanish-speaking staff).
- Community resistance to harm reduction,
- Staff retention difficult, due to the demands for multi-tasking (obligations to other agency prevention projects).

Relative effectiveness of specific DEBIs and possible contributory factors by agency:

Voices/*Voces*
This intervention was a condom negotiation skills training, targeting African American and Hispanic men and women. This prevention strategy targets people who were in drug & alcohol programs; prison facilities, and HIV-positive persons and their families.
Significant barriers included:

- Limited funding
- No incentives to promote participation
- A lack of bilingual staff
- Duplication of services provided by other agencies

Adaptations*:*

- To accommodate inmates in prison facilities
- To accommodate HIV-positive persons and their families

Voices
Targets HIV-positive men & women, as well as, women in drug & alcohol facilities.
A five-session intervention extended services to youth (10 years & older).
Significant barriers included:

- Participant adherence and participant recruitment
- The lack of bilingual staff (and related materials)
- Program was adapted to accommodate mixed race groups
- HIV testing & counseling is being conducted at numerous sites. However, only two of the eleven identified sites, actually reported capturing newly HIV infected persons
- According to the program statistical report by this facility, between January and March (2007), the Bethlehem Health Bureau AIDS Program tested 371 persons. Only, two people tested positive for HIV infections
- Adaptations:
- To accommodate mixed racial groups
- Preface culturally specific video by highlighting the importance of the lessons versus focus on race/ethnicity
- Include discussions on STDs
- Attempting to appeal to youth
- Condoms provided to inmates upon discharge

SISTA
Targeting heterosexual African American women. Significant barriers included:

- Implementing this program including retention
- A lack of incentives for participants
- Limited funding
- Clients' transportation needs
- Childcare needs.
- Adaptations:

- Recruitment hampered by the misperception that SISTA is a program for HIV-positive women
- To accommodate mixed races: Whites and Hispanics

SISTA
Targeting African American women (18 & older). Attempts to recruit African American women were not successful. Only 4 women enrolled in the program, three of whom were committed.
Significant barriers included:

- Recruitment limited by the number of African American women residing in Bucks County
- Childcare needs
- Transportation problems
- Adaptations:
- To include Whites and Hispanics participants
- Increased advertising efforts, as well as, collaborating with other agencies and community leaders to locate and recruit African American women
- Attempting to take the program into schools

VOICES/*VOCES*
Targeting White MSM; Black & White IDU; and, Black, White, and Hispanic heterosexuals.
Significant barriers included:

- Locating high-risk clients
- Language
- The public's perception of service needs
- Client transportation needs
- The lack of client interest in multiple sessions, and the lack of funding for non-science based programs
- Adaptations:
- To accommodate a small group format
- To accommodate mixed racial groups
- Staff facilitators preface the videos with discussions regarding the need for information, while instructing participants NOT to focus on the race of the actors

VOICES/*VOCES*
This Health Department is planning on implementing VOICES /VOCES in July 2007. They will seek to collaborate with community based agencies and organizations for help in recruiting participants. The remainder of their presentation dealt with their HIV prevention programs and National Electronic Data Survey System (NEDSS).

SISTA
This Health Department first implemented SISTA in October 2006 and focused on recruiting African American women 18-30. They reported having problems with recruitment. They collaborated with a faith-based and residential D&A facility for female offenders. However, significant problems were experienced in implementing SISTA:

- Limited access to African American women
- The stigmas associated with HIV/AIDS
- Consumers' misperception that SISTA is designed for HIV positive women
- Limited funding
- Retaining clients for the 5-week sessions (prisoners, sometime transferred to other facilities)

- Staffing needs; currently York City has no HIV coordinator
- MSM from this area travel to Washington, DC and Baltimore for their HIV prevention, treatment, and/or related care needs
- Another CPG member suggested providing a similar program for 'their Brothers'
- Adaptations:
- Allow all age ranges
- Accommodate for all racial/ethnic groups
- Provide education and services
- Accommodate Latino women

Usefulness of the Plan:

Most representatives reported that they used it as a guide for developing HIV prevention strategies; for the identification of target populations; and for grant writing. However, a small number reported feeling that the plan was more discouraging than helpful. They felt that the plan did not take into account the realistic needs of their respective areas. One representative questioned the validity of "looking at transgender persons and Asians" because they "don't see TGs & Asians in our community." Another representative complained that the Plan "took away (their) youth funding." That representative further directed readers to page 138 of the Plan. Generally, the plan was well received. As noted above, most of those critiqued welcomed the information provided in the plan, and found it useful as a guide for proposal and grant writing, and in identifying target populations.

Health D*epartment and Subcontractor Response:*

What prompted you to participate in the session?

- Erie County Health Department (2):
- My county.
- I wanted to promote this very wonderful DEBI intervention done by subcontractors in York County.
- The York county Health Bureau, Joanne Sullivan, who was in training with us for the SISTA program.
- Invited as a SISTA facilitator. Also, my passion for HIV education.
- I was asked to participate; program SISTA I am committed to and wish to see it implemented elsewhere.
- Providing an opportunity to present our program, as well as, doing an internal evaluation of our own area.
- It gave me an opportunity to show what is working for us and wanted to learn what other people were doing and how it was working for them.
- So we could see what other agencies are doing.
- The opportunity to discuss the implementation challenges and successes of DEBI.
- Our supervisor highly suggested that we participate.

What do you think went well?

- Very well organized. The smaller group sessions were good. Gave us the opportunity to get personal & show our passion for the program.
- Everything (2)
- The questions of interest we had from the participants were great. An informal question/presentation atmosphere that provoked interest.

- The discussions as a whole went well. It was relaxing as well as informative for not only us but also the participants.
- I was nervous about what was going to be asked of me, but I felt comfortable and I felt that it went well.
- Sharing experiences of implementing SISTA program.
- I felt the presentation went great, the participants were receptive to the information we provided as well as the pros & cons we have come across.
- Questions & answers session. The group was focused on the questions & feedback.
- Had the opportunity to talk to other agencies at the end to see what they are doing and how it is working in their communities.
- The opportunity to discuss the implementation, challenges and successes about DEBI.
- We had the opportunity to ask questions once we knew what was expected of us.

What problems did you encounter?

- None (7)
- We were not really clear what was expected of us. (2)
- Not being able to speak too loudly in attempt to not disturb other presenters.
- Misconceptions from community that SISTA is for those actually infected; actual training to implement, actually trying to convey info to panel.
- None what so ever. Everything went well. Organized. Great job!

Suggestions for change?

- None (6)
- This should be somewhat mandatory for every program…to do a poster presentation
- More time to present all the programs that are being implemented besides just DEBIs.
- Time frame expanded & specific questions submitted by panel that they would like to know actual people who implement / not the budget people of organizations.
- Let the agencies know how the presentations went…was it what was expected.
- Larger rooms, otherwise everything was good.
- Feedback from the day's activities would be helpful. We never heard anything from the last
- "Poster" presentation.

Summary for evaluation responses:

The majority of the representatives stated that their respective county health departments prompted their participation in the 2007 poster session (one presenter worked as a facilitator for SISTA). The representatives were satisfied with the presentation format. All welcomed the opportunity to present their successes and the challenges associated with their DEBI interventions. The majority of the representatives felt the space did not accommodate the number of presentations being made. Most felt the noise level was intrusive and affected their ability to focus. The primary recommendation was for larger rooms or fewer presenters. Other recommendations included making presentations "mandatory" for all subcontractors, as well as, providing feedback to the agencies regarding their presentation.

Evaluations by CPG Members:

- A few of the CPG members did not utilize the questionnaire format and responded with the following:
- "The fact that SISTA isn't getting too far with their program disappoints me. I can't believe they're basically over."
- A second CPG member was far less specific about identifying the project they were concerned about. "Why they really weren't problems, more like concerns. I hope that they can get more people involved with their project."

What didn't work so well?

- None (13)
- Wrong room. Too small. Noise level high. Hard to hear presenters.
- Hearing!!!
- I would like to see them "qualified." i.e.: How many individuals were impacted? What are the barriers to large-scale implementation?
- Not being able to hear well. Not enough time to get to all the questions. Distractions around me.
- We have 20 minutes to hear a presentation & ask 12 questions. Let's re-think the questionnaire
- Was difficult to hear presenters at times. List of questions could have been shorter.
- Handouts. More handouts at each booth would have been helpful.
- It was hard to hear some of the presenters. Small room= lots of people = hard to hear.
- Could not ask any questions at York CPG, due to the length of their presentation.
- Overcrowded and a lot of talking where you have to decipher and listen well to the presenter.
- Some were not interesting, not easy to follow.
- Members not sticking to the questions at hand, going off subject during session, instead of waiting till the end when there was extra time.
- More funding.
- More support.

Suggested changes for next time?

- Nothing. (7)
- More Health Dept. representation.
- Allowing more time for the presenters to provide more detail about their programs & discussion of their program outcomes, success, failures, and ways to improve.
- More DEBI program presentations and their progress.
- An even number of presenters.
- Because we couldn't see all presenters, ask them to bring copies of their presentation or at least a summary.
- Larger room to allow for louder speaking.
- Make the presentations as scientific and quantitative as possible.
- Separate rooms or a border for sound purposes.
- Just a bigger room & early time.
- Announce no sidebar from moment one. Encourage presenters to speak loudly, clearly & annunciate.
- I would have liked to have heard all of the presentations, not just 4 of them.
- Secure bigger room/space. Remind CPG members to keep focus on the presentations & to set a good example to newer members and the presenters
- Try to gather more young adults and get them to get the word out. Keep the good work up.

- Larger room – more room for presenters. Question possible partitions between presenters. Some need better handouts. Outline 15 minutes for presentation, 5 minutes for questions. Outline for presenters to follow. Help keep presentation on-track.
- More funding.
- Some presentations are specific to the 12 questions (Allentown). Perhaps this should be the model for the presentations. Why don't the presenters answer the questions before the presentation? At least, fewer questions.
- To come on time.
- More dessert.

Summary for CPG member evaluation responses:

Most CPG members reported positive comments about the 2007 Poster Session. The terms "great," "organized," "prepared and knowledgeable" were frequently used terms to describe the session's overall format and the style of the presenters. A number of those questioned reported a positive response to chairs being placed at each presenter's station. (One member identified the "seating" as a positive response to a previously identified need.) All felt the information provided was valued and appreciated. Responses to the question of what did not work well addressed the noise level, the room, and limited time provided to respond to the 12-point questionnaire. One respondent suggested that other DEBI interventions needed to be highlighted. However, that person failed to identify which DEBI interventions should be welcomed.

6.5.5. Results of the 2008 Poster Presentation
Prepared by Katherine Fitzgerald, MPH

During the May 2008 Pennsylvania Community Planning Group meeting, a poster session was held to review six HIV/AIDS interventions that had been implemented across the Commonwealth of Pennsylvania. The evaluation included six posters of four CDC DEBI (Diffusion of Effective Behavioral Interventions) and one non-DEBI intervention (based on social and behavioral theory) which had been implemented. The projects this year focused on incarcerated or recently released jail/prison populations. The participating organizations and their interventions are as follows:

Name or Organization	Intervention	Location
Atkins House	**SISTA** (Sisters Informing Sisters on Topics about AIDS)	York County Jail
DEBI goes to Jail	**VOICES/VOCES** (Video Opportunities for Innovative Condom Educations and Safer Sex)	Allentown/Lehigh County Prison
First Baptist Human Services Corporation	**HHRP** (Holistic Health and Recovery Program)	Beaver County jails and halfway houses
Gaudenzia	**Healthy Relationships**	Albion, Cambridge Springs State Correctional Facilities
Mon Yough Community Services	**ARRM** (AIDS Risk Reduction Model)	Allegheny County Prisons
Pittsburgh AIDS Task Force	**SISTA** (Sisters Informing Sisters on Topics about AIDS)	Allegheny County Jail

There were 12-15 assessments by CPG members for each poster. Members were asked to appraise poster presentations and interventions on 12 different areas. Topics of the appraisal included: a description of the intervention, the process used to select the intervention, any adaptations of the intervention, the barriers associated with the intervention and how the barriers were overcome.

Seven general themes/observations related to interventions

1. Factors that facilitate successful program implementation included a) institutional support from the host site, b) word of mouth recruitment of new members by the participants, c) flexibility from program staff and d) creative solutions by staff to barriers presented during the program implementation.

2. Factors that inhibit successful program implementation include a) privacy concerns of the participants, b) lack of administrative support, c) facility conditions including noise and access to private meeting spaces, d) language barriers e) image of the program within the prison population and f) funding concerns, g) and confounding additional issues of the participants such as mental health issues.

3. Adaptations of the intervention were most frequently done to reflect the needs of the recruited population or policies within the host institution. For example, interventions were adapted to include populations outside of the original design of the DEBI (i.e., the recruitment of nonminority populations or different minority populations).

4. The selection of intervention or DEBI type was based on three main criteria: 1) economy of the intervention, 2) coordination of the DEBI goal with the organizational mission, or 3) recommendation from either a funding source or a collaborating partner.

5. Most interventions cited that additional training was needed on HIV 101. Other training topics include drug and alcohol, couples counseling, cultural sensitivity training, and recruitment techniques.

6. Of the six interventions assessed, five used the Pennsylvania State HIV Prevention Plan for planning purposes. The State HIV Prevention Plan was used to identify the target population, to identify the needs of a specific geographic area, to determine the most appropriate intervention for a specific target population and to provide background information and education on risk reduction. The sixth intervention used a local plan for assistance in the implementation of a non DEBI based behavioral theory risk reduction model.

7. The participating organizations used other interventions in conjunction with the four DEBIs and one behavioral theory. These other interventions were listed as HIV positive support groups, counseling and treatment referrals for substance and alcohol abuse, referrals to needle exchange programs, demonstrations on condom use, HIV counseling, testing, and referral (CTR), and HIV 101 training.

Intervention Adaptations

1. Atkins House
Type: DEBI
Intervention: SISTA (Sisters Informing Sisters on Topics about AIDS)
The target population was African American female offenders on the York County Prison system. The intervention was structured into 2-hour weekly group sessions over a five-week period. The intervention was chosen by Atkins House on the recommendation of the York County Health Department. The intervention was adapted and customized to reflect the Latina culture. The intervention was expanded to 6 sessions and included an interpreter to meet the needs of non-English speakers. Music was added during the sessions. Male and female condoms were not distributed but were used during demonstrations.

2. Debi Goes to Jail
Type: DEBI
Intervention: VOICES/VOCES (Video Opportunities for Innovative Condom Educations and Safer Sex)
The target population was incarcerated men and women in the Lehigh County prison system. The intervention was structured a one-time meeting. The intervention was chosen by the City of Allentown based on its economy and brevity. The intervention was adapted to use with Caucasian populations. Also condoms distribution was prohibited in the facility so arrangements were made to distribute condoms upon the inmate's release. This intervention was used in conjunction with HIV testing and HIV 101 training.

3. First Baptist Human Services Corporation
Type: DEBI
Intervention: HHRP (Holistic Health and Recovery Program)
The target population was African American adult males who are incarcerated or have a history of incarceration and are now reentering the community. The intervention used was HHRP. The intervention was selected based on its faith based design and economy. The intervention was adapted to include any interested participant regardless of race or ethnicity. Also, letters of progress were provided to participants to share with parole officers and to include in court appearances.

4. Gaudenzia, Erie
Type: DEBI
Intervention: Healthy Relationships
The target population was incarcerated men and women at the Albion State Correctional Institution (SCI) for men and the Cambridge SCI for women. The intervention used was Healthy Relationships. The intervention was chosen per design which met the needs of the target population. The intervention was adapted to meet for expanded sessions (7 instead of the designed 5); inspiration cards were given in lieu of incentives directly to participants while monetary incentives were distributed to the family members of participants who are outside of prison. HIV 101 was also added as an educational component to the sessions. Upon a participant's request, a prayer was added to the sessions. Upon completion of the program, a graduation ceremony was added. Further, a special guest was brought to talk with the women's group.

Mon Yough Community Services

Type: Non-DEBI intervention based on the Behavioral Theory Model

Intervention: ARRM

The target population was incarcerated males or males who are reentering the general population with a history of drug and alcohol abuse. The intervention used the Aids Risk Reduction Model (ARRM) which is not a DEBI. ARRM was developed in the early 90's as a conceptual framework to organize behavior change factors related to HIV risk reduction. The intervention was chosen by the funding office based on mission compatibility; the intervention was selected as the intervention purpose coincided with the agency's harm reduction philosophy. The intervention was adapted to include Health Communication and Public Information Principles (HC/PI) and to include educational pieces on counseling, advocacy, and condom education.

5. Pittsburgh AIDS Task Force

Type: DEBI

Intervention: SISTA (Sisters Informing Sisters on Topics about AIDS)

The target population was incarcerated African American women in the Allegheny County Jail. The intervention was chosen for economy and proven efficacy of the program. The program was adapted to fit criteria associated with incarcerated populations. For example, condoms were prohibited in the prisons so organizers substituted video demonstrations. Also incentives were prohibited in the prison facility so gift cards were sent to a family member of choice. Homework assignments that we were to be done with family members were redesigned to be completed over the telephone. The intervention added an additional introductory session. In conjunction with SISTA, counseling, testing and referral services were also provided.

Barriers associated with the interventions and how they were overcome:

1. Atkins House (SISTA)

Barriers

Barriers to program success included issues with recruitment, trust in the programming staff in maintaining participant confidentiality, language barriers, drug and alcohol and mental health issues of the participants and the mobilization of the incarcerated population who were sometimes transferred to correctional facilities outside of the intervention.

Overcoming barriers

Organizers were able to overcome recruitment issues by employing participants to market the intervention by word of mouth. Language barriers were overcome by having participants bring a friend to the sessions who would be willing to translate. Trust in the population was gained by maintaining the strictest confidentiality.

2. Debi Goes to Jail (VOICE/VOCES)

Barriers

Barriers to successful implementation of the intervention included structural problems within the facility. Noise levels presented a tremendous barrier. A lack of space for programs and competition for the existing space with other institutional programs was challenging to program staff. Administrative issues such as staff cooperation and coordination with city and county offices were also barriers. Further, program materials such as condoms were prohibited in the prisons.

Barriers overcome

Barriers were overcome with the negotiation of a more private workspace. Also, arrangements were made to distribute condoms packages to inmates upon their release. In addition, a DVD was shown to demonstrate condom use as substitute for actual condoms

3. First Baptist Human Services Corporation (HHRP)

Barriers

Barriers to the program's success include conflict with jail personnel, recruitment issues, funding issues and reluctance of the jail chaplain to participate.

Barriers overcome

Barriers to recruitment were overcome by word of mouth recruitment of participants for new participants. Program staff educated the chaplain on tenets of the program which fostered his support for the intervention. Funding barriers were not overcome; the funding agency did not provide monetary contribution to participants of other ethnic groups.

4. Gaudenzia (Healthy Relationships)

Barriers

Specific barriers to the intervention's success included institutional procedure. The prison experienced an escape during the time that the intervention was facilitated. This event changed the protocols within the institution and increased security. Other barriers included the prohibition of incentives in the prison, language barriers for Spanish speaking participants and privacy concerns.

Barriers overcome

Incentives for participants were distributed to family members outside of prison. The prison infection-control nurse became a trusted program ally and helped to facilitate sessions. An interpreter was found for non-English speaking participants.

5. Mon Yough Community Services (ARRM)

Barriers

Barriers to program success included a lack of institutional support from the jail facility, difficulty finding appropriate materials for dissemination to the participants, such as handouts, videos or pamphlets.

Barriers overcome

Poster materials indicate that a positive resolution to barriers was not accomplished.

6. Pittsburgh AIDS Task Force (SISTA)

Barriers

Barriers to the program's success included confidentiality and fear of disclosure of HIV status in the prisons, access to counseling, treatment and referral, administrative support within the prison, confidentiality of the participants HIV status, and access to program materials such as the condoms.

Barriers overcome

Facilitators implemented a protocol to confidentially address participants to insure privacy. Further, relationships were established with each participant to increase trust in the staff and intervention. The Pittsburgh AIDS Task Force now provides HIV counseling, treatment and referral within the jail. Relationships were established with the Allegheny County Health Department and jail administrators to foster institutional support for this intervention. The program was adapted to use video demonstration of condoms to overcome the institutional prohibition of condoms.

Requests for future training:

1. **Atkins House (SISTA)**
Several additional specific training needs were listed for the SISTA intervention facilitated by Atkins House. The training needs were: Department of Health Training on couples counseling, training on how to adapt the SISTA intervention for Asian populations, training needs on procedures for maintaining participant confidentiality, and HIV 101 training.

2. **Debi Goes to Jail (VOICE/VOCES)**
Training for partner services was suggested by the CPG evaluation. The State HIV Prevention Plan was used in the design of this site's intervention. The plan provided information on the target population as well as providing needs assessment of what services were needed.

3. **First Baptist Human Services Corporation (HHRP)**
No other HIV prevention training needs were listed. The State HIV Prevention Plan was used to identify the at risk population. Additional comments on this specific intervention included recommendations for a more detailed description of the program implementation process and compliments on the educational components of the intervention.

4. **Gaudenzia (Healthy Relationships)**
Additional training needs are still a concern. Assessments cited that training in recruitment techniques would enhance future programs. The intervention did use the State HIV plan while designing the intervention. The plan was used to identify the services available and determine what strategies would be most effective for the target population.

5. **Mon Yough Community Services (ARRM)**
Mon Yough Community Services also recommends that the target population and host site might benefit from substance abuse and HIV 101 trainings.

6. **Pittsburgh AIDS Task Force (SISTA)**
PATF notes that training needs that are still recommended for the host population include cultural sensitivity, drug and alcohol training, and HIV/STD 101. SISTA in Allegheny County Jail used the State HIV plan to define the target population and to determine the appropriate intervention for this population.

Methodological Issues:

Some methodological issues evolved during the poster assessment process. Data collection was hindered by both the presentations' designs and the data collection instrument. Not all posters clearly identified the Project Name or the geographic area where the intervention occurred. This led some participants to confuse and misidentify the program name and the program purpose.
Not all posters disclosed information related to the appraisal questions. For example not all projects presented information related to intervention adaptations on the posters. Therefore, the participants were unable to fully assess these projects.

The poster criteria also omitted information related to the number of participants, the project/intervention status such as ongoing or completed, what is included in the outcomes measurements, and the community and individual impacts of the intervention. To overcome some of these methodological issues, a template of

potential poster criteria for the 2009 poster session is attached to this document. However, a discussion should be held by the evaluation subcommittee to determine all the fields of inquiry to be included in future assessments.

Questions included on the 2008 poster session:

1) Target population
2) Description of DEBI, science based or other and other interventions provided
3) Process used to select the intervention
4) Has the intervention been adapted
5) If so, in what way was the intervention adapted
6) Describe any other intervention (not science-based) that is being provided
7) Describe the biggest barriers to implementing these interventions
8) How have these barriers been dealt with?
9) Describe HIV prevention training needs (if any)
10) Is the State's HIV Prevention Plan used?
11) If so, how is the HIV Prevention Plan used?
12) If it is not used, describe why.

Template of fields of data for future poster sessions:

- Name of the Agency
- Name of the intervention/DEBI used
- Describe the criteria that selected the intervention
- Please describe the intervention
- Where was the intervention done
- Who was the target population
- Were other interventions or program used as well. If yes, please list and describe
- Was the intervention adapted in any way? If yes how?
- What were barriers to the intervention?
- How were barriers dealt with?
- What recommendations does the agency have for future users of the intervention?
- What other training needs does the population still need (according to the agency)?
- What the State HIV plan used? If yes, how?
- Was any other plan used?
- How many people did the intervention see?
- Was there an outcomes assessment to measure the intervention's impact? If yes, what were the results?
- What were your thoughts on the intervention? How would you adapt the intervention?
- What population would you suggest could be helped by this intervention?

Interventions discussed in Poster Session:

AARM "Client-centered counseling is utilized, meaning that the counseling has an underlying belief that each individual tells the counselor his/her needs and choices rather than telling an individual what his/her needs are or what choices to make. Client-centered counseling is supportive rather than directive. The role of the counselor is to create an environment in which an individual can reflect upon his/her own decisions.

This client-centered counseling approach utilizes the AIDS Risk Reduction Model (ARRM) identifies behavior change as a multi-step process with different psychological and social determinants for each stage. The three stages of behavior change, according to this model are, 1) Labeling of high-risk behavior (becoming knowledgeable about HIV transmission and HIV risk behaviors)-Health Communication/Public Information presentations teach about risky behaviors; 2) Commitment to changing high-at risk behaviors-self referral for ILI; and 3) Enactment of risk-reduction behavior – development of an individualized plan for safer behaviors and linkage to identified needed services. (Effective Interventions: Findings from CDC compendium and Connecticut CPG's Literature Review, 2001)" Submitted by Cathleen Komorowski, Mon Yough Community Services, June 12, 2008.

Healthy Relationships "Healthy Relationships is a five-session, small-group intervention for men and women living with HIV/AIDS. It is based on Social Cognitive Theory and focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills." (http://www.effectiveinterventions.org/go/interventions/healthy-relationships Accessed June 12, 2008)

HHRP "The Holistic Health Recovery Program (HHRP) is a 12-session, manual-guided, group-level program for HIV-positive and HIV negative injection drug users. The primary goals of HHRP are health promotion and improved quality of life. More specific goals are abstinence from illicit drug use or from sexual risk behaviors; reduced drug use; reduced risk for HIV transmission; and improved medical, psychological, and social functioning. HHRP is based on the Information-Motivation-Behavioral Skills (IMB) model of HIV prevention behavioral change. According to this model, there are three steps to changing behavior: Providing HIV prevention information, motivation to engage in HIV prevention and opportunities to practice behavior skills for HIV prevention."

SISTA: "This group-level, gender- and culturally- relevant intervention, is designed to increase condom use with African American women. Five peer-led group sessions are conducted that focus on ethnic and gender pride, HIV knowledge, and skills training around sexual risk reduction behaviors and decision making. The intervention is based on Social Learning theory as well as the theory of Gender and Power."

VOICES/*VOCES*: Video Opportunities for Innovative Condom Education & Safer Sex: A group-level, single-session video-based intervention designed to increase condom use among heterosexual African American and Latino men and women who visit STD clinics.
Background on the intervention sites:
Albion State Correctional Facility: Population MALE. Houses over 2100 inmates. Medium security prison.

Allegheny County Jail: Population MALE and FEMALE. Houses over 2000 inmates. A wide range of treatment and educational initiatives are hosted including drug and alcohol treatment, Family Counseling, and Mental Health Services. For more information: http://www.alleghenycounty.us/jail/index.aspx

Beaver County Jail and halfway houses: Jail Population MALE and FEMALE.
Houses over 355. Gateway Rehab Satellite, GED Education and a schoolteacher comes in to offer classes towards High School Diploma for inmates under 21.

Cambridge Springs State Correction Facility: Population FEMALE. Minimum security prison. Majority of inmates are nearing completion of sentence.

LeHigh County Prison: (per conversation) MALE and FEMALE Population 1135.
Mental Health, Drug and Alcohol, Family Counseling, AA, NA, GED, Anger Management, Prerelease Work Programs.

York County Prison: Holds prisoners for any crime in York County for up to five years.
Also one of the largest INS holding facilities in the country.
http://www.york-county.org/departments/prison/prison.htm

Summary:

A comparison of the 2004, 2005, 2006, 2007 and 2008 poster sessions reveals several themes that are universal to all sessions. It should be remembered that each group of presenters differed from the other as did the prescribed content of their presentations. Representatives of community based organizations involved in HIV prevention activities presented in 2004. Presenters were uncomfortable with the process because they thought that they were being evaluated. They became much more comfortable once they understood that the purpose was not to evaluate them but to increase communication between providers and the Department of Health and the Committee and to have the DOH and Committee better understand the work of the providers. Nevertheless, the concerns of the providers may have had an effect on what information they were willing to provide. PA Department of Health regional staff presented in 2005 on their prevention activities. Community-based providers of prevention services also presented in 2006. However, they focused on their experiences in conducting DEBIs. It should be noted that throughout much of the data and the analysis of the data the "what interventions don't work as well" and "barriers to providing effective HIV prevention" data appear to be merged. As a result, those two areas for this overview are combined.

There are a number of themes shared by each group of presenters (with respect to "what works" "what doesn't work as well/barriers to effective HIV prevention"). This is not to say that all providers within a poster session necessarily agreed on each point. Nevertheless, while there may have been an exception, the general consensus among providers, across poster-sessions, was as follows. They agreed that the following prevention activities were moderately to very effective: 1) peer-to-peer preventions, 2) interventions that include testing and counseling, 3) interventions that specifically address the culture of a target population, 4) interventions that provide community-based outreach using strong networks that target a specific population.

There were also several themes shared by the three groups of presenters with respect to "what doesn't work as well/barriers to effective HIV prevention." The most cited and most strongly voiced barrier is the lack of funding/resources. It was stated that this results in a lack of staffing, increased staff turnover, lack of training for staff, and lack of transportation to access individuals. A second major theme across poster sessions relates to stigma. It was stated that negative attitudes about HIV and people with HIV, the conservativeness of many areas, the lack of community support for, for example, harm reduction stands in the way of providing effective prevention. A third major theme was that interventions in schools lack effectiveness due to the inability to speak what needs to be spoken and to distribute condoms (this was not explicitly stated by many of the 2006 presenters because most DEBIs do not target schools, which in and of itself may speak to this theme.) A fourth major theme is that prevention in rural areas has limited impact due to transportation issues, the difficulty of accessing target populations there, and the conservativeness of these areas. A fifth major issue was the difficulty or, in some cases, the inability to access MSM (especially young MSM) and IDUs. This issue is the reason why several presenters felt that their programs were not effective. A sixth major theme was the lack of training for staff. This is mentioned above under the theme of lacking resources, but also appears to be a unique theme across poster sessions. Applying "canned" prevention programs in small cities or in rural

areas and with populations that may differ from what is prescribed was highlighted by two of the three poster sessions. This theme, while not "universal", should still be pointed out given how strongly those two groups felt about it. The final shared theme is the extent that cultural barriers (including language) stand in the way of providing effective prevention.

6.5.6. Results of the 2009 Poster Session

Prepared by Ms. Katherine Bulova, MPH

During the May 2009 Pennsylvania Community Planning Group meeting, the Evaluation Subcommittee facilitated the sixth consecutive poster session to review HIV prevention interventions. This year's focus area was immigrants and refugees. The evaluation included eight posters of existing programs' home grown interventions that may or may not have based on an evidence based intervention (DEBI or EBI). As a result, this year's summary is a clear picture of the programming available to the population of immigrants and refugees but is not a standard summation of CDC funded programming. In fact, some organizations listed no prior knowledge of the State HIV prevention plan prior to the invitation the event. The participating organizations and their interventions are as follows:

Name or Organization	Location
African Cultural Initiative	Chester County
African Family Health Association	Philadelphia County
El Consejo Hispano	(Lehigh and Northampton)
Keystone Farm workers	Five counties: mobile units
La Communidad Hispana	Chester County
Latino's for Healthy Communities	Lehigh and Berks County
Nuestra Clinica	Lancaster City and County

Members were asked to appraise poster presentations and interventions on 10 different areas. Topics of the appraisal included recruitment and retention strategies, the barriers associated with the intervention and how the barriers were overcome, HIV prevention training needs and if, and how, the state HIV prevention plan was used.

General themes/observations related to interventions:

It should be noted that the participating agencies' missions are predominately to serve the needs of immigrants and refugees within each community. This population often includes migrant workers and recently resettled persons who have limited English skills and few community resources. For these reasons, the participating agencies provide translation services and escort services. Some of organizations themselves are primarily general health care or mental health clinics who felt that this population required additional services. The need to provide HIV/AIDS interventions presented itself and was incorporated into their missions as an unmet need.

The agencies' activities were conducted with limited interaction with state and federal HIV programs. Some of the intervention utilized were created in-house and were not tested for efficacy. Two of the participating agencies were unfamiliar with the HIV prevention plan prior to the presentations, and additional agencies did not use the plan to guide programming and adaptation of interventions. Only three agencies noted that they used the CDC Diffusion of Effective Behavioral Intervention (DEBI).

It is unclear from the presentation and the presentation assessments what the success rate of each of these interventions has been. It is also unclear if pre and post intervention assessments were administered by the participating agencies.

Uniform throughout these assessments is the sense of commitment of the staff of participating agencies. Most rely on untraditional methods to provide interventions to the community. This commitment includes ingenuity in how services are delivered, where services are delivered, and the persistence of staff in creating personal connections with "unconnected" populations. Nontraditional offsite locations include weddings, teen centers and mushroom farms.

Barriers associated with the interventions and how they were overcome:

1) **African Cultural Initiative (Chester County)**
   Barriers: Fear of deportation, fear of disclosure fear maternal: breastfeeding, and pregnancy

The most significant barriers associated with the African Cultural Initiative are fear of disclosure and risk of deportation. To overcome these barriers staff has taken great strides to provide a safe place for interventions to occur. Talk of immigration and residency status is avoided. The staff also tried to incorporate cultural beliefs and educational level into service delivery Untraditional documentation, such as a letter from the church vouching for identity, is allowed. The practice of using family members as interpreters is discouraged to maintain privacy. Fears related to childbirth and risks of spreading HIV are dealt with through education.

2) **African Family Health Association (Philadelphia County)**
   Barriers: Fear of deportation, stigma and culture

The most significant barriers for the African Family Health Association are cultural competency of staff and fear of deportation and stigma for disclosure of HIV status. Cultural barriers have been addressed with education and staff training. Further, the organization has adapted existing DEBIS (SISTA, *Voices/Voces*) to meet the consumer need. Skills training and education on navigating legal and health systems helps alleviate fears, while the organization also offers community leader education to help influence policy.

3) **El Consejo Hispana (Lehigh and Northampton Counties)**
   Barriers: Misinformation stigma, religious beliefs, lack of testing equipment, clients not wanting to wait, and confidentiality

El Consejo Hispana is working to overcome capacity limitations for testing in the region. Clients do not want to wait for results. The program is working on implementing rapid testing to overcome this. Also, confidentiality related to sex, condoms and HIV is crucial. Simply using darker packaging is one way to mask safer sex materials for clients. Religious beliefs (refusal to use condoms) and lack of knowledge are barriers to prevention for the region. Tools such as counseling and education are used to circumvent misinformation and beliefs. Staff strives to be consistent in their message while motivating and encouraging clients to practice safer behaviors. The staff is hoping to developing new services via the internet to expand educational opportunities.

4) Keystone Farmers (Five Counties in South Central Pennsylvania)
Barriers: Culture client sense of powerlessness, alcohol, prostitution and distrust of medical establishment

Barriers of Keystone Farm-workers are frequently associated with conditions of poverty that can be associated with some immigrant/migrant worker communities. Workers have little education and few resources. According to Keystone Farmers' staff, working in camps for long hours in communal living environments, leaves the consumers vulnerable to alcohol abuse, drug use and use of prostitutes. One reviewer wrote of the lifestyle barriers to prevention: "unprotected intercourse, multiple partners and widespread alcohol use. Sex habits are disregarded as long as he sends money home and provides for wife and children." As an added barrier, consumers are often distrustful of the medical establishment.

Using bilingual staff, Keystone offers individual and group education. Staff strives to become familiar to the consumers and even offers home visits. Peer outreach and cultural beliefs are incorporated into interventions. Reviewers noted that staff was able to reach clients by acting in a courteous and respectful way. Services are provided without cost. One reviewer notes that the agency brings "healing traditions of country of origin and services to the field".

5) La Communidad Hispana (Chester County)
Barriers: Funding/marketing (capacity), population served is transient, migrant workers access to population and no transportation

La Communidad Hispana experiences both internal and external barriers to service delivery. Internal struggles for funding and community awareness have been helped by coupling service delivery with other health initiatives such as tobacco cessation. Also, the agency is now using mass mailings and newsletters to raise awareness of the agency among community members and farms, the employers of the target population. Overcoming the transiency of the consumers themselves has been eased with the identification of community leaders who help to disseminate information. Additionally, the staff goes to the farms to meet with consumers to overcome some transportation issues.

6) Latinos for Healthy Communities (Lehigh and Berks Counties)
Barriers: Trust of medical establishment, culture, religion, machismo, mobile resources and access to schools

Latinos for Healthy Communities works to overcome community mistrust and to integrate into the establishment by recruiting staff from the population it serves. Reviewers note that staff struggles with "trust versus machismo". This is overcome, in part, by finding a leader within the community to assist with health messaging. Machismo is overcome in part with one-on-one counseling; the staff also strives to use "street" language and to maintain the strictest of confidentiality to encourage and maintain client trust. Additionally, insuring that the staff keeps consistent, culturally sensitive health messages helps to overcome religious and cultural barriers to safer sex choices.

Access to the populations within schools seems to remain a barrier. The agency is working to overcome this with mobile units that can move within communities.

7) Nuestra Clinica (Lancaster City and County)
Barriers: Fear of deportation, no documents, language and access to care

Nuestra Clinica's population is largely undocumented immigrants. Fear of deportation and fear of accessing care without proper documentation are barriers to programming and treatment. Barriers related to fear of deportation and documents are dealt with through group meetings in the community that orient the population to the services available. Individual client meetings are used to provide tailored services to clients. Nuestra Clinic has joined with the Spanish Civic Association to offer education and assistance on individual and group levels. Education includes health messaging for HIV prevention.

Conclusion:

While it has previously been noted that these agencies do not have missions primary focused on HIV prevention, their techniques and means in which the recruit and retain clients should be lauded. That some of these agencies did not know of the existence of the HIV prevention plan is unfortunate. Working with the HIV prevention plan in the future should be of benefit to all parties. In addition, the 2003 CDC HIV Prevention Plan Community Planning guidance requests knowledge of HIV prevention programs regardless of their funding sources.

6.5.7. Results of the 2010 Poster Session – Interventions Targeting High-Risk Rural Populations

Introduction:

During the May 2010 Pennsylvania CPG meeting, the Evaluation Subcommittee facilitated the sixth consecutive poster session to review HIV prevention interventions. This year's focus area was rural service delivery. The evaluation included six posters of existing programs that may or may not have based on an evidence based intervention (DEBI or EBI). The participating organizations, presenters and city of program location are as follows:

Name or Organization	Presenter	Location
Prevention Education at the Red Cross	Michelle Belito-Stanford	Scranton, PA
United Neighborhood Centre of Lackawanna County (DEBI invades NEPA)	Angel Atell	Scranton, PA
AIDS Community Alliance	Phil Goropoulos.	Harrisburg, PA
First Baptist Human Services	Rev. Anthony Massey	Pittsburgh, PA
Caring Communities for AIDS	Christopher Kupchick, Scott Preisel	Berwick, PA
Adagio Health	Damion Wilson	Western PA

Members of the CPG were asked to appraise poster presentations and interventions on eleven different areas. Topics of the appraisal included recruitment and retention strategies, the barriers associated with the intervention and how the barriers were overcome, HIV prevention training needs and if, and how, the state HIV prevention plan was used.

General themes/observations related to interventions:

Though the theme this year was service delivery to rural areas The interventions were delivered to a broad and diverse population base including IDU, MSM, at risk women, African Americans, Latinos, recently released or soon to be released prisoners, homeless, low income and public housing communities.

Intervention descriptions:

1) Prevention Education at the Red Cross
Target Population: Rural, IDU, Homeless and low income populations, high risk women, African Americans, Latinas
Intervention: DEBIs: Safe in the City, POL, Respect, VOICES

In Scranton, Pennsylvania, the Red Cross implemented a series of DEBIs targeting high risk populations within the community. Interventions included Safe in the City, POL, Respect and Voices.

Adaptations:
Specific adaptations that facilitators integrated into the program include mobile rapid HIV testing, lengthening instruction time of specific interventions, and expanding curriculum to include HIV prevention education and condom use.

2) United Neighborhood Center of Lackawanna County (DEBI Invades NEPA)
Target Population: African American Youth, Hispanic/Latino
Intervention: DEBIs: Including RESPECT, SISTA, VOICES/VOCES,, Street Smarts, Safety Counts, Popular Opinion Leader
United Neighborhood Center is a nonprofit based in Scranton, Pennsylvania with a 10-year history in HIV prevention. Interventions included onsite and mobile HIV testing and implementation and adaptation of DEBIs. Recruitment into the interventions included incentives such as food cards and shirts.

Adaptations:
Several of the interventions were adapted for language. Specifically, the SISTA program was translated to Spanish and was well received by the Latina community. It was noted that the setting/location of the interventions were also changed but no further information was available. It is noted that adaptations meeting the needs of clients (such as language and location) have increased retention and encouraged participants to continue contact with the agency after the interventions ended.

3) AIDS Community Alliance
Target Population: MSM/IDU
Intervention: DEBIs: Community Promise, Health Relationships

AIDS Community Alliance has served those impacted by HIV in the community of Lancaster since 1985. This year they presented DEBIs targeting MSM and IDU in the region. In addition to facilitating the interventions Community Promise and Healthy Relationships, AIDS Community Alliance also offered safer sex kits, initiated rapid HIV testing in the field, including to homeless populations and gay bars, and used role model stories to share experiences of HIV diagnosis and prevention.

Adaptations:
The interventions were adapted to meet the needs of a rural population. Included in this shift was a greater emphasis on stigma and its impact. Both interventions incorporated role model stories.

4) First Baptist Human Services
Target Population: Inmate populations, IDU
Intervention: DEBIs: Holistic Health Recovery Program (HHRP), Respect

Interventions HHRP and Respect were offered to incarcerated populations and those in halfway houses. Poster presentation surveys cite that 2800 participants completed the interventions. First Baptist Human Services states that both interventions were used as designed and no adaptations were made.

Adaptations:
No adaptations were listed. The program did cite a success rate in this community of reunited families (parents regaining custody of children), of early prison release, and of participants becoming so invested that the agency board would like to invite them to serve on the board of directors as well.

5) Caring Communities for AIDS
Target Population: MSM in Northeastern and Central PA (rural)
Intervention: DEBIs: Popular Opinion Leader, Respect

Caring Communities serves MSM in Northeastern and Central Pennsylvania. Interventions focused on Popular Opinion Leader and Respect. Caring Communities worked hard to be accepted by local bars which allowed them to ultimately offer onsite testing. Social networking was an important component of these interventions.

Adaptations:
Social networking was an important aspect of the interventions for Caring Communities. The agency built upon this by adapting the intervention to use different methods of communication to reach participants; Caring Communities listed both smart phones and email as a mechanism to "meet" with participants. This also overcame geographic barriers associated with rural communities.

Additionally, Caring Communities adapted the DEBI to meet in community locations such as bars, where patrons welcomed staff, and campgrounds. Staff also tested in these locations and diagnosed HIV positive individuals with rapid testing.

6) ADAGIO Health
Target Population: Youth
Intervention: EBIs geared towards adolescents: Too Good for Drugs and Violence (SAMSA), Focus on Kids

Adagio Health worked with local school districts in order to gain access during school hours/class time to facilitate interventions to HIC students. Interventions included:
Teaching life skills to adolescent's age 9-12 and sex and drug prevention messages to 9^{th}-12^{th} graders. Results from one school indicated that students demonstrated increased knowledge about HIV and reduced risk behaviors.

Adaptations:
The intervention curriculum was modified to meet school period time slots (48-minute period).

Barriers associated with the interventions and how they were overcome:

1) Prevention Education at the Red Cross
Barriers: Funding cuts, stigma, transportation, staff

Barriers existed for the Scranton area intervention. Most frequently, stigma and community perception of the program itself was cited as a barrier to enrollment and facilitation. Organizers overcame this by changing program name. Another important barrier, transportation issues of clients was overcome through mobile testing. HIV testing was taken to neighborhoods deemed "at risk".

2) United Neighborhood Center of Lackawanna County
Barriers: Childcare, safety, transportation, stigma, planning issues related to time and cost

Barriers for the DEBI invades NAPA intervention were overcome through planning for the specific needs of participants. Those who needed transportation and childcare had it provided by the agency. Additionally, meeting in small group and different locations brought the intervention to the community. Incentives were provided to increase community buy-in and strengthen retention rates of participants. Involving family and friends also increased community buy-in and reduced stigma. Although safety, time and cost were listed as barriers solutions were not listed.

3) AIDS Community Alliance
Barriers: Staffing, message fatigue, location/geography

Staffing issues were address through new applications for funding and filling service gaps with volunteers. Message fatigue was countered through new messaging sources such as posters and information cards. Overcoming transportation and geographic concerns of the clients was a goal of switching testing to all rapid HIV testing thus ensuring results are delivered immediately.

4) First Baptist Human Services
Barriers: Community sentiment towards faith based organization

The largest barrier was participant and community attitudes towards a faith based organization. There was some community rejection of service delivery through this mechanism. However, services were predominantly delivered to an incarcerated population and therefore participants had fewer options.

5) Caring Communities for AIDS
Barriers: Funding, retention, transportation

Funding barriers were overcome by diversifying funding sources including using other unrestricted funds. Further, staff was cross trained to allow multiple roles to be filled. Retention was improved through more meaningful incentives such as movie passes and use of technology to allow different types of access such as "internet meetings". Finally, transportation was provided to overcome geographic concerns.

6) Adagio Health

Barriers: time constraints, ability to distribute condoms, travel, weather

Condoms were not allowed to be distributed in schools. The agency understood this and this component of the intervention was not offered. Time constraints required flexibility on the part of the staff: educational curriculum was cut with a priority of placing the most important educational components at the beginning of each session. Also, to maintain fidelity to the program and consistency in intervention delivery, the same facilitator was sent to each 8-week session.

Use of Community HIV Prevention Plan:

Of the six included agencies, five discussed the Pennsylvania Community HIV Prevention Plan. Agencies felt that the plan was most helpful as a planning guide. Agencies also used the HIV Prevention Plan as a reference and resource list. Data within the plan was used to justify funding in grant applications. Limitations of the plan as a guide included the HIV Prevention Plan's defined "priority population" not paralleling the priority population of the community. One organization, First Baptist Human Services, did not make mention of the Prevention Plan.

Methodological Issues and Recommendations:

Some methodological issues emerged during the poster assessment process. Some surveys were not included as they identified neither a contact person (nor presenter) nor agency. Also, content from several surveys were not admissible due to illegibility of the forms.

DEBI and evidence based interventions were not a targeted question on the evaluation form and were not mentioned in most survey responses. It might also be helpful to include a question that requires the number of persons served by the intervention.

Not all presenters included biographical information on their intervention or agency. Attempts were made to contact these agencies after the presentation but to date these facilitators have not been reached. While the process differs from year to year, this might be helpful to include in next year's data collection. Also, the included questions for this year survey tool did not assess the process itself. There is no way of knowing if incomplete forms were related to external issues, such as lack of time, noise or other issues, or as a result of the quality of the information presented.

A question and answer session is available at the end of each presentation. It would be helpful if there were some way to gather the conversation that occurs at this time. This communication often offers both anecdotal and incidental experiences that enhance the understanding of both the true barriers of interventions and how these barriers were resolved.

Finally, perhaps a question can be added to ensuing data collection sheets that allows the reviewers to add a question for the upcoming year. Perhaps this could serve as a small process evaluation that allows the reviewers to communicate what information was not available to them.

Conclusion:

Rural areas are being served through a myriad of interventions. While many of the existing DEBIs have had to be adapted to meet the specific barriers associated with a rural population, programming does exist. More research should be gathered to understand the scope of the adaptations and the success of these adaptations.

Offering interventions in new and creative forums, such as campgrounds, is a sensitive response that should benefit the population served.
Of particular interest are the interventions that were delivered through new technologies. Using smart phones and email are a cost effective way to deliver programming; this technique might also overcome staffing limitations.

Appendix 1
Contact information of participating agencies
1) Red Cross, Scranton, PA
Contact: Michelle Bonita Stanford
545 Jefferson Avenue
Scranton, PA 18510

2) United Neighborhood Center of Lackawanna County
Administrative Office
Address: 1004 Jackson St.
Scranton, PA 18505
Telephone: (570) 961-1592
Contact: Angel Atell

3) AIDS COMMUNITY ALLIANCE
100 North Cameron Street, Ste. 301-East
Harrisburg, PA 17101
717.233.7190
800.867.1550
Fax: 717.233.7196

4) First Baptist Human Services
PO Box 151
Freedom, PA 15042
Telephone: 724 312-1990
Contact: Rev. Anthony Massey

5) Caring Communities for AIDS
301A W 3rd St
Berwick, PA 18603
570-752-5655

6) Adagio Health
http://www.fhcinc.org/pages/education/HIV-prevention.htm
412-288-2130 x 176
Contact: Damion Wilson

Appendix 2
Survey questions
1) What target population do you reach in rural areas and how did you decide who to target?
2) Describe the interventions/testing and counseling provided to these populations

3) If you are using a "packaged" (DEBI/EBI) intervention, have you adapted it?
4) What outcomes have you seen as a result of these interventions?
5) What have been the biggest barriers to reaching this population
6) How have you overcome these barriers?
7) How do you recruit and retain participants for your intervention?
8) Have you identified any HIV prevention training needs of staff, if so, what?
9) Are you familiar with the Pennsylvania Community HIV Prevention Plan and its contents?
10) If so, are you following the recommendations within the Pennsylvania Community HIV Prevention Plan? If yes, please tell us how?
11) If the HIV Prevention Plan is not used, describe why/

Appendix 3
Template of fields of data for future poster sessions

- Name of the Agency
- County, City of intervention (please list all if multiple sites)
- Name of the intervention/DEBI used
- Describe the criteria that selected the intervention
- Please describe the intervention
- Where was the intervention done
- Who was the target population
- Were other interventions or program used in conjunction with this intervention? If yes, please list and describe
- Was the intervention adapted in any way? If yes how?
- What were barriers to the intervention?
- How were barriers dealt with?
- What recommendations does the agency have for future users of the intervention?
- What other training needs does the population still need (according to the agency)?
- What the State HIV plan used? If yes, how?
- Was any other plan used?
- How many people did the intervention see?
- Was there an outcomes assessment to measure the intervention's impact? If yes, what were the results?
- What were your thoughts on the intervention? How would you adapt the intervention?
- What population would you suggest could be helped by this intervention?

6.6. Activities Conducted by the Evaluation Subcommittee and the University of Pittsburgh

The University of Pittsburgh in collaboration with evaluation subcommittee of the CPG conducts evaluations of two programs (see Figure VI.1).

The first is an assessment of the impact of the planning process on actual CDC funded HIV activities; the CPG employs two different methods. The first predated the CDC's PEMS program by a few years. That project is the Pennsylvania Uniform Data System (PaUDS). This system collects process-monitoring data in electronic form on a quarterly basis. Data from this system is aggregated and analyzed. The aggregated data is then submitted to the CDC.

The Pennsylvania Department of Health requires all CDC funded prevention programs including local health departments to collect data about their activities. These data include the demographic and risk-behaviors of people reached by the program and other variables. This system collects much of the same data that PEMS intends to collect. Once the data are cleaned and summarized, they are sent back to the agencies and to the Department where they are used to identify strengths and weaknesses and to revise programs so that they better conform to the CPG's Plan.

The second method is the Young Adult Roundtable Process Evaluation. It is administered annually at the November meeting to CPG members. This survey provides CPG members the opportunity (both qualitatively and quantitatively) to comment on the progress of the Roundtables during the past year. The evaluative tool assesses young people's parity, inclusion, and representation in the planning process. Roundtable members use the Committee's feedback to strengthen the project and Roundtable member involvement in the community planning process.

6.6.1. Results of 2010 Pennsylvania Uniform Data Collection System (PaUDS) Activities

The PaUDS program is an Internet-based computerized uniform data collection system for HIV prevention services. The PaUDS system collects data based on intervention types – interventions delivered to individuals (IDI), interventions delivered to groups (IDG), outreach (OR), health communication/public information (HC/PI), and comprehensive risk counseling services (CRCS). Within each of these interventions, the service provider collects information on race, ethnicity, gender and age, for persons receiving these services. Additional information, such as the setting that the intervention had taken place and number of times a certain person has been contacted, is also collected.

Currently all nine local county and municipal health departments and the seven Ryan White Coalitions (as well as the Council of Spanish Speaking Organizations of the Lehigh Valley) are required to report using either the PaUDS system or the CDC PEMS system. Reports are submitted to the Commonwealth on a quarterly basis. Funded agencies submitted data for each quarter in 2009 and 2010. Data were accepted to the Commonwealth in quarterly reports. The quarterly reports summarize all of the data for that current quarter and present a "snapshot" of Pennsylvania HIV prevention activities. Beginning in 2008, the nine local county and municipal health departments have begun to report their data using the CDC PEMS system. For these reasons, 2008-2009 PaUDS data may not represent all HIV prevention activities delivered under the purview of the Pennsylvania State Department of Health.

6.6.2. Young Adult Roundtable Process Evaluation Data: 1998-2009

Trends in Pennsylvania CPG Process Evaluation Data: 1998-2009
Each year in November, Planning Committee members complete an anonymous survey as part of the Roundtable process evaluation. Below are the means (average) of Planning Committee responses to the first ten questions from last November's survey (extreme right column), together with mean responses from the eight prior years. Four numeric responses to each of the ten items were possible: 1= "completely disagree"; 2= "disagree"; 3= "agree"; 4= "completely agree." Those items marked by an asterisk * were not included in that year's survey. 25 CPG members completed this 2007 survey. Due to the change in scheduling that required CPG orientation to be conducted in November 2008 rather than January 2009, an evaluation was not conducted in 2008. Annual evaluations resumed in November 2009.

#	**Variable:** "Your belief that…"	1998 n=26 (67%)	1999 n=20 (67%)	2000 n=22 (67%)	2001 n=27 (70%)	2002 n=15 (42%)	2003 n=28 (87%)	2004 n=26 (72%)	2005 n=27 (75%)	2006 n=17 (41%)	2007 n=25 (69%)	2009 n=23 (66%)
1	*YART gives youth a voice in the community planning process*	3.5	3.4	3.5	3.4	3.3	3.7	3.6	3.6	3.7	3.8	3.9
2	*Roundtable members reflect epidemic in Pennsylvania*	3.0	3.0	2.9	2.9	3.0	3.0	3.0	3.2	2.9	3.1	3.5
3	*Important needs assessment data from YART to PC*	3.2	3.1	2.9	3.0	3.1	3.5	3.2	3.5	3.4	3.6	3.5
4	*Young PC members have parity in planning process*	3.5	3.0	3.2	3.3	2.8	3.6	3.5	3.6	3.6	3.7	3.7
5	*Young PC members contribute to community planning process*	3.7	3.4	3.2	3.6	3.4	3.6	3.7	3.7	3.7	3.5	3.7
6	*Mentors convey data from YART to PC*	3.3	2.7	2.5	2.4	2.0	2.7	3.0	3.2	2.9	3.1	3.2
7	*YART important part of Community planning process*	3.8	3.6	3.5	3.5	3.3	3.8	3.6	3.9	3.8	3.8	3.7
8	*Roundtable Exec meetings important for PC to meet youth*	3.5	3.3	3.4	3.3	2.9	3.4	3.3	3.6	3.4	3.5	3.5
9	*Consensus Statement provides important data for process*	3.6	3.4	3.1	3.1	3.1	3.7	3.5	3.6	3.5	3.4	3.6
10	*YART ensure young people PIR in PA's planning process*	*	*	*	*	2.8	3.6	3.5	3.7	3.6	3.6	3.7

The following table represents the breakdown of 2009 Planning Committee responses to the first ten questions. Four numeric responses to each of the ten items were possible: 1= "completely disagree"; 2= "disagree"; 3= "agree"; 4= "completely agree."

#	**Variable:** "Your belief that…"	**2009 Surveys n=23**	**2009 Survey Average**
1	*YART gives youth a voice in the community planning process*	**0% Completely Disagree 0% Disagree 13% Agree 87% Completely Agree**	**3.9**
2	*Roundtable members reflect epidemic in Pennsylvania*	**0% Completely Disagree 0% Disagree 52% Agree 44% Completely Agree**	**3.5**
3	*Important needs assessment data from YART to PC*	**4% Completely Disagree 0% Disagree 39% Agree 52% Completely Agree**	**3.5**
4	*Young PC members have parity in planning process*	**4% Completely Disagree 0% Disagree 17% Agree 70% Completely Agree**	**3.7**
5	*Young PC members contribute to community planning process*	**0% Completely Disagree 0% Disagree 30% Agree 70% Completely Agree**	**3.7**
6	*Mentors convey data from YART to PC*	**0% Completely Disagree 9% Disagree 57% Agree 30% Completely Agree**	**3.2**
7	*YART important part of Community planning process*	**0% Completely Disagree 0% Disagree 26% Agree 70% Completely Agree**	**3.7**
8	*Roundtable Exec meetings important for PC to meet youth*	**0% Completely Disagree 0% Disagree 43% Agree 48% Completely Agree**	**3.5**
9	*Consensus Statement provides important data for process*	**0% Completely Disagree 0% Disagree 34% Agree 52% Completely Agree**	**3.6**
10	*YART ensure young people PIR in PA's planning process*	**0% Completely Disagree 0% Disagree 30% Agree 70% Completely Agree**	**3.7**

Below are the numbers of Planning Committee responses (November 2009) to inquiries about how much information you have about the Roundtable Consensus Statement:

(Note: not everyone answered the question)	none	very little	some	a lot
Roundtable Consensus Statement	0 (0%)	6 (26%)	10 (44%)	5 (22%)

Below are the numbers of Planning Committee responses (November 2009) to inquiries about the extent to which needs assessment information from the Roundtable Consensus Statement was used in the planning process, the extent to which Planning Committee mentors to the Roundtables have provided information to the Planning Committee about the prevention needs of Roundtable members, and the perceptions of Roundtable members' participation at Planning Committee meetings:

	not at all	very little	a bit here and there	a lot
The extent to which the ideas in Consensus Statement have been used in Comprehensive Prevention Plan	0 (0%)	1 (4%)	13 (57%)	7 (30%)
(note: not everyone answered the questions below)	**none**	**very little**	**some**	**a lot**
Amount of information shared by Mentors with Planning Committee about prevention needs of Roundtable members	1 (4%)	3 (13%)	6 (26%)	4 (17%)
Perception of Roundtable members' participation at Planning Committee Meetings.	0 (0%)	2 (9%)	7 (30%)	8 (35%)

6.6.3. Qualitative Data from November 2009 Surveys:

In addition to the above numeric data, Planning Committee members also provided additional verbal comments about and recommendations for the Roundtables. Here are their responses.

Recommendations to improve the Pennsylvania Young Adult Roundtables:

- Continue present direction and request for additional focus groups if needed. Expand on additionally representation in rural regions of PA.
- Continue to encourage current members to recruit among their peers.
- Continue what you're doing.
- Extremely rural areas need to be courted for recruitment. They are not represented as well as they could be. Suggest using senior project requirements as an incentive.
- Get more community planning members to become an active mentor especially at our bigger YART locations, i.e. it can include more than one mentor.
- I would like to see how the Young Adult Roundtables recruit from surrounding rural communities in an effort to target how the disease process radiates out of the cities into the surrounding communities.
- Increase the Roundtable to the Southeast area of the state to have representation of the Southeast area.
- Mentors should routinely report to the larger body...perhaps a brief report at the start of the first day of the meeting.
- More communication.
- No recommendations.
- Representation from outlying areas.

- While the attendance by co-chairs has greatly improved the turnover rate does not allow the co-chairs to properly involve themselves in subcommittees.
- Would like to see more data about epidemic in young people. I also would like to see better internet engagement of youth.
- Would like to see/hear from YARTs at every meeting and would like to have 1 or 2 YART members sit in at every/each subcommittee, to gain from their outlook.

About the Roundtable HIV Prevention Consensus Statement:

- Am most pleased with the info and participation of YART and the inclusion of the Consensus Statement in our Plan and Update.
- Late in coming.
- Sorry, haven't read it lately, however I can remember it being very comprehensive and easy reading.
- The Consensus states accurately that a need/gap exists in data gathering for young adults and youth. No strong suggestion for trapping this information was given.
- Useful in the development of how YART fit into the planning process and help to identify the varying needs relative to epidemic.

About Planning Committee Mentors/Planning Committee:

- Great experience, we need more mentors and better ways to offer and provide counseling/testing opportunities on site. Involve other outside agencies to do presentations on site at meetings. Create an inclusive opportunity to better identify the needs and other recruitment possibilities.
- I am delighted we now have a Roundtable in Lancaster.
- I have been a very bad mentor this year, so my suggestion is for me to attend more Roundtables.

Young Adult Information needed by Planning Committee to effectively plan:

- Consistent input from young people.
- HIV data. Location of areas hardest hit by HIV? And solutions.
- I have no suggestions presently.
- Information that is taught by public schools as well as private education schools. Also need to explore HIV/AIDS knowledge required by cyber schools and home schooled young people, as they are becoming more practiced in PA.
- Insight on how to reach youth.
- More evaluation of interventions.
- More info on the consensus statement.
- Specific information always about risks, demographics, culture, ethnicities/race, what is working and what is not.
- The prevention needs perceived by young adults.
- Update information also such as effectiveness, where are they being held (city). What is the outcome of the meeting? How do they measure the effectiveness?
- What has been done to reach extremely rural areas for youth in those areas to provide input to YART?
- What works for youth? How would we best reach youth?

Improve Executive Committee participation at Planning Committee meetings:

- Encourage all in attendance to vocalize their experiences and suggestions to CPG. (note: representative spokespersons do an excellent job and obviously devote much time to the YART).
- Great job being accomplished.
- If allowed please attend more committee meetings. More input from YART is greatly appreciated!
- No suggestions at this time. I am not completely clear on the process yet.
- Personal, I haven't seen too much participation. In the large group--? Maybe in smaller groups I haven't attended.
- They are doing a great job.

Other Comments:

- You are doing a tremendous job and I applaud all that you have done. Continue at your present rate and keep the committee on their toes about what the youth in PA need. Fight for a consistent or out-based education on HIV in all school settings (i.e. every school needs to follow same curriculum regarding HIV regardless of religious beliefs of the school districts.)
- Since Sara YART seems to have become a silent group -- or better said semi-silent.
- No suggestions at this time.
- I am so pleased that we have YART here. Please encourage them to continue to participate and encourage CPG members to mentor YART in their areas.
- How is the planning process coming along. I suggest targeting public schools, being that YART members are young. I present in public school and I see a lot of interested youths that gain knowledge on HIV/AIDS and STDs.
- Expand Roundtables to rural area and reach cyber schools, and home schooled youth. Possibly explore reaching young people social centers throughout PA.

6.6.4. Final Report on Demonstration Projects: Prevention with Positives

Prepared by Scott Arrowood, MSW

PREVENTION WITH POSITIVES INITIATIVE
LESSONS LEARNED

Introduction:

In 2001, both the Pennsylvania Department of Health and the Centers for Disease Control and Prevention (CDC) publicly addressed the need for targeting HIV positive people with effective prevention interventions. The Department, in collaboration with the Pennsylvania HIV Community Planning Committee, identified necessary research to understand and create demonstration projects. The purpose of the projects was to understand barriers and facilitators to implementing these interventions.

The need for these interventions has not diminished. The Department and the Planning Committee are calling for the institution of effective HIV prevention interventions in every medical clinic and in every AIDS agencies providing services to this population. This report provides valuable information that will help clinics

and agencies design or modify their programs. The Department also provides capacity building consultation to agencies as they institute these interventions.

Summary:

As we close in on three decades of the HIV/AIDS epidemic, it is evident that the disease remains both persistent and dynamic in nature from when it first emerged. As of 2008, all 50 states, the District of Columbia, and five US dependent areas are now reporting HIV cases to the CDC. While data from all regions are pending, the CDC estimates that approximately 1.1 million persons are living with HIV in the United States. Transmission rate has declined significantly over time, but as of 2006 is estimated at five transmissions per 100 persons living with HIV. Previous research has shown that the majority of people who know they are infected take steps to prevent transmission to their partners. However, one in five persons living with HIV is estimated to be unaware of their status, and therefore, may be unknowingly transmitting HIV to their partners. This data underscores the importance of both reaching all infected persons either through their health care providers or by targeted counseling and testing to recruit persons unaware of their HIV status.

Upon examining the HIV/AIDS profile in the state of Pennsylvania, the CDC ranks the state as the 6th highest among the 50 states in cumulative reported AIDS cases. Although HIV data from confidential names reporting is still pending, Pennsylvania reports an estimated total of 19,236 persons living with AIDS and a total cumulative incidence of 35,489 of AIDS cases for the period of 1980 to December 2007. Reflective of the national trends, African Americans represented the most affected ethnic group and MSM the largest transmission risk group among cumulative cases. The number of persons living with AIDS has increased, further underscoring the need for prevention with positives.

As the nature of the epidemic has transformed over the years both nationally and regionally, public health efforts have strived to produce innovative, tailored, and culturally competent strategies that effectively address the various challenges and trends. Prevention has been an integral factor in this equation and has recently shifted its gears and entered an era of risk reduction among the HIV positive population. Historically, the introduction of HAART in the mid 90's allowed HIV and AIDS infected individuals to live longer and lead healthy lifestyles. With a diagnosis of HIV and the newly available treatment, many people stop engaging in risky sexual behavior. A significant proportion of people do not reduce risk behaviors while many others initially engaged in safe sex practices but reverted to risky behavior later on in life. It is now apparent that continued HIV transmission is due in part to risky behavior of individuals with known HIV status. Prevention strategies in the first half of the epidemic targeted high-risk HIV negative persons, but now they must also target those with known HIV infection.

The Pennsylvania Department of Health recognized this need early and initiated a needs assessment in collaboration with the Pennsylvania Prevention Project of the Graduate School of Public at the University of Pittsburgh. Shortly thereafter, the CDC mandated that states assign top priority for prevention with positives. There were no tested interventions for the target population; however, the CDC recommended Prevention Case Management. In addition, the it released recommendations for the integration of prevention into the health care for HIV positive persons: "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV" *Morbidity and Mortality Weekly Report/Recommendations and Reports*, (July 18, 2003; Vol. 52; No.RR-12).

In order to assist HIV clinics and other providers with the development of HIV programs, the Pennsylvania Department of Health continue its initiative to gather data about HIV+ adults in care and then decided to fund

demonstration projects. The ultimate goal would be to use data gathered from these projects to provide guidance to other Pennsylvania HIV providers.

Needs Assessment:

In preparation for the demonstration projects, the Pennsylvania Prevention Project conducted a literature review, a statewide series of focus groups, and two self-administered questionnaires of consumers and providers. A growing body of literature suggests that at any given time most patients will act to reduce their risk; however, behavior changes are often not maintained and a significant number of HIV-positive individuals engage in high-risk behaviors.

The literature review of 139 articles published from 1995 to 2009 revealed that 20 to 40% of HIV-positive patients report engaging in behaviors that put others at risk for HIV infection. In addition, sexually transmitted infections are still common among people who are HIV-positive. Various factors associated with high-risk behavior include:

- Perceived effect of recent treatment advances on transmission risk
- Having a sense of physical well-being
- Challenges of maintaining consistent safer sex with a monogamous or primary partner
- More frequent use of alcohol and illegal drugs, particularly prior to sex.
- Having a poor relationship with physician
- Lack of disclosure of status, particularly with casual partners
- Prevention burnout

Next was a series of focus groups and surveys of both health care providers and HIV+ adults in care. The focus groups totaled eight and were comprised of three MSM, three women, and two male IDU. The first questionnaire was self-administered with 78 HIV care-providers attending a state-wide conference on secondary prevention. Among the providers were social workers, nurse practitioners, physician assistants, case managers, administrators and physicians. The final questionnaire was conducted with 203 HIV+ adults in care.

Major conclusions of the focus groups and survey questionnaires:

- Both Providers and consumers say that most participants act to protect themselves and others; however, significant high-risk behavior exists among HIV+ individuals-in-care.
- Both providers and consumers say HIV+ patients are not getting sufficient prevention and education from providers and health clinics.
- Providers say additional training and resources are needed in medical clinics to provide prevention services.
- Providers say more research is needed on successful interventions with HIV+ individuals.
- Consumers say physicians need to be more involved in prevention.

HIV prevention needs to be supported for all patients throughout their span of treatment. Literature also suggests that prevention messages and referrals are particularly effective when provided by the patient's primary medical-care provider. Acknowledging this need, preparations were made for demonstration projects to explore the incorporation of risk assessment and reduction into the medical care of persons living with HIV.

The Initiative:

Under the guidance of the Pennsylvania Department of Health and the Pennsylvania HIV Prevention Planning Committee, the University of Pittsburgh put out an RFP to fund an HIV provider to integrate prevention into the care of their patients/clients.

The submitted proposals needed to demonstrate how prevention may be integrated into their institution for all HIV+ patients/clients and ultimately to reduce risk behaviors. Minimally, the submissions needed to propose the following:

1. Incorporate recommendations from the *Morbidity and Mortality Weekly Report/Recommendations and Reports* entitled, "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV" (July 18, 2003; Vol. 52; No.RR-12).

2. Implement Prevention Case Management for patients or clients in need of intensive support. The CDC approved intervention is now known as Comprehensive Risk Counseling Services (CRCS).

Seven proposals were received and evaluated. Volunteers from the PA HIV Prevention Community Planning Committee were recruited to review and evaluate the proposals based on the following criteria:

- Demonstrated history of work with the target population in their community
- Institutional support and capacity to implement the program goals
- Capacity to provide routine risk assessment with every patient/client
- Provision of appropriate behavioral intervention at the clinical encounter
- Assessment of the need for more intensive support for the patient/client, including CRCS.
- Provision of referral for additional services, such as Partner Notification, Mental Health, or Substance Abuse.

After proposal review, the volunteers selected the top three for submission to the PA Department of Health. The Department funded two of the proposals:

1. Site A is a Ryan White Part C clinic (at the time, know as Title III) based in an urban area. At the time of initial funding, they had 209 predominantly white and African American male patients. A majority was MSM and 40% shared a history of substance abuse. Staff was a multidisciplinary team comprised of a Nurse Practitioner, Infectious Disease Physician, Registered Nurse, two Social Workers, Nutritionist, and a Peer Patient Advocate. The clinic also had a community advisory board comprised of patient volunteers. Patients received primary and HIV care based on a multidiscipline case consultation held prior to the appointment.

2. Site B is based in a multi-use clinic that is part of a regional network of healthcare facilities serving a small city and suburban area. At the time of initial funding, they had 70 patients that were predominantly city residents, heterosexually identified, and Latino. Staff was comprised of an Infectious Disease Physician, Medical Residents, and Social Worker. A dietician and dentist were also based in the multi-use facility for free care to all patients of the HIV clinic. The clinic also had a community advisory board comprised of patient volunteers.

Upon startup of each program, a prevention specialist was hired and completed training for CRCS (known at the time as Prevention Case Management) with the Denver Prevention Training Center. Each site adapted the

assessment and prevention tools for their needs. Education and prevention materials employed include condoms for free distribution, educational brochures, and posters supporting prevention.

In the first year of implementation, three meetings were conducted to adapt materials, assess institutional and program challenges, determine necessary program changes, and agree upon data reporting expectations. Meetings were conducted at the University of Pittsburgh and attended by project liaisons and prevention specialists from both sites. All-staff meetings were continued annually in the second and third years of implementation. In consultation with both sites, PPP developed an evaluation and data reporting form to be completed by each prevention specialist and project liaison on a biannual basis. Reporting continued throughout the three-year implementation. Finally, PPP conducted annual site visits in the second and third years for quality assurance and additional data gathering. Site-visit activities included record review, interviews with project liaison and prevention specialist, following a patient volunteer through clinical and prevention services, and additional interviews with the nurse practitioner, social worker, and other clinic staff.

Results:

Results were generated using both quantifiable and qualitative data. Both sites submitted 6 month reports documenting the patients served, their risk behaviors, and the delivered services. They also scored patients on their scale of risk for both the first and last clinical encounter during the reporting period. Qualitative data was gathered at three conferences bringing together staff from both sites, through follow-up phone interviews, and by conducting on-site visits to interview additional staff and observe a volunteer patient during their clinical encounter.

A Two Year Summary of Quantifiable Data

Total number of clinic patients: 599

Patient Population Descriptors:

- 73% Male 27% Female
- 59% Caucasian 39% African American
- 17% Hispanic/Latino
- 9% Speak only Spanish
- 55% Gay/Bisexual 45% Heterosexual
- 73% Fall in the age range 35-55 years

Self Reported Risk Behaviors

- 12% UVI and/or UAI
- 16% Injection drug use
- 2% Sharing needles
- 22% Alcohol abuse and illegal drug use
- 8% STI diagnosis after first visit

Total # of patients screened for services: 342 (57%)

Services Delivered by Prevention Specialist:

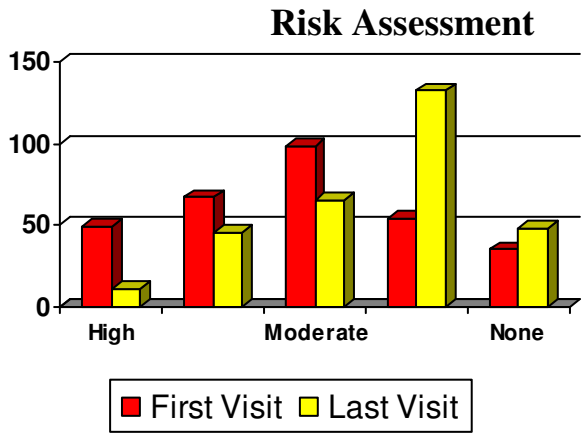
- 97% Prevention Education and/or Risk Reduction Counseling
- 12% Comprehensive Risk Reduction Counseling Services (CRCS)

5-9 Sessions per patient
15-20 Minutes per session
25 Patients in group intervention (Site A)

Prevention services from other staff (n=599):
100% Brief prevention education message from clinician
5-6 clinical encounters per patient
70% from social worker and/or peer

Minutes per clinical encounter:
Site A: 30-40 minutes (HIV and primary care)
Site B: 15 minutes (HIV care only)

Both sites agreed upon a scoring system to assign risk at each visit. Scores are based on reported risk behaviors and factors such as unprotected intercourse, sharing drug needles, alcohol and recreational drug use, homelessness, and mental health issues. For example, unprotected intercourse or multiple factors would categorize a patient as high risk. The chart below represents the aggregate scores of the first and last visits for each patient during the two year period. The columns represent the number of patients.



The yellow columns yield an overall lower risk while the red columns yield overall higher risk scores. While not scientifically conclusive, this comparison between the first and last visits suggests that aggregate patient risk has reduced over time.

B. The Impact of Environmental Change

Both sites were located in major medical centers and were challenged to implement changes in a large institution:

1. Staff turnover: Both sites experienced turnover in the prevention specialist position.
2. Staff time: Both sites had to prioritize the prevention specialist's time. Unlike clinicians, the specialist does not have coverage and could not see every patient. About one half of the patient load was screened, thus emphasizing the need for clinicians and other service providers to address prevention.
3. Patient load: One site doubled its patient load over a two year period without a proportionate increase in staff resources.

4. Space and location: Both sites were challenged in different ways including inadequate private and confidential meeting space, off-site location of personnel offices, and sharing space in a multi-use clinic.
5. Provision of care: In the first year, one site provided only HIV specialist care which greatly limited the time allowed for the prevention specialist to meet with patients. During the course of the project, the site was awarded Ryan White Part C and began providing primary care thus affording more time with both clinician and prevention specialist during the clinical encounter. More clinical time also allowed for multi-disciplinary case consultation prior to each patient visit. The shared use of clinic space required primary care appointments to be held on different dates. This institutional factor negatively affected adherence to appointments, integration of the HIV specialist with multi-disciplinary team, and furthered the challenge for the prevention specialist to engage patients. Also during this time, the site merged with a local AIDS service organization (ASO). The ASO shared the same clients and afforded the specialist more time with patients outside of their clinic appointment.

Lessons Learned:

1. Patient self-reported risk can be reduced.

- Risk reduction: Patients face a variety of psychosocial and economic stressors that affect their risk-taking behavior. Many have real or perceived barriers to eliminating risk entirely. Therefore, clinical staff should encourage patients to explore realistic and achievable goals to reduce their risk.
- A qualified and trained staff person dedicated to prevention is necessary. The prevention specialist not only spends dedicated time with patients, but also provides patient information, case consultation and a reminder to other staff where and what prevention messages may be appropriate for any given patient. The prevention specialist must be warm, non-judgmental, and empathetic. They should be skilled in developing trust with patients, knowledgeable of behavioral change theories, comfortable in addressing sexual and drug use behavior, trained in risk-reduction counseling, and competent in working with marginalized populations.
- Physician and other clinician support: The prevention specialist should remain an integral part of patient services and be supported by the clinician. The demonstration project, along with the literature, suggests that patients are more responsive to prevention with physician engagement. Given time constraints, engagement may comprise a brief message, inclusion of the prevention specialist during the patient encounter, and encouraging the patient to participate with the specialist.
- Providers should implement cross-training of risk reduction counseling for other staff, including social workers and patient advocates. Repeated assessment of risk and delivery of prevention messages in a variety of patient interactions may increase the likelihood of adopting healthy behaviors.
- Multidisciplinary case consultation: Clinical staff should consult in preparation for each patient visit. Including the Prevention Specialist in consultation ensures that prevention planning is addressed and supported in clinical encounter with clinicians, social workers, peer advocates, and other health related professionals.
- Institutional support: The clinic needs to implement policy and protocols to integrate prevention into all aspects of care. Resources need to be appropriated to hire and train qualified prevention staff. The prevention specialist requires appropriate space and allocated time with patients.
- Peer advocates employed on staff: Patients have been found to casually give information to the peer that they do not share with professionals. For example, the patient may divulge risk behavior to the advocate that they had previously denied to the physician. Peers can serve a vital interest in providing for prevention planning.

- Spanish speaking professionals: Clinicians may also be trained in medical translation, where appropriate. Culturally appropriate staff is preferred.
- Record keeping: Records should be maintained for each risk assessment, prevention intervention and delivered message. Record keeping is also necessary for evaluation, quality assurance, and improvement. Electronic record keeping is preferred as is maintaining a separate patient file for keeping risk assessments, prevention intervention, and other case management services.
- Community Advisory Board: A board is comprised of patient volunteers should be used to review policy, protocol, and materials for prevention. Feedback from the board should be incorporated into the plan for integrating prevention with patient services.

2. Patient implications for prevention planning.

- Complex psychosocial and economic needs: Patients with histories of mental health, substance abuse, and financial issues have the greatest prevention needs. They are also more likely to have other case management services and to resist participation in prevention planning. As noted above, risk reduction requires warm empathetic encouragement and the setting of realistic and achievable goals. The prevention specialist and clinical staff should also be knowledgeable about community resources and be able to make appropriate referral.
- Transient patient populations: Migrant workers, homeless, or immigrant patients may be inconsistent with appointments, thereby limiting follow-up and multiple prevention opportunities over time. Workers will need to make every effort to encourage patients to keep appointments, including automated and personal follow up through mail and phone contacts. Home or alternate site visits should be considered when needed.
- Risk behavior stigma: Patients may not self-report accurately due to a perceived fear of being branded as "bad" and being assigned to a new provider. Cultural competency and appropriate staff training is necessary. Any clinical staff can address risk behavior and as such, a patient may confide in someone other than the prevention specialist. Providing a warm, nonjudgmental, and empathetic environment can help reduce stigma. **Communication, case consultation, and record-keeping are recommended to address potentially inaccurate patient reports. A Peer Patient Advocate can also provide feedback and reach out to patients in an effort to minimize stigma.**
- Relationship building: The prevention specialist and clinicians must allow for relationship building over time in order to foster more openness. They must join with patients to honestly explore risk reduction.

Limitations:

1. The initiatives did not target HIV positive individuals who were unaware of their status. Appropriate outreach and referral to counseling and testing remains an imperative.
2. Comprehensive Risk Counseling Services: CRCS is time intensive, dependent of patient willingness, and as such, has very limited application in the clinical setting. Project staff were unable to implement the intervention as developed and were forced to adapt CRCS materials and protocols to the setting. The primary limitation is the time demands placed on both the patient and the clinical encounter. Many patients, particularly those in the most need, often receive other case management services for basic needs and are unwilling to participate in CRCS. Fieldwork is impractical for the prevention staff as they are needed during clinical hours. Frequent and multiple office visits for patients are also impractical, particularly for clinics placed in large institutional settings that serve a large geographic area. Finally, multiple professionals may compete for limited patient time, resulting in a clinical encounter that can become overextended.

3. Brief interventions: Although more intensive services may be needed, brief interventions are most practical for the clinical encounter and most preferred by patients. **Risk assessment, prevention planning, and message delivery are best integrated into existing clinical and case management encounters.**
4. Time limitations for the prevention specialist: Only one half of the patient load was successfully screened for services. Unlike clinicians, the prevention specialist does not have coverage for leave on vacation, sickness or training. Clinical assessment is necessary to ensure appropriate referral of the neediest patients to the prevention specialist.
5. Capturing all prevention services provided: While the prevention specialist maintained appropriate records, it is unknown if all risk assessment and prevention was documented by other professionals. It is possible that all prevention interventions have not been captured on record. In addition, the peer advocate did not have access to the records; therefore, staff communication and documentation with the peer is very important.
6. Evidence based brief interventions are needed for HIV positive patients in the clinical setting. Interventions should be time-appropriate for the physician, other clinicians, and the prevention staff.
7. Need for additional resources: Resources, including staff time and training, are needed for appropriate application of recently developed programs from the CDC's Diffusion of Evidence Based Intervention project (DEBI).

Lessons Not Learned:

What was not learned from the demonstration projects may also be helpful:

1. Effectiveness in reducing risk behavior: The primary purpose was to demonstrate integration of prevention into patient care. Although data is suggestive of a decrease in patient-reported risk, actual effectiveness has not been established. Implementing and evaluating DEBIs is the best avenue for demonstrating that risk behavior has been reduced. The projects were not able to implement DEBIs, and therefore, cannot address the efficacy of their application in the clinic setting. It should be noted that DEBIs for HIV+ individuals have been made available only recently. HIV care providers need to allocate resources toward implementing DEBIs in their setting.
2. The model of the brief intervention provided: The prevention specialist and clinician provided brief intervention to patients who were not appropriate for CRCS, either by lack of need or their unwillingness to participate in an intensive case management intervention. The projects were not evaluated for the exact nature of the brief intervention, such as how risk may have been assessed in a short period and what prevention messages were delivered. As already noted above, evidence based interventions need to be implemented for a clinic setting.
3. Relationship between staff and patient characteristics: The projects did not explore any potential relationship between staff characteristics and patient characteristics that may affect delivery of prevention services. Such characteristics may include gender, race, sexual orientation, cultural background, and HIV status. It should be noted that one project hired a HIV+ peer as their prevention specialist and believed the choice has been advantageous.

Recommendations to HIV Care Organizations:

Integration of prevention into care may vary depending on the setting; however, the lessons learned from the demonstration projects yield the following recommendations.

1. Assess HIV positive patients or clients for risk as often as possible, but minimally on an annual basis.
2. Hire or contract a qualified prevention specialist who is or may be trained in risk reduction counseling and appropriate evidence based interventions.
3. Integrate risk assessment, prevention planning, and message delivery into existing clinical and case management encounters. Such encounters may occur with social workers, clinicians, counselors, peer advocates, therapists etc.
4. Adopt a risk-reduction model that helps clients to explore realistic and achievable goals.
5. Clinicians, such as physicians, nurse practitioners, or physician assistants should deliver time appropriate risk assessments and prevention messages. They should also make referral and follow up with prevention specialist or social worker to address prevention needs where more time is allowed.
6. Implement protocols to integrate prevention into all aspects of care and service to the HIV positive individual.
7. Where the client or patient has multiple professional encounters, implement multidisciplinary case consultation in preparation for service or treatment.
8. Train and utilize peer volunteers or employees to support prevention efforts where appropriate.
9. Record risk assessment and prevention planning in client/patient file
10. Maintain a Community Advisory Board, including HIV positive members, to review policies and protocols for integrating prevention into care and services.
11. Individuals with histories of mental health, substance abuse, and financial issues often have the greatest prevention needs. Organizations should prioritize prevention planning with such individuals.
12. Address inconsistent participation of transient populations, such migrant workers, immigrants, and the homeless. Offer home or alternate site visits and provide appointment reminders through mail and personal phone contact.
13. Provide warm, nonjudgmental and empathetic environment to help reduce stigma of risk behaviors.
14. Allow time for and engage in relationship building to foster more openness between professional and client/patient.
15. Address potential inaccuracy of patient/client reports through multidisciplinary case consultation, record-keeping, relationship building, peer support, and any measures to increase communication and reduce stigma.
16. Explore and implement evidence-based interventions for intensive case management, brief individual encounters, and groups.
17. Target high risk populations where HIV status may be unknown. Provide or refer to counseling and testing.

For more information on new and available evidence-based interventions targeting HIV positive individuals:

http://www.effectiveinterventions.org/

http://www.cdc.gov/hiv/topics/research/prs/evidence-based-interventions.htm

The University of Pittsburgh and the Pennsylvania Department of Health would like to acknowledge the dedication and invaluable contribution of the project staff from both sites.

6.7 Evaluation Subcommittee Recommendations:

- Continue to conduct evaluations as outlined in paragraph two of the introduction to this evaluation section of the plan.

- Continue to utilize the evaluation data collected to inform the activities of the CPG needs assessment and intervention committees as well as the activities of the CPG and its committees and work groups.
- Although considerable progress has been made in the education and delivery of DEBI intervention, continued monitoring by the CPG is warranted.

7. CONCLUSIONS AND RECOMMENDATIONS

7.1. Subcommittee and Workgroups

Epidemiology

Conclusions: The Epidemiology Subcommittee is structured to review the Integrated Epidemiologic Profile of HIV/AIDS in Pennsylvania by means of the roundtable review process that provides a focused picture of the epidemic in Pennsylvania and linkages between Epidemiology and other subcommittees work by means of the Roundtable process. The Epidemiology Subcommittee has an existing mechanism to handle data request from other committee members in addressing the overall goals of the Commonwealth's prevention plan.

Recommendations: The Epidemiology Subcommittee will maintain updates to the Integrated Epidemiologic Profile with the ultimate goals of providing accurate and timely data about HIV incidence and prevalence in Pennsylvania. The subcommittee will continue to solicit data needs from the entire CPG. In addition, they will use the Epidemiologic Profile to prioritize HIV positive populations at risk of spreading the virus and those who are at high risk of acquiring HIV infection throughout the jurisdiction.

Evaluation

Conclusions: There are two major annual endeavors for the Evaluation Subcommittee 1) CPG process monitoring and 2) poster presentations. The Poster Presentations elicit dialogue and networking between the CPG and HIV prevention funded agencies, as well as elicit information for program evaluation. The poster sessions reveal the activities performed; the use and challenges of using the HIV Prevention Plan/Updates; difficulties with implementation, and barriers and needs for staff training. The Process Evaluation evaluates the CPG planning process using external facilitators to increase the objectivity. The strengths and weaknesses of the planning process are identified and recommendations are made for improvement.

Recommendations: The Poster Presentations process needs to be continued, as well as more support needs to be provided to agencies **prior** to implementing the EBIs. Based on the Process Evaluation, we propose that 1) The rules of respectful engagement be reinforced; 2) The role of the University of Pittsburgh be clarified and enhanced; 3) Diversity of membership be increased

Interventions

Conclusions: As the Interventions Subcommittee (IS) recommends a comprehensive approach to HIV prevention, we are therefore troubled by the reduction in funding towards HE/RR services. However, it is wholly recognized that in order to maintain core HIV prevention services (i.e. CTR, PS) the Department had to reduce funding to HE/RR services. That said, the IS recognizes the need to accomplish more services with less prevention funds allocated. Therefore, the IS would like to highlight the opportunity that targeting prevention services to injection-drug users offers, that is, HIV and viral hepatitis C initiatives can be achieved simultaneously. Further integration opportunities for the HIV program would be to align with the Syphilis Elimination Project (SEP) to conduct HIV CTR and the SAMSA (Substance Abuse and Mental Health Services Administration) "HIV Early Intervention" grant, which provides HIV education and CTR funds to select PA counties.

The Intervention Subcommittee continues to focus on increasing provider awareness of the need to effectively select and implement evidenced-based interventions. As the Pennsylvania Department of Health gains more

insight into the nuances involved with implementing evidenced-based interventions, the Intervention Subcommittee continues to emphasize the importance of providers' understanding of the *systematic process* of selecting EBIs. We also emphasize that the effective implementation of any intervention depends on the capacity of the agency implementing the intervention.

The Interventions Subcommittee would like to recognize the Pennsylvania Board of Pharmacy's efforts in expanding syringe access in PA. Pharmacists can now sell up to 30 hypodermic needles and syringes per person 18 years of age or older without a prescription. This expanded syringe access serves as a means to reducing the transmission of blood borne pathogens, including HIV and viral hepatitis. Also regarding syringe access, the Intervention Subcommittee approves of the Consolidated Appropriations Act, 2010, which modified the ban on the use of federal funds for needle exchange programs. This action allows CDC and its partners to more fully implement a comprehensive, evidence-based approach for reducing HIV infection among injecting drug users, who account for approximately 16% of new HIV infections. However, Pennsylvania's Controlled Substance, Drug, Device and Cosmetic Act ("Paraphernalia Law") remains a barrier to our use of federal funds for syringe service programs in PA.

Interventions Subcommittee recognizes that sigma still acts as a barrier to MSM accessing HIV interventions and services; therefore, we see the importance of internet interventions in bridging that gap. Also, given that PA is a predominately rural state we recognize the usefulness of internet interventions in facilitating access to populations in those rural areas. Finally, through the integrated roundtable process IS identified that the following populations have very few or no evidenced-based interventions: transgendered, heterosexual males, and heterosexual male injection-drug users.

Recommendations:

The Intervention Subcommittee recognizes the effectiveness of syringe-exchanges as an HIV and hepatitis C prevention tool. That said, we recommend that the department explore ways to implement effective syringe programs in accordance with existing PA laws, i.e. the *Paraphernalia Law*.

Intervention Subcommittee (IS) recognizes the Department's efforts in providing support and technical assistance for providers across coalitions, specifically the capacity building meeting where prevention program priorities are conveyed. IS recommends the development of an online messaging board, possibly through www.stopHIV.com, for providers to discuss challenges and successes in real time.

The Intervention Subcommittee recommends that the Department allocate resources to directly monitor the implementation of evidenced-based interventions with fidelity.

The Intervention Subcommittee recognizes and encourages the Department's continued commitment to adaptation as well as the development of novel interventions to address those target populations that are not currently covered by the DEBI Project.

- As HIV-infected persons are the highest priority population for prevention services, the IS recognizes the need for interventions that target the sex partners of known HIV-infected persons.
- Also, we recommend that interventions addressing (1) the individual needs of sex partners as well as (2) the needs of sero-discordant couples be identified.

After reviewing the compendium for interventions that address HIV and Hepatitis C viral infections, the IS encourages providers when appropriate to select interventions that address both infections.

The Intervention Subcommittee recommends that the Department investigate the feasibility of implementing Non-occupational Post-exposure Prophylaxis (nPEP) in Pennsylvania.

Needs Assessment

Conclusions: Based upon the Epidemiologic profile and the prioritized target population and in consultation with the Department of Health, the CPG has identified the target populations to be assessed and the types of needs assessments to be implemented, which are to be carried out by University of Pittsburgh staff. The 2009-2010 needs assessments included focus groups on services provided to HIV positive men and women, MSM internet study, and the mental health and substance abuse treatment provider studies.

Future needs assessments include the continuation of the mental health and substance abuse treatment provider study and additional MSM focus groups.

Recommendations: Since reprioritization is still in progress, we will focus on the unmet needs collaboration with the Integrated Planning Council and Ryan White funded coalitions to provide ongoing assessment of the prevention needs of HIV positive individuals. Future needs assessments will include a follow-up to focus groups conducted 10 years ago that focused on MSM, IDU, and heterosexual risk categories. Based on recent epidemiological data we recommend a focus within these specific groups: racial/ethnic heterosexual minority women, sex workers, white women IDU, and MSM-IDU.

Rural Work Group

Conclusions:
It is the role of the Rural Work Group to continue to advocate for rural HIV prevention efforts and to examine the social and cultural issues that make each of the rural counties and the seven HIV coalition areas unique. The challenge is accessing at-risk subgroups and providing meaningful HIV prevention interventions tailored specifically for these groups. A major concern is that programming for designated priority populations is based upon racial/ethnic categories that do not exist in many of Pennsylvania's rural counties. A further concern is the issue of stigma as a barrier to AIDS prevention programming. In the data presented from the Rural Men's Study, the effect of stigma on sexual risk taking behavior is clear – more intolerance leads to higher risk taking. Furthermore, the data collected from all of the poster presentations indicate that stigma in rural communities is a major barrier to prevention programming.

The Rural Work Group continues to encourage the CPG and the Pennsylvania state health department to meet the Core Public Health functions of assessing the health needs of HIV+ residents in our communities and implement policies which increase resources to address these needs while informing and educating the public about HIV disease and infection. (National Advisory Committee on Rural Health, February, 2000)

Identification of HIV issues specific to rural areas is just beginning. This workshop is the first major effort within the Department of Health and Human Services to address HIV/AIDS in rural areas. Providing care for the HIV infected people in rural areas will present a major challenge to rural health care systems. Before the coming of the AIDS epidemic, rural health care in some areas of the United States was already in crisis, with many areas unable to meet the health care needs of the local populations. The problems of rural health care systems include shortages of health care professionals, financially fragile hospitals, gaps in public and private health insurance which leave many rural residents without the ability to pay for necessary care, lack of ready access to specialty care, and lack of care coordination services. The spread of AIDS to rural areas places even greater pressure on already stressed health care systems. The challenge is how to provide AIDS services in communities which are already deficient in health care services, and have limited financial resource to develop new services. Workshop participants are unanimous in their conviction that mastering this challenge will

require the collaboration of Federal, state and local governments, public and private providers of health care and social services, and community organizations.

Preventing the spread of HIV in rural areas is another major challenge which will require new strategies and programs. The models of HIV prevention which have proved effective in urban areas – street outreach programs for IV-drug users and community-wide programs targeting the gay community – are simply not appropriate for rural areas. Workshop participants enunciated a series of principles and assumptions which underlie the recommendations developed by this workshop:

- The human factor. The human experience of those living with AIDS and HIV should frame any discussion that addresses HIV.
- Denial. In many rural communities, there is denial that HIV disease is a problem that must be addressed.
- Barrier to care. Individuals in rural areas with HIV/AIDS confront a series of obstacles to receiving adequate care.
- Need for coordination of existing services. Coordination of medical and social services is lacking in many rural areas, for people with AIDS and the many others needing this service.
- Integration of prevention and treatment. HIV prevention and HIV care activities must be explicitly integrated in rural area.
- Diversity of rural populations. Policies to fill the gaps in rural HIV/AIDS prevention and care must be sensitive not only to urban/rural differences, but also to the diversity of rural areas and the differences among special populations within those areas.
- Need for public health leadership. Effective coordination of public and private HIV activities in rural areas is the responsibility of state and local public health sectors.

Recommendations**:**

- Identify the priority groups at risk for HIV that is location-based
- Identify Best Practices – programs that have been successful with rural populations, e.g. monitoring the DEBI programs that can be best adapted for use with rural populations
- Advocate for continued retention and training of HIV providers.
- Identify the methods by which rural populations adopt prevention behaviors (adoption/diffusion theory).
- Assist rural providers in developing community networks to help reach difficult populations.
- Identify ways in which stigma in rural communities can be reduced
- Address DEBI intervention adaptations to facilitate their use and application for rural providers

7.2 Department of Health, Division of HIV/AIDS (Department) response to the Pennsylvania Community HIV Prevention Plan Update (Plan) for 2011

The Department conducts a process for demonstrating to the Community Planning Group (CPG) that there is a correspondence between the Plan and the Centers for Disease Control and Prevention (CDC) application for future funding and that services funded by the CDC grant and state HIV prevention funds, correspond to the Plan. This process includes the following actions:

- The CDC grant application/Interim Progress Report (Grant), including budget, is provided to all members of the CPG.

- The Department provides a presentation to the CPG on the Grant, wherein the Department demonstrates the linkages between the Grant and the Plan. An opportunity is provided for questions and discussion.
- The Department provides a presentation to the CPG on the intervention/services that the Department will be funding in the next federal fiscal year with Grant funds and State funds. An opportunity is provided for questions and discussion.
- A concurrence process is conducted wherein each CPG member has the opportunity to cast a written vote on whether the Department's Grant does or does not, and to what degree, agree with the priorities set forth in the Plan.

The Department is committed to HIV Prevention Community Planning and ensuring that HIV prevention resources target priority populations and interventions set forth in the HIV Prevention Plan. The Department has established the following priorities that correspond to the priorities set forth in the Plan:

- The provision of targeted HIV Counseling, Testing & Referral Services (CTRS) and expanding access to CTRS (examples include: modification of the Participating Provider Agreements to encourage increase outreach testing; implementation of Social Network Strategies and targeted CTRS in county/municipal health department contracts; collaboration with STD outreach CTRS activities; and expansion of screening in health-care settings).
- An emphasis on Partner Services (PS) in the public sector and expansion of PS in collaboration with the private sector. Implementation of a PS monitoring and evaluation project and implementation of Internet-based PS.
- Implementation of evidence-based activities/interventions (through state-funded contracts) for prevention for persons diagnosed with HIV and their partners; and for other priority populations identified in the Plan.
- Training for selection and implementation of evidence-based interventions and adaptations of these interventions.

The following examples demonstrate how the Plan priorities (and Department priorities) are reflected in the Grant:

- Grant funding is provided to support HIV CTRS at 5 county and 4 municipal health departments and at all Department supported sexually transmitted disease (STD) providers. State funding supports targeted testing through fee-for-service Participating Providers Agreements (PPAs). Language in the PPAs has been modified to be more testing focused.
- Grant funding will continue to support the Social Networks Strategy for CTRS at the Bethlehem, Bucks, Montgomery and York health departments.
- Grant funding is provided for HIV testing laboratory contracts for serum, oral fluid and rapid testing.
- Grant funding is provided to support 11 HIV Prevention Program Field Staff and county/municipal health department staff to provide PS for all publicly supported CTRS and expand collaborative PS efforts with the private sector. A project is being implemented to determine the PS approaches that are most effective in order to further develop guidelines for collaborating with private clinical providers in providing PS to patients under their care.
- A variety of internet-based health communication/public information activities have been implemented to target MSM and rural MSM. These include: an information-based website focusing

on STDs (including HIV) – m4mhealthysex.org; health alerts; a chat room health educator; and, an evidence-based internet intervention.
- State HIV prevention funds are provided to the seven HIV Planning Coalitions to implement evidence-based interventions for individuals with HIV/AIDS and other priority populations identified in the Plan.

In addition, the following actions demonstrate the Department's support of community planning and efforts to address recommendations identified by CPG Subcommittees, in the Plan:

- Adequate Grant funds are provided to support the CPG meeting site, CPG members' travel, lodging and subsistence expenses, the development of the Community Services Assessment, and to support meeting facilitation and the planning process.
- Funds have been budgeted for additional epidemiologic support for Community Planning through a contract with Pennsylvania State University.

Epidemiology Subcommittee:
- The Department has implemented a data driven, competitive resource allocation process for the funding of the county/municipal health departments that incorporates an HIV epidemiologic resource allocation model.
- The Department, in collaboration with the CPG, has commissioned a reprioritization process of the target populations that has been completed and has been introduced into the 2011 Plan. This will be fully integrated throughout the 2012 Plan during the next planning year.
- The Department has provided presentations on services funded for target populations, as part of the Integrated Roundtable review.

Evaluation:
- The Department has supported evaluations of the CPG planning process (CPG Survey Part II and focus groups/process evaluation).
- The Department has supported prevention contractor poster presentations.
- The Department has supported process monitoring data collection of funded interventions (PaUDS and PEMS).
- The Department has provided the CPG with presentations of process monitoring data for all funded interventions/activities.
- The Department is funding the development of a Resource Registry for HIV prevention and care providers to assist in the evaluation of unmet needs.

Interventions:
- The Department continues to support training for contractors to implement evidence-based interventions and related trainings (selecting evidence-based interventions, adapting interventions, client recruitment and retention, social networks strategy for CTRS, etc.).
- The Department has made state funding available for contractors to implement evidence-based interventions.
- The Department Department's HIV/AIDS and STD programs have collaborated on the development of a web-based electronic PS system.
- The Department's HIV/AIDS and STD programs are collaborating on the provision of outreach CTRS and internet-based services targeting MSM.

- Pennsylvania State University, Hershey Medical Center, in collaboration with the Department, continued to expand routine HIV in clinical sites (emergency departments, correctional facilities, health centers). An application for continuation funding has been submitted to the CDC.
- The Department has created and budgeted funds in the 2011 CDC grant for one additional staff position within the Prevention Section to monitor contractors' to ensure that funded evidence-based interventions are implemented with fidelity.

Needs Assessment Subcommittee:

- The Department's HIV Prevention and Care Sections, in collaboration with the CPG, have commissioned a needs assessment project among individuals with HIV/AIDS to identify unmet needs for HIV-related primary medical care and HIV prevention. This project includes collaborative efforts in all areas of the CPG Community Services Assessment (needs assessment, resource inventory and gap analysis).
- The Department developed a strategic plan to enhance HIV prevention services for MSM.
- The Department continues to fund the University of Pittsburgh to conduct needs assessments of target populations, as directed by the Interventions Subcommittee.

Rural Work Group:

- The Department will work with the Rural Work Group, the Interventions subcommittee, the CDC and other national partners to identify and disseminate information on evidence based interventions and adaptations of evidence-based intervention that are appropriate for priority populations in rural communities. The Department will work to obtain capacity building assistance to train contractors in these interventions.
- The Department is providing funding to the University of Pittsburgh to implement internet activities targeting rural MSM.

GLOSSARY OF KEY TERMS

Asian Pacific Islanders (API)
"Asian" refers to those having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan and the Philippine Islands. "Pacific Islander" refers to those having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

AIDS Service Organization (ASO)
Local community-based non-profit organizations providing HIV/AIDS care and prevention

CARE Act Data Reports (CADR)
Monthly data reports on HIV care provided for persons living with AIDS.

Centers for Disease Control & Prevention (CDC)
An agency of the Unites States Department of Health and Human Services (HHS) based east of Atlanta, GA. It works to protect public health and the safety of people by providing information to enhance health decisions and promotes health through partnerships with state health departments and other organizations. The CDC is the primary funding and informational source for HIV prevention in the United States.

Community Level Intervention
These are HIV prevention interventions with community-wide impact such as school-based programs, social influence models, street and community outreach, social marketing, media interventions and social action and community mobilization. Also known as community directed interventions (CDI).

Community Resource Inventory
This is an inventory of all known HIV prevention resources within the jurisdiction.

Community Services Assessment (CSA)
The HIV prevention community planning process of examining the HIV prevention needs and barriers of specific populations through needs assessment, the HIV prevention resources available and a gap analysis between the needs and resources.

Comprehensive Risk Counseling Services (CRCS)
These are intensive sessions with HIV-positive individuals to reduce their HIV risk-related behaviors.

Decisions For Life (DFL)
This is a group level HIV prevention intervention for sexually active young adults developed by young adults.

Diffusion of Effective Behavioral Interventions (DEBI)
CDC approved interventions of scientifically proven effectiveness for HIV prevention. These interventions are designed to be implemented by community based service providers and state and local health departments.

Evidence-Based Interventions (EBI)
HIV prevention interventions that are based in behavioral and social science theory; these interventions are not part of the CDC's Diffusion of Evidence Based Interventions (DEBI)

Gap Analysis
The analysis of HIV prevention services based upon an examination of the Community Resource Inventory producing a view of what is not available for HIV prevention.

Gap Analysis Grid
A process developed by the Community Planning Group in which target populations and HIV prevention resources in each county in Pennsylvania are examined.

Group Level Intervention (GLI)
HIV prevention directed to small groups and workshops with the goal of creating change in HIV risk-related behaviors. Also known as interventions directed to groups (IDG).

Health Communication/Public Information (HC/PI)
This is HIV prevention interventions such as mass media (print, electronic, broadcast), small media (brochures, flyers), social marketing, hotlines and clearinghouses.

Health District Offices
There are six geographic divisions in the Commonwealth that provide heath department services outside of the ten local county and municipal health departments.

Health Education/Risk Reduction (HERR)
Individual counseling (peer counseling, non-peer counselor, skills training), group counseling (peer mediated, non-peer mediated, skills training), Institution-based programs (school-based programs and work site health programs)

Health Resources and Services Administration (HRSA)
An agency of the Department of Health and Human Services (HHS) that administers and funds the Ryan White HIV/AIDS Care Act for persons living with HIV/AIDS.

Hepatitis C (HCV)
A blood borne sexually transmitted virus that is spread by sharing of syringes and drug works. Approximately 40% of those infected with HIV are co-infected with HCV. Hepatitis disease can become chronic and lead to liver failure and death.

Individual level interventions (ILI)
HIV prevention directed toward individuals one-on-one to create change in HIV risk-related behaviors such as, HIV testing and counseling, partner notification, individualized prevention counseling, couples counseling and telephone hotlines. Also known as interventions directed to individuals (IDI).

Injection drug user (IDU)
A population at higher risk for HIV transmission based upon their syringe, needle and injection drug works sharing.

Integrated Epidemiological Profile
This is the combined epidemiological profile for HIV Prevention and HIV care.

Men who have sex with men (MSM)
A population at higher risk for HIV transmission that is comprised of men who self-identify as gay or bisexual and/or had sexual activity with another man in the past five years.

Needs assessment
This is a formalized process for gathering both qualitative and quantitative HIV prevention needs and barriers through surveys, focus groups and key informant interviews with specific populations.

Pennsylvania HIV Prevention Community Planning Committee
The CDC designated Community Planning Group (CPG)

Pennsylvania Uniform Data Collection System (PaUDS)
The Division of HIV/AIDS services data collection system for HIV prevention and care services completed on a monthly basis by contractors/providers.

Pennsylvania Prevention Project
The Pennsylvania Department of Health, Division of HIV/AIDS funded subcontractor at the University of Pittsburgh Graduate School of Public Health providing needs assessments, evaluations, facilitation, and behavioral health science support to the Community Planning Group (CPG).

Prevention Poster Session
This is a process by which multiple individuals and/or community-based organizations can present information about their HIV prevention work in a group setting.

Prioritized Target Populations
A process for directing limited HIV prevention resources to those populations in which HIV/AIDS epidemiology reveals the greatest incidence as well as emerging HIV-infected populations.

Program Evaluation Monitoring System (PEMS)
This is the CDC data gathering system for HIV prevention services.

Rural Work Group
The members of the CPG who focus their attention on HIV prevention in rural areas to insure representation on the CPG and HIV prevention efforts directed towards rural communities.

Ryan White Coalitions
Seven designated Ryan White HIV/AIDS Regional Planning Coalitions that receive Health Resources and Services Administration funds for HIV care through the Pennsylvania Health Department, and state funds for HIV prevention.

Surveillance Biannual Summary for HIV/AIDS
The Pennsylvania Department of Health, Bureau of Epidemiology diagnosed AIDS statistics for the Commonwealth provided twice a year.

Young Adult Advisory Team (YAAT)
A group of youth and young adults who have developed and assisted in the pilot testing of the Decisions For Life HIV prevention intervention for sexually active young people.

Young Adult Roundtable (YART)
These are groups of youth and young adults directly providing the CPG with their perspective on unmet needs and barriers to HIV prevention. These groups meet five times per year in various locations throughout the Commonwealth.

YART Consensus Statement
A document produced by the Young Adult Roundtable participants on the HIV prevention needs and related barriers for youth and young adults.

YART Process Evaluation
The annual evaluation of the Young Adult Roundtable process facilitated by the various YART groups as well as by the Community Planning Group; this evaluation assesses the group's perceptions of the YART process.

2010 HIV Prevention Community Planning Committee (CPG)

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