PENNSYLVANIA COMPREHENSIVE COMMUNITY HIV PREVENTION PLAN

September 25, 1998

Tom Ridge, Governor
Daniel F. Hoffmann, Secretary of Health

ACKNOWLEDGEMENTS

The Co-Chairs of the Pennsylvania HIV Prevention Community Planning Committee wish to acknowledge the extraordinary support of the Committee members, staff members of the Pennsylvania Department of Health Division of HIV/AIDS, and the team from the University of Pittsburgh Graduate School of Public Health.

The trust, commitment, and hard work of all of the parties involved made the timely issuance of this Comprehensive HIV Prevention Plan possible.

"Our deepest fear is that we are inadequate. Our deepest fear is that we are powerful beyond measure. It is our light, not our darkness, that frightens us. We ask ourselves, 'who am I to be brilliant, gorgeous, talented, and fabulous?'….As we let our light shine, we consciously give other people permission to do the same. As we are liberated from our own fears, our presence automatically liberates other."
--Nelson Mandela

PENNSYLVANIA COMPREHENSIVE COMMUNITY HIV PREVENTION PLAN

APPENDICIES

Young Adult Roundtable Consensus Statement

Relating State-Funded Prevention Activities to the Centers for Disease Control and Prevention HIV Prevention Planning Process

Pennsylvania Prevention Project Staff

PENNSYLVANIA HIV PREVENTION COMMUNITY PLANNING COMMITTEE
September 1998

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EXECUTIVE SUMMARY

This is the fifth annual Pennsylvania Comprehensive HIV Prevention Plan. Each year, the Plan is prefaced with an explanation of the collaborative effort involved. This year is no exception. In fact, members of the HIV Prevention Community Planning Committee (Committee) and the Pennsylvania Department of Health, Division of HIV/AIDS (Division) recognizes that collaboration becomes more evident and stronger with each passing year. This cooperative process is given impetus by the Centers for Disease Control and Prevention's (CDC) guidance for prevention planning. The Division is commissioned by the CDC to oversee the planning process; and the Committee is asked by the Division to deliberate and compose a statewide Prevention Plan (excluding Philadelphia). Further, the University of Pittsburgh Graduate School of Public Health (Pitt) is contracted for technical, planning, facilitation, evaluation, and data collection assistance. This arrangement combines the vision and resources of a federal office with the capabilities and resources of local communities, state government, and an academic institution, resulting in a comprehensive and representative process and Plan.

Perhaps the most important ingredient in this formal arrangement is the ability for individuals and agencies at the local level to have input into the statewide planning process. These persons and organizations include: consumers of HIV/AIDS prevention and treatment services, providers of these services, persons identified as being at risk of HIV infection, various young people and their parents, state employees outside of the Department of Health, providers outside of HIV/AIDS services, experts in a number of relevant fields, and numerous other individuals deeply concerned with HIV prevention. Although the collaborative process would not be possible without any of these above entities, a consistent highlight of Pennsylvania's process has been the emerging "voice" of young people, represented by the formal inclusion of three young people on the Committee.

This Plan is divided into three parts.

Part 1 describes the entire planning process, including:

- Progress towards current objectives and plans for future attainment of the National Core Objectives of Community HIV Prevention Planning Process
- Committee composition and decision making processes
- Epidemiological and needs assessment information that informed the Committee selection of high-risk populations to be targeted with prevention interventions
- The process utilized to determine priority populations
- Linkages between the Plan's priority populations within communities, the seven Ryan White HIV/AIDS Regional Planning Coalitions, Department of Health Field Offices, and the nine Independent County and Municipal Health Departments
- Progress towards attainment of the 1997-1998 objectives in Counseling, Testing, Referral, and Partner Notification; Health Education/Risk Reduction and Public Information; and HIV Prevention Capacity Building Activities

- Cross Program Activities of the Pennsylvania Department of Health Bureau's of Communicable Diseases and Drug and Alcohol Programs, and Bureau of Corrections

Part 2 describes the HIV/AIDS epidemic in Pennsylvania including:

- Overviews of HIV/AIDS in Pennsylvania (using the CDC's and the state's AIDS surveillance data, estimates of HIV prevalence, and HIV-related mortality data)
- Modes of Transmission (using reported cases of AIDS in defined populations and HIV antibody testing and counseling data)
- Demographic Groups (using the state's AIDS surveillance data; information from the HIV Seroprevalence Survey in Pennsylvania Childbearing Women, and statewide STD, pregnancy, HIV-related mortality, and counseling and testing data)

Part 3 describes the priority populations and goals, objectives, and actions:

- The process for the development of priority populations
- Specific goals, objectives, and actions for priority populations within the interventions of Counseling, Testing, Referral, and Partner Notification; Health Education/Risk Reduction and Public Information; and HIV Prevention Capacity Building Activities
- Linkages between primary and secondary HIV prevention activities
- Linkages with other HIV prevention efforts
- Coordination of HIV prevention services and programs
- Technical Assistance

A goal in writing this Plan is to make it "user-friendly." To this end, abstracts are provided at the beginning of each section or part of the Plan. Another goal was to make the document useful. Therefore, each section is designed so that it can stand alone, making it possible for planners and providers to pull out and use sections as they are needed. For this reason, terms rather than acronyms are used the first time they are introduced in each section and, when necessary, concepts are explained anew in each section.

An overview of the Plan's contents follows:

Part 1 more fully describes the formal collaboration of community, government, and academic sectors addressed above. Committee progress in meeting all five CDC core objectives is described. Highlights of this progress include: the continued ability (since 1994) of the Committee to reach consensus on all significant Committee decisions; heightened participation of all Committee members through regular small group activities; Committee membership representing the diversity of state regions and the HIV/AIDS epidemic; the ability to utilize relevant needs assessments across the state; priority populations based on explicit consideration of needs assessments, outcome effectiveness, cost effectiveness, theory, and identified community norms and values; and clear linkages between the planning process, the Plan, application for CDC funding, and allocation of HIV prevention resources.

Part 2 presents an epidemiological profile of HIV/AIDS in the state--a profile which has assisted in HIV primary and secondary prevention planning. Using various data sources--reported cases of AIDS in defined populations, the HIV Seroprevalence Survey in Pennsylvania Childbearing Women, statewide STD, pregnancy, HIV-related mortality, and counseling and testing data --the epidemiology of HIV/AIDS shows that: (1) the highest numbers of AIDS cases among adults continue to be in regions with the largest metropolitan areas, but the highest percentage increase of newly reported cases typically occurs in more rural regions; (2) numbers of cumulative cases of AIDS (prevalence) are highest for Men who have Sex with Men (MSMs) and Whites; (3) percentage increase of cases of AIDS (incidence) are greatest among African-Americans and Latino(a)s, and among women in general; and (4) AIDS surveillance data and Counseling and Testing data both support high numbers of HIV transmission through MSM, with increasing significance of injection drug use (IDU).

Part 3 describes the priority populations at risk of HIV infection and the subsequent goals, objectives and actions within each intervention area as well as a report of current evaluation objectives, a comprehensive evaluation plan and technical assistance.

Priority populations are defined in two broad HIV transmission mode categories: (1) Injection Drug Users (IDUs) and (2) those who engage in HIV risk-related sexual behavior. The following rank order of priority populations is utilized when appropriate: African-American, Latino(a), youth and young adult injection drug users and their sexual partners and/or young men who have sex with men, sexually active youth and young adults, sexually active Latino(a)s, and African-American and Latino men who have sex with men.

A three-year need assessment process has been performed with these populations in mind, and cumulative data from this process comprises a “data bank” from which the Committee draws when planning prevention interventions. The three-year process provided the basis from which emerged several community-based activities including:

- Young Adult Roundtables
- Prevention Outreach Demonstration Projects
- MSM and Minority Community Leadership Development Groups
- Male-Mentoring Project
- Community-Wide Planning Groups

Committee members decided that these projects offer a link to Pennsylvania communities and have become an effective tool for on-going verification of needs assessment findings. Throughout the year, the Committee receives reports, often from project participants themselves, on all project activities, issues, and evaluation findings. These project reports and Committee meeting visits by project participants provide an opportunity for Committee members to continually assess whether findings from the need assessments are valid and determine future needs assessment priorities.

PART ONE
PROGRESS REPORT

SUMMARY:
HIV prevention community planning in Pennsylvania results from the cooperative efforts of the State Department of Health's Division of HIV/AIDS, the HIV Prevention Community Planning Committee, and the University of Pittsburgh Graduate School of Public Health. These efforts represent a strong collaboration of community, government, and academic sectors. This section describes the roles of each of these entities, as well as Planning Committee and implementation progress made since 1994, with emphasis on progress made in the past year.

The Planning Committee has exhibited progress along all five core objectives described by the CDC Guidance. Highlights of this progress include:

- Consensus on all significant Committee decisions since 1994
- Increased participation of all Committee members through regular small group activities
- Committee membership representing the diversity of the epidemic, including increased participation of more rural regions of the state in 1996, as well as participation of racial/ethnic minorities congruent with proportions of people with AIDS in these populations
- A unique program of Young Adult Roundtables enabling youth participation in Community Planning
- An on-going HIV prevention needs assessment, including a statewide epidemiological profile, focus groups, and key informant interviews
- Prioritized interventions based on explicit Committee consideration of the needs assessment, outcome-effectiveness, cost-effectiveness, theory, and identified community norms and values
- Clear linkages between the community planning process, the Prevention Plan, application for CDC funding, and allocation of CDC and State HIV prevention resources

Implementation of interventions has included:

- HIV prevention outreach projects to injection drug users in Erie and disadvantaged women in Chester
- Minority and MSM (men who have sex with men) Community Leadership Groups in eight communities implementing prevention interventions and developing capacity for new funding programs
- Young Adult Roundtables in seven communities to allow young people a voice in prevention planning and the creation of the Young Adult Consensus Statement of HIV prevention needs created by and for youth and young adults
- A Mentoring project in three communities to provide HIV prevention to minority youth

- An Internet web site at http://www.stophiv.com to provide on-line HIV/AIDS information and a computer distribution program to AIDS service organizations.

BACKGROUND AND PROGRESS:

The Pennsylvania Department of Health, Division of HIV/AIDS (Division) convenes the Pennsylvania HIV Prevention Community Planning Committee (Committee) as the single statewide planning body for the ongoing development of the Pennsylvania Comprehensive Community HIV Prevention Plan (Plan). The Committee's jurisdiction includes all of Pennsylvania except the City of Philadelphia. The University of Pittsburgh Graduate School of Public Health (Pitt) serves as facilitator of the planning process.

The cooperative efforts of the Committee, Division, and Pitt constitute a strong collaboration of community, government, and academic organizations. This successful collaboration is due, in part, to the clearly defined roles of each entity as described below.

Pennsylvania HIV Prevention Community Planning Committee	***Pennsylvania Department of Health, Division of HIV/AIDS***	***University of Pittsburgh Graduate School of Public Health***
• Develop an annual Comprehensive HIV Prevention Plan to include objectives and recommended interventions and activities • Review Division CDC applications to ensure concurrence with the Prevention Plan • Monitor Prevention Plan implementation • Provide input and recommendations in the development of evaluation standards for prevention interventions and counseling and testing programs • Provide input and recommendations to the Division on other HIV prevention-related issues (e.g., standards for AZT use by pregnant women, HIV reportability)	• Convene the Committee, including selecting meeting sites, providing meals and lodging, and assisting members with travel arrangements • Provide technical assistance and staff support to the Committee and Sub-committees regarding AIDS epidemiology, counseling and testing activities, updates on other federal and state HIV-related activities, and other input as requested by the Committee • Develop CDC funding applications consistent with Prevention Plan objectives, recommended activities and interventions, and priorities • Initiate and monitor sub-contracts as determined in the application • Coordinate with other state agencies as appropriate regarding priority of Prevention Plan objectives • Coordinate media requests and distribution of the	• Facilitate all Committee and Sub-committee meetings, including recommendations for agenda content and structure, meeting facilitation, production of minutes, and development of small group and prioritization processes and activities • Coordinate needs assessment activities • Provide technical assistance to the Division regarding behavioral science, prevention planning, and program evaluation • Develop and implement sub-contracts for some community-based interventions as necessary to expedite distribution of funds • Provide technical assistance to sub-contractors regarding program development and evaluation • Conduct an evaluation of the prevention planning process

	Prevention Plan	

National Community Planning Core Objectives: Progress Report and 1999 Objectives.

Following is the current progress report for the time period July 1, 1997 through June 30, 1998 in meeting the five core objectives as described in the CDC *Guidance* and the future steps that will be taken to accomplish the national core objectives from July 1, 1998 through June 30, 1999.

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

Current: The forty-member Pennsylvania HIV Prevention Community Planning Committee (Committee) meets for two five-hour days in July and August and for one five-hour day in September, November, January, March, and May in Harrisburg, Pennsylvania (the state capital). There are no other prevention community planning groups that meet nor have there been any changes in the planning structure within this jurisdiction.

Data from annual process evaluations support the continuation of several methodologies that encourage an open and participatory planning process. These methods include a modified consensus model, small group activities (Sub-Committees, Task Groups, and planning work groups), and an open selection process for new members.

Modified consensus model: Committee decision-making occurs using a modified consensus model: the majority rules if necessary, however every attempt is made to achieve consensus. Nearly all Committee votes taken since October 1994 have been by consensus. Significant decisions achieved by consensus include:

- Agreement on which populations to target with prevention efforts, and adoption of objectives and annual action plans
- Concurrence with the all CDC continuation grant applications
- Adoption of recommended prevention program standards for all programs in the state
- Adoption of variables and standards for Counseling, Testing, Referral, and Partner Notification (CTRPN) and prevention program evaluation
- Adoption of membership selection procedures and criteria
- Establishment of Sub-committee structure
- Adoption of Committee policies including Committee charter, attendance policy, conflict of interest statement and guidelines, and procedures for public relations issues and letters of support

Small group activities--Sub-committees and Task Groups: Small group processes, including the establishment of Sub-committees and Task Groups, represent the most effective means for reaching all Committee decisions mentioned above. Sub-committees are considered permanent, while Task Groups convene to accomplish

specific tasks in a fixed period of time. The Sub-Committees and Task Groups, along with their functions, are described in the following table.

PA HIV PREVENTION COMMUNITY PLANNING COMMITTEE SUB-COMMITTEE STRUCTURE	
Prevention Planning and Evaluation	Monitors and makes recommendations regarding evaluations of the planning process, the Prevention Plan, demonstration projects and input on the epidemiological profile.
Counseling and Testing	Monitors and makes recommendations regarding issues relating to the HIV counseling and testing system.
Funding Guidelines	Monitors and makes recommendations regarding funding applications and contract guidelines.
Women's Issues	Monitors and makes recommendations regarding HIV-related issues affecting women.
Youth Empowerment	Monitors and makes recommendations regarding issues affecting young people. Membership includes representatives from the Young Adult Roundtables Executive Committee.
Membership	Monitors and makes recommendations regarding on-going membership on the Committee and Sub-committees.
Community-based Initiatives	Monitors and makes recommendations regarding initiatives designed to increase community involvement in prevention planning.
Public Relations	Monitors and makes recommendations regarding issues of public relations.
Training and Development	Examines training and development requests to improve the knowledge and skills of the Committee
Harm Reduction Task Group	Developed an information paper relating to the HIV harm-reduction strategy of needle exchange.
HIV Reportability Task Group	Developed an information paper relating to the possibility of making HIV infection a reportable condition in the state.

Committee members are requested to participate on at least one Sub-Committee and membership of Sub-Committees is limited to no more than eight participants. Sub-Committee meetings are pre-scheduled to meet four times per year by telephone conferences. Unless explicitly commissioned by the Committee, Sub-Committees and Task Groups are empowered only to make recommendations that are subject to approval by the full Committee. As the prevention planning process has progressed, the role of Sub-Committees has changed from one of direct development of prevention initiatives to a role involving more a monitoring and evaluation of existing initiatives.

Small group activities: Apart from the Sub-committee structure, additional small group activities play an important role in many Committee activities; most important is the development of priority population goals, objectives, and actions for the Prevention

Plans. Three small groups were formed in the development of goals, objectives, and action steps within the interventions of Health Education/Risk Reduction and Public Information, HIV Prevention Capacity Building, and Counseling, Testing, Referral and Partner Notification.

Open selection process for new members: The Committee maintains a policy of relying on the natural annual attrition of approximately one-third of its members to create vacancies on the Committee. As such, member terms are considered to last approximately three years.

In 1998, new members were selected utilizing the two methods established in previous years. Recognizing the need for representation from young people in the planning process, the Committee continues to support eight Young Adult Roundtables across the state of Pennsylvania (these are described in greater detail later). Each roundtable elects co-chairs, who form the Young Adult Executive Committee. This Executive Committee selects three young adults to serve as Committee members.

In addition, the Committee filled five vacancies for new members utilizing the existing statewide selection process. Process evaluation data indicate that members consider the established selection process to be open and effective.

The selection process is as follows:

- The Committee reviews representational gaps on the Committee as a result of member turnover.
- The Committee develops explicit criteria for new member selection based on CDC recommendations and representational gaps.
- An Ad-Hoc Committee consisting of both Committee and non-Committee members is chosen to review applications solicited through an extensive 600 piece statewide mailing.
- The Ad-Hoc Committee reviews applications with regard to Committee selection criteria and submits its recommendations to the full Committee.
- With Committee approval, these recommendations are sent to the Secretary of Health for appointment to the Committee.
- The new members are seated after attending a daylong orientation. In addition, new members are assigned a mentor from the Committee to ease their transition.

Future: During the current planing cycle, the Committee followed a process that more carefully examined the HIV risk-related behaviors in the establishing of priority populations. Therefore, the creation of intervention goals, objectives and action steps more accurately target the HIV risk-related behaviors of priority populations. The HIV prevention plan serves as a guide for community programs and will engender greater collaboration with the seven Ryan White HIV/AIDS Regional Planning Coalitions.

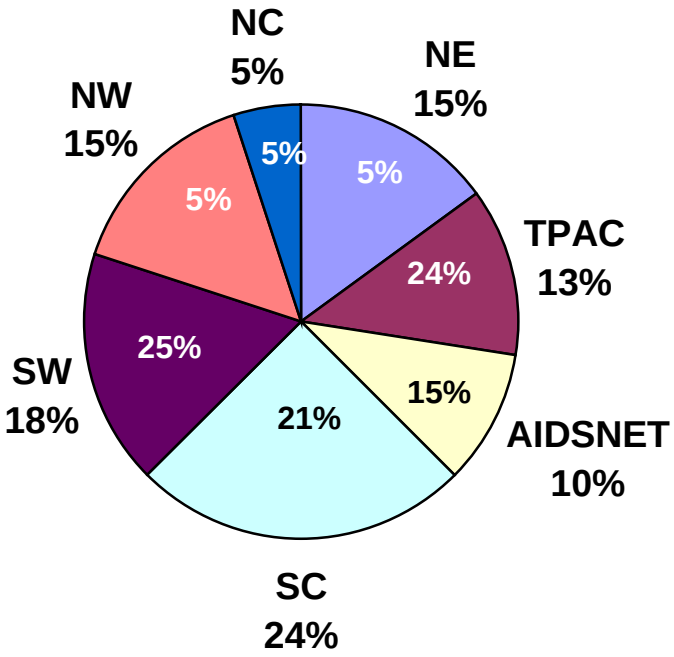
2) Ensuring that the community planning group reflects diversity of the epidemic in your jurisdiction, and that expertise in epidemiology, behavioral science, health planning, and evaluation are included.

Current: *Geographic diversity:* Committee members reflect diversity with respect to geographic representation, as shown in the chart below. Community Leadership Development initiatives, designed to assist local communities in encouraging HIV counseling and testing in at-risk populations (described in detail later) and to develop local capacity, continue to be important recruitment sources for the Committee.

Racial/Ethnic Diversity: Percentages of racial/ethnic representation on the Committee vary by less than 1.5% from the previous year. The overall racial/ethnic composition of the Committee continues to closely match that of the epidemic as illustrated below.

PA HIV Prevention Community Planning Committee Membership by Region (Compared to Reported AIDS Cases by Region

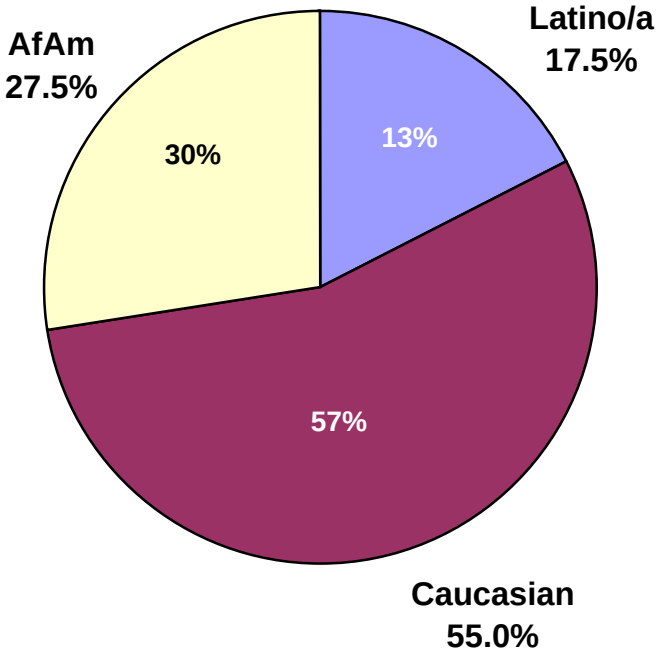
Note: Percentages outside the pie represent Committee membership; percentages inside the pie represent reported AIDS cases (excluding Phila.)



PA HIV PREVENTION COMMUNITY PLANNING COMMITTEE
RACIAL/ETHNIC DIVERSITY

Percent of PA HIV Prevention Planning Committee Membership by Race/Ethnicity (Compared to Reported AIDS Cases)

Note: Percentages outside the pie represent membership by race/ethnicity; percentages inside the pie represent reported AIDS cases (excluding Philadelphia)



*Young people: M*eetings of young people are designed to encourage the participation of adolescents and young adults in the planning process. As described previously, three young adults are now permanent Committee members as a result of their participation in the Roundtables.

Consumer representation: Fifteen percent of the Committee membership currently consists of both male and female HIV-positive consumers.

Committee expertise: Committee members represent a wide cross-section of expertise and disciplines, including:

- AIDS service organization administration
- Minority and gay HIV prevention outreach
- Independent health departments
- Community AIDS education
- Gay/lesbian/bisexual community
- Minority and women's social services
- Hospital-based health care
- Women's reproductive health care
- Migrant health
- Sexually transmitted disease clinics
- HIV counseling and testing site staff
- Community planning and evaluation
- Drug and alcohol treatment and prevention
- Domestic violence
- Religious community
- Hemophilia
- College-based health care
- Young people

Governmental membership on the Committee has always included representation from:

- Department of Health
- Department of Public Welfare
- Department of Education

Following recommendations from the process evaluation, representatives from additional government offices were added as consultants to the Committee. Additional consultants include representatives from:

- Bureau of Drug and Alcohol Programs
- Bureau of Maternal and Child Health
- Bureau of Communicable Disease Prevention
- Bureau of Corrections

Staffs from the Division of HIV/AIDS and the University of Pittsburgh provide additional expertise relating to:

- Epidemiology
- Behavioral science
- Needs assessment and evaluation

Future: When the ad-hoc committee meets to make selections for new Committee members in 1999, they will consider the recommendations from the CDC review of the 1998 Plan. In particular, they will explore recruitment and involvement of HIV-infected persons who are not employed by or volunteer as part of the HIV/AIDS service delivery system, as well as men of color who have sex with men. The Committee has eliminated

the designation of alternate membership. This designation is no longer useful and has prevented participating Committee members from voting on the Committee. Also to be considered, when examining the proportion of diagnosed AIDS cases, the northern tier counties remain over-represented on the Committee.

3) Ensuring that priority HIV prevention needs are determined based on an epidemiological profile and needs assessment.

Current: The epidemiological profile was derived from (1) Pennsylvania AIDS surveillance data; (2) HIV seroprevalence surveys of defined populations (i.e., childbearing women and persons receiving publicly funded HIV counseling and testing); (3) state HIV-related mortality data; (4) statewide statistics on STDs and pregnancies, which provide surrogate information about populations participating in risk behaviors also associated with HIV transmission; and (5) statewide estimates of HIV seroprevalence based on extrapolation from national estimates and from data from the HIV Seroprevalence Survey in Pennsylvania Childbearing Women (these methods are described in more detail in the Epidemiological Profile of the Plan). The data listed in 4 and 5 above represent additional approaches incorporated in this year's epidemiological profile based on CDC's recommendations.

Additionally, the University of Pittsburgh conducted needs assessments from 1994 to 1996. These assessments included 96 focus groups and 138 key informant interviews.

Focus group topics in this multi-year assessment included:

- Prevention needs in the state
- Specific behavioral strategies utilized by HIV-negative individuals that allowed them to maintain their HIV-negative status
- Asian and Native Americans
- Impact of HIV education in school systems
- Utility and usability of the Prevention Plan

Initial key informant interviews were part of a general assessment of state prevention needs. Other key informant interviews were conducted to assess the prevention needs of people living with challenges, sex workers, and those in county and municipal correctional facilities.

In 1998, Committee members utilized the various community-level interventions as a feedback mechanism to monitor any possible changes from the original needs assessment findings. A review of the needs assessment analysis is included in the new member orientation. In addition, structured planning work group assignments include explicit references to utilizing the needs assessment analysis as part of decision making.

Future: Next year's development of the HIV/AIDS epidemiological profile will benefit from a newly formed expert panel which will study, recommend, and assist in the

inclusion of additional data sources in deriving the profile. This panel will be facilitated by the University of Pittsburgh Graduate School of Public Health. Additionally, the Prevention Committee has developed recommendations and a consensus statement for Commonwealth officials to consider regarding the incorporation of HIV reportability from the standpoint of the need for better data for planning, while preserving confidentiality of individuals who test seropositive for HIV by using unique identifiers.

Needs assessment will include focus groups and key informant interviews including and focusing on HIV-positive individuals. These assessments will solicit participants' perspectives about barriers to secondary as well as primary HIV prevention. Additional needs assessment will involve group meetings with injection drug users and those who engage in HIV risk-related sexual behavior, which will result in a consensus statement based upon the Young Adult Roundtable Consensus Statement model.

4) Ensuring that interventions are prioritized based on explicit consideration of priority needs, outcome-effectiveness, cost-effectiveness, theory, and community norms and values.

Current: Prioritizing HIV prevention needs is a critical part of program planning. In order to establish priority populations for HIV prevention in the Commonwealth of Pennsylvania excluding Philadelphia, the Pennsylvania HIV Prevention Community Planning Committee followed a logical, evidence-based process.

That process commenced with the Committee being provided with the following reference materials:

- Current HIV/AIDS epidemiological profile for Pennsylvania
- Sexually transmitted disease data by county
- HIV antibody testing and counseling data within each of the seven Ryan White HIV/AIDS Regional Planning Coalition
- Status of previous objectives and action steps
- Statewide HIV prevention snapshot
- HIV prevention efforts funded by the Pennsylvania Department of Health not utilizing the Centers for Disease Control and Prevention funding
- HIV prevention efforts conducted by the independent county and municipal health departments
- Previous needs assessment data from 96 focus groups with almost 700 participants and 138 key informant interviews
- Counseling, testing, referral, and partner notification evaluation recommendations
- Young Adult Roundtable Consensus Statement

A matrix, which numerically rates HIV risk-related behaviors and categories with four HIV prevention criteria (riskiness of behavior, difficulty in meeting the need, emerging issues, and resources needed) was created by the University of Pittsburgh to better insure that HIV prevention planning efforts are based on HIV risk-related behavior. The matrix and instructions were mailed to the 40 Committee members. Sixty-three percent

(n=25) of the forms were returned in the self-addressed stamped envelope. Committee members were also offered additional opportunities to communicate their opinions about priority populations.

The results, which rank ordered 44 HIV risk-related behaviors/categories, were distributed to the Committee for discussion. The high, medium, and low numerical ranking by 25 respondents created a possible total score of 300. The final range of scores was from (1) African-American women injection drug users with 271 points to (44) occupational-related HIV exposure with 70 points.

The thirteen top priority populations identified in this manner were:

(**1**) African-American female injection drug users
(2) Young injection drug users
(3) Latino injection drug users
(4) Sexually active Latinas
(5) Latina injection drug users
(6) African-American male injection drug users
(7) Sexual partners of injection drug users
(8) Latino men who have sex with men
(9) Young men who have sex with men
(10) Injection drug users who are men who have sex with men
(11) Pregnant Latinas
(12) African-American sexually active women
(13) Pregnant African-American women

In order to learn whether Pennsylvania's current HIV prevention interventions served priority populations, as well as where gaps of service remained, the University of Pittsburgh staff administered a ten-question telephone survey. The goal was to determine whether or not the needs of the priority populations are being met by current HIV/AIDS organizations and to examine the existing HIV/AIDS programs to determine if they are conducting HIV prevention and education activities. The seven Ryan White HIV/AIDS Regional Planning Coalitions were telephoned to provide a listing of HIV prevention efforts within their areas. Sixty-four agencies were identified, of which fifty-seven (89%) responded to requests for a telephone interview.

A summary of findings is as follows:

- Less than half of the groups surveyed reached the high-risk groups
- More than three-quarters reached the general community
- Only 36% of surveyed programs provided HIV prevention, and 63% of them offer HIV education
- Forty-seven percent of programs reach injection drug users, 35% reach racial/ethnic minorities, and 32% address youth in alternative settings
- There is a significant shortage of programs targeting HIV prevention for women and men who have sex with men

Future: During the next year, technical assistance on targeting, marketing, prevention theory and proven HIV prevention interventions will be provided to the seven Ryan White HIV/AIDS Regional Planning Coalitions to develop community level HIV prevention interventions related to the priority populations. In addition, the University of Pittsburgh and Pennsylvania Department of Health is committed to building an infrastructure for evaluation in which common understanding, tools, data system, and when appropriate, data itself may be shared among many interested parties across the state. Since the process of identifying priority populations was based within HIV risk-related behavior, the Committee will need to monitor and further refine that process to insure that HIV prevention interventions are targeted towards the identified priority populations.

5) Fostering strong, logical linkages between the community planning process, the Prevention Plan, application for funding, and allocation of CDC HIV prevention resources.

Current: The single statewide Prevention Planning Committee is directly responsible for the development of the Prevention Plan. The planning process is structured such that the objectives and recommended interventions of the Plan can be directly linked to the objectives and funded activities of the application.

Objectives and recommended interventions for the Prevention Plan are constructed and prioritized before the development of the funding application. Division staff reviews the recommendations and develops a draft application that is then reviewed by the Funding Guidelines Sub-Committee prior to presentation to the full Committee. As part of this review process, Division of HIV/AIDS staff members present the application objectives and activities as they correlate with the objectives and interventions of the Plan. Final Committee concurrence includes a Division presentation of the Application to the full Committee demonstrating this correlation.

The Division has also begun to create linkages of Committee priorities with other planning initiatives and funding streams. This is occurring through changes in Department of Health contracting requirements to reflect prevention planning priorities and through technical assistance from the Division and the University of Pittsburgh staffs to community-based providers and other organizations engaged in HIV/AIDS-related planning as described below.

Minority involvement in regional coalitions: The Division engaged in an initiative to increase racial/ethnic minority involvement in the Ryan White HIV/AIDS Regional Planning Coalitions. Committee members received copies of the final report and recommendations from this initiative. Further, representatives from the contractor in this project assisted in several of the initiatives in the plan that involved minority communities.

Regional coalition needs assessment: Protocols, instruments, and data analysis from focus groups and key informant interviews are available to the Ryan White HIV/AIDS Regional Planning Coalitions to assist in the development of regional needs assessments.

Response to AZT and Pregnant Women Guidelines: The Women's Issues Sub-committee of the HIV Prevention Community Planning Committee assists Division staff in the development of responses to the Health Resources Services Administration (HRSA) guidelines (076) relating to AZT use by pregnant women to reduce perinatal transmission.

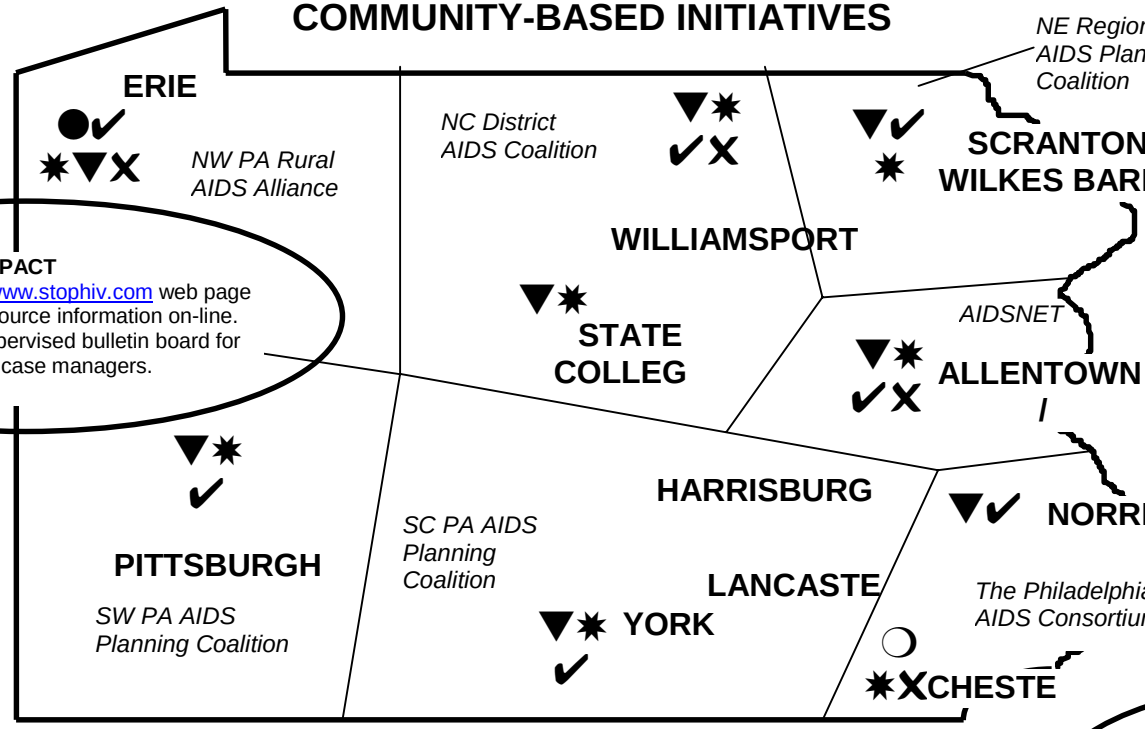
Future Development of a statewide coordinated statement of need, HIV prevention standards, and projected HIV prevention technical assistance to be provided to the seven Ryan White HIV/AIDS Regional Planning Coalitions, has created strong linkages between the community-level HIV prevention efforts, statewide HIV prevention planning, and funding and allocation of the CDC HIV prevention resources by the Pennsylvania Department of Health. Those linkages will require continual monitoring and strengthening.

IMPACT
1,445 IDUs were provided with one-on-one contacts (duplicated and unduplicated) through outreach project in Erie.

Community-Wide Planning Group receives state grant for street outreach targeting Latino(a)s, African American males and females, youth and young adults.

IMPACT
MSM Community Leadership Group in Williamsport provide HIV prevention information, condom distribution, and counseling and testing information in gay bars and other locations where MSMs frequent.

Pennsylvania HIV Prevention Community Planning
COMMUNITY-BASED INITIATIVES



IMPACT
Pitt staff maintains the www.stophiv.com web page to provide HIV/AIDS resource information on-line. Launches state-wide supervised bulletin board for Pennsylvania HIV/AIDS case managers.

IMPACT
Young Adult Roundtable Summit in Harrisburg resulting in a Consensus Statement produced for and by youth and young adults.

- ● IDU Outreach Demonstration Project
- ❍ Women's Outreach Demonstration Project
- ▼ MSM Community Leadership Group
- ✸ Minority Community Leadership Group
- ✔ Young Adult Roundtable
- ✕ Mentoring Project

IMPACT
Minority Community Leadership Group in York receives state grant to provide street outreach targeting economically disadvantaged minority women between the ages of 9 and 13.

IMPACT
16,602 duplicated group and one-on-one contacts, 7,574 of which involved women and girls, as part of the Outreach to Minority Women Project in Chester.

Progress toward achieving selected program objectives for the time period 1 July 1997 though 30 June 1998; the final year of a three-year Comprehensive HIV Prevention Plan

Counseling, Testing, Referral, and Partner Notification (CTRPN)

Pennsylvania is comprised of 67 counties. Of the 67, there are six independent county and three independent municipal health departments. These nine health departments are contracted by the State Health Department to provide individuals a choice of anonymous or confidential HIV counseling and testing (C/T) within their jurisdictions. The choice of anonymous or confidential C/T is required by the State. Anonymous and confidential HIV C/T in 58 of the remaining 61 counties is assured at HIV clinic sites located in State Health Centers operated by the State Health Department. In three counties where no State Health Centers exist, HIV C/T is available confidentially at an STD clinic or is available anonymously by calling the toll free AIDS Factline for an appointment with an HIV Prevention Program field staff member. HIV Prevention Program field staff routinely provide C/T services outside the clinic setting for at-risk clients who cannot or will not use services in a clinic setting. Field staff also have the responsibility, along with the seven regional coalitions, of developing and making available local and regional referral sources.

State Health Centers provide a variety of other services including STD diagnosis and treatment, childhood and adult immunization, and in some areas, Well Baby clinics. There is, therefore, little community stigma associated with visiting these offices. HIV clinics operate either by appointment and/or as walk-in clinics. For the most part, HIV clinic hours in State Health Centers fall between 8:00 a.m. and 4:30 p.m.

HIV C/T services are provided according to CDC and State Health Department standards, guidelines and Pennsylvania law that address client and record confidentiality, use of client-centered counseling, cultural sensitivity, counselor training and evaluation, quality assurance, psychosocial and medical referrals, and awareness of cultures being served. These standards, guidelines and law are included in education and training which is required for all HIV counselors at publicly supported sites and documented in the following; Pennsylvania's Confidentiality of HIV-Related Information Act, Act of 1990, P.L. 585, No. 148, the Manual for the Completion of the HIV C/T Report Form and Recommended Standards and Guidelines for Voluntary HIV Partner Notification developed by the Division of HIV/AIDS, and CDC's HIV Counseling, Testing and Referral Standards and Guidelines published and adopted by the State Health Department in 1994. Chart audits conducted during 1998 at selected sites indicated that use of a risk reduction plan is an integral part of HIV prevention counseling. HIV counselors are evaluated annually through performance evaluations.

Contractors who provide HIV C/T services are required to provide all staff with semiannual in-service training on the biology and epidemiology of HIV infection and AIDS, HIV counseling and testing, HIV treatment modalities and HIV prevention education and risk reduction methods. A manual on basic HIV/AIDS information was developed by the Division of HIV/AIDS to provide new counselors with the basics of HIV/AIDS infection, prevention, and treatment. The manual will also be made available to each current HIV site.

The Division of HIV/AIDS has contracted with the Distance Learning Center located in Gibsonia, Pennsylvania to coordinate the CDC Public Health Training Network Satellite Broadcasts and other state funded broadcasts that relate to basic HIV/AIDS issues, including treatment and care, behavior change models, and drug and alcohol issues and services. Broadcasts are offered at multiple sites throughout the State and are made available to

counselors from all publicly supported sites. Regional HIV/AIDS updates, called “Booster Sessions,” were conducted for HIV counselors in each of the Health Department’s six Health Districts. Training was provided on the use of the female condom and its availability. Results of the HIV C/T site evaluation process conducted over the previous two years was presented. Local HIV/AIDS topics of interest were also included in the update such as AIDS treatment updates, home testing kits, and reports on the operation of the State’s AIDS Factline.

The State Health Department has allocated in excess of three million dollars of Substance Abuse Prevention and Treatment (SAPT) Block Grant funds for HIV C/T and HIV early intervention services to substance abusers in treatment. The Division of HIV/AIDS was given the lead role in the development and implementation of this initiative. Currently, more than 100 drug and alcohol treatment programs in twelve Pennsylvania counties provide on-site HIV C/T services. Services include the following: HIV prevention (pre-test) counseling; blood and oral fluid specimen HIV antibody testing (ELISA and Western Blot); results (post-test) counseling; CD4, viral load and TB testing; and other diagnostic, evaluation and therapeutic services.

The State Health Department’s policy on HIV counseling and testing of pregnant women recommends universal HIV counseling of all pregnant women. HIV testing and voluntary treatment with AZT for HIV positive women is strongly encouraged. HIV counseling and voluntary HIV testing is recommended as a routine standard of care.

A video was developed by the Division of HIV/AIDS in 1997 entitled, “HIV, Women, and Pregnancy,” that provides information from women regarding what they felt they needed from their physician or other health care provider about HIV, counseling, testing and treatment, continues to be distributed. A 1997 initiative to survey hospitals to determine whether they had AZT in the appropriate form for treatment of HIV positive expectant mothers and newborns, will be repeated during the latter part of 1998 to determine if there has been any increase in AZT availability.

During 1998, the Division of HIV/AIDS established a Perinatal Transmission Working Group in order to comply with the federal mandate to demonstrate a 50% reduction in the vertical transmission of HIV by 1999. Representatives included health care providers, consumers, and staff from the State Health Department and from the county and municipal health departments. This working group is also formally linked to the statewide Integrated HIV Planning Council. A multi-level strategy has been initiated by the working group to address both the community education, provider education, and health care systems response to the issues surrounding informed, voluntary HIV counseling and testing of women, advances in the treatment of pregnant women, post-partum women and children. Sub-Committees of the Working Group draft strategies dealing with provider education, community HIV prevention, and contract/legal work. For example, strategies have suggested conducting focus group training for physicians, conducting a poster campaign, and conducting best practices session with managed care organizations.

The Division of HIV/AIDS continues to make available two pamphlets specific to the issue of HIV infection and pregnancy. “New Information for Pregnant Women” is targeted to all pregnant women. The other, entitled, “Pregnancy and HIV: is AZT the Right Choice for You and Your Baby?” is targeted to HIV-infected pregnant women.

During 1998, the State Health Department made State Health Department funds available to the seven Ryan White HIV/AIDS Regional Planning Coalitions for the provision of HIV C/T services. Many family planning agencies viewed this as an opportunity to combine state funded HIV/CT with prenatal and obstetric care they already provide to women.

The Division of HIV/AIDS continues to fund a demonstration HIV outreach project targeting substance abusers in the city of Erie. In addition, program staff keep informed of harm reduction models and have facilitated the dissemination of this information out in the field by sponsoring a harm reduction satellite conference and adding a harm reduction course to the on-site training curriculum.

The Pennsylvania Department of Health does not support funding needle exchange programs because of the federal funding restrictions, Pennsylvania's drug paraphernalia law, and the State Board of Pharmacy's administrative rules. However, the HIV Prevention Community Planning Committee has investigated the scientific merits of HIV infection harm reduction through needle exchange programs and accordingly has produced a position paper in support of such programs.

The numbers of individuals counseled and tested at publicly supported sites for HIV in FY 96-97 was 41,458. Because HIV counseling and testing data submitted from publicly funded sites lags behind by almost three months, records are available on a total of 38,039 individuals who were HIV counseled and tested thus far during FY97-98. A review of the numbers tested during the first nine months of FY97-98 provides an average monthly total. When applied to the entire 12-month period of the fiscal year, it appears that the number of individuals who will receive HIV counseling and testing during FY97-98 will remain approximately the same as the number provided services during FY 96-97.

Numbers counseled and tested in populations most at-risk as determined by the HIV Prevention Community Planning Committee-MSMs, women, IDUs, and minorities did not increase significantly. Additionally, 47% of C/T services were provided to individuals who acknowledged HIV risks including MSM, IDU, exchange of sex for drugs or money, victims of sexual assault, female sex partners of MSMs, and sex partners of a person with HIV or someone who injects drugs. A comparison of the data by gender, race, age and risk factors showed little, if any, significant difference in numbers counseled and tested between FY96 and FY97. The overall HIV-positive rate of individuals counseled and tested between FY96 and FY97 also remained the same, at approximately 1%.

No significant increase in the provision of HIV counseling and testing services to populations determined to be most at risk of HIV infection was noted thus far in 1998. Other ways to provide HIV counseling and testing services to individuals most at risk are currently being explored, including the provision of services CBOs and ASOs and other agencies that deal directly with the populations engaging in high risk activities who are already receiving HIV prevention education services. Increased services to drug treatment clients and inmates of prisons and jails are also being pursued to reach those at risk.

A one-day refresher course on client-centered HIV prevention counseling for counselors from publicly supported sites is planned for 1999. During 1998, the Division of HIV/AIDS contracted with the Pennsylvania AIDS Education and Training Center (PA AIDS ETC) to take the three-day prevention counseling course and condense it into a one-day course that could be used as refresher for counselors that had previously gone through the three-day course at least twice.

This information was provided to the Planning Committee. Prioritization of client placement into treatment is determined in part by the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant provisions and in part by Single County Authorities (SCA) and individual program policies. SAPT Block Grant funds give preference to treatment of pregnant injection drug users, pregnant substance abusers and injection drug users. There are some SCAs and treatment programs that give preference to treatment of individuals with HIV disease.

The Division of HIV/AIDS has developed and distributed to treatment programs throughout the state a pamphlet entitled, "HIV Guidelines for Drug and Alcohol Abuse Treatment Programs in Pennsylvania," which provides information and guidelines about HIV/AIDS that can be translated into meaningful, realistic clinical and administrative practice. In addition, the Division continues to offer a series of on-site workshops to substance abuse treatment facilities on Substance Abuse Counseling in the Age of HIV Disease.

The Division of HIV/AIDS continues to operate the State HIV/Substance Abuse Training project. In State FY 1997/98, seventy-six (76) on-site training events were delivered and approximately one-thousand, six-hundred sixty-four (1,664) individuals received training. Courses on HIV Prevention Counseling and Harm Reduction were added this year.

Education on home testing was provided to HIV counselors during the HIV/AIDS program updates provided in each of the State Health Department's six regions. The lone company that continues to produce a home testing kit does possess a referral list of counseling, medical, and psychosocial services for residents of Pennsylvania. Referrals of individuals identified as HIV positive through the home HIV test was reported during 1998 and provided evidence that a referral process was in place and was working.

Training was conducted for the HIV Prevention Program Field Staff on the use of OraSure, an oral fluid specimen collection device. This training was conducted by staff of Epitope, Inc. All counseling and testing protocols remain unchanged.

Health Education/Risk Reduction and Public Information

Outreach to Disadvantaged Women in Chester, Pennsylvania: The "ChesPenn Project" was established in 1995 to target African-American women and Latinas with HIV prevention interventions. Chester, PA is an economically distressed community, having lost much of its economic base that relied on manufacturing and defense (ship-building and Navy-material production). Poverty and unemployment rates are high, and the school district ranks last of the 501 school districts in the state.

Racial/ethnic minorities constitute 98% of the city's residents. Incidence of AIDS among women in Chester is very high, accounting for 71% of all reported cases in the city. Seventy-eight percent (78%) of these cases represent women of color.

The following summarizes numbers and types of individuals reached by the project:

TOTAL CONTACTS	**16,602 (Duplicated & Unduplicated; Individuals in Groups & One-on-One Contacts)**
Female	7,574 (46%)
Male	8,445 (51%)
Missing	583 (3%)

13-19 years old	2,434 (15%)
TOTAL CONTACTS	**16,602 (Duplicated & Unduplicated; Individuals in Groups & One-on-One Contacts)**
20-29 years old	6,337 (38%)
30-39 years old	4,538 (27%)
40 and over	2,441 (15%
Missing	882 (5%)
African American	10,029 (60%)
Latino/a	3,070 (19%)
White	1,656 (10%)
Other/Missing	1,847 (11%)
Risk Behaviors: Note—Not all contacts report risk behavior, and those who do may report more than one risk behavior:	
Heterosexual Unprotected Sex	2,179
Sexual Partner of Injection Drug User	72
Sex for Drugs	141
Drug Abuse/Alcohol Abuse	55
Injection Drug Use	155
MSM	28
Other Risks	450

In 1997, additional funds were available for program expansion and another component was developed, extending the street outreach program for disadvantaged women to Upper Darby, a community east of Chester where a large Southeast population has settled. Funding for this project will end by the end of 1998, and University of Pittsburgh staff have provided technical assistance to the project's administrative staff for developing plans and strategies to secure funding to continue the project.

Outreach to Active Injection Drug Users In Erie, Pennsylvania: Serenity Hall Outreach/Crossroads, Inc. (SHOUT), was established in 1996 to target injection drug users and their sexual partners. The project was subcontracted through the Erie County Health Bureau and Serenity Hall because of these organizations' respective backgrounds in HIV prevention and drug and alcohol treatment. Serenity Hall has had a longstanding interest in street outreach, and this project provided the opportunity and resources to use this expertise for HIV prevention outreach.

SHOUT has become well established in the community, and staff have built good relationships with community "gatekeepers," biker police, and staff from other outreach programs that are active in community-based prevention. At the onset of the program, a need assessment showed that approximately 1,500 active IDU's were in need of HIV prevention services, which could be delivered on the street or in other drug-trafficking venues. To address this need, the project has implemented the following:

- Distribution of literature, condoms, and bleach kits
- Counseling, testing, and risk-reduction education for IDUs and their sex partners
- Enrollment of individuals at-risk for HIV infection in an intensive risk-reduction education program

The staff identified areas in the City of Erie in which high levels of drug trafficking and sexual activity occur on a regular basis and established a presence in those areas. They provide street and community outreach activities through sponsorship of community events, visitation to local bars and sites where groups of people gather, and coordinating outreach efforts and activities with drug and alcohol and HIV prevention programs.

The following summarizes numbers and types of individuals reached by the project:

TOTAL CONTACTS	**1,445 (Duplicated & Unduplicated; One-on-One Contacts)**
Female	451 (31.2%)
Male	987 (68.3%)
Missing	7 (.5%)
7 –13 years old	16 (1%)
14-19 years old	350 (24%)
20-29 years old	647 (46%)
30-39 years old	241 (17%)
40 and over	179 (12%)
African American	1,169 (81%)
Latino/a	87 (6%)
White	129 (9%)
Other/Missing	60 (4%)
Risk Behaviors: Note—Not all contacts report risk behavior, and those who do may report more than one risk behavior:	
Heterosexual Unprotected Sex	1,382
Sexual Partner of Injection Drug User	64
Sex for Drugs	202
Drug Abuse/Alcohol Abuse	947
Injection Drug Use	57
MSM	8

Community Leadership Development: Community Leadership Development (CLD) groups began in 1995 to target men who have sex with men and racial/ethnic minorities. A major focus of the groups' activities is to promote HIV antibody testing and counseling in gay and racial/ethnic minority populations, provide interventions, and increase local capacity. In 1998, Community Leadership Development groups continue to operate six CLD groups in four communities (Erie, Pittsburgh, Williamsport, and York).

CLDs focusing on men who have sex with men currently meet in Wiliamsport, Erie, and Pittsburgh, and all four communities focus on racial/ethnic minority outreach. Outreach activities have evolved from local meetings, including community gay bar outreach; participation in community information events; presentations on positive approaches to implementing safe sex practices and promoting counseling and testing; and establishment of saving stations to distribute condoms and prevention brochures. A summary and full roster of activities in these communities are available in report form from the University of Pittsburgh and the Pennsylvania Department of Health.

The Bureau of Communicable Disease: initiated two-year contracts in July 1998 with eight of the nine independent county/municipal health departments. Such contracts stipulate that each contractor develop HIV educational programs and HIV risk-reduction activities specifically for Latino(a)s and African-Americans. In addition, contractors are required to develop and/or update their current efforts with injection drug users and their partners and carry out one or more of the following activities: CTRPN in drug treatment centers, street and community outreach, risk-reduction, community level intervention, and HIV prevention case management.

The Division of HIV/AIDS: continues to operate the HIV and Substance Abuse Training Project. Between July 1997 and June 1998, seventy-six training events were delivered on-site to approximately 1,664 individuals. A course on HIV Prevention Counseling and Harm Reduction was added this year.

The Division of HIV/AIDS has developed and is currently piloting prevention/education standards for all Division-funded HIV prevention programs in the state. These standards were developed in concert with the HIV Prevention Community Planning Committee, the Integrated HIV Planning Council composed of the Ryan White HIV/AIDS Regional Planning Coalitons, and the University of Pittsburgh. Among the standards are requirements that educators and outreach workers are representative of the populations they serve.

HIV Prevention Planning Capacity Building Activities

Young Adult Roundtables: In 1995, four diverse groups of youth at risk of HIV infection were founded to assist in Pennsylvania's needs assessment process. Two additional groups were added in 1996, and another two were added in 1997 based on formative and process evaluation data obtained from the Planning Committee and the Roundtable Executive Committee (see explanation below). The Roundtable Executive Committee and University of Pittsburgh staff terminated one of the original Roundtables in 1998 due to poor attendance. The remaining seven groups, listed below, continue to operate in 1998.

Roundtable location	Year convened	Composition
Allentown	1995	Latino/a and African-American
Erie	1995	Young people of mixed race/ethnicity, although predominantly African-American
York	1995	Teen mothers (mixed race/ethnicity)
Pittsburgh	1995	Gay/lesbian/bisexual youth (mixed race/ethnicity)
Norristown	1996	Gay/lesbian/bisexual youth (mixed race/ethnicity)
Wilkes-Barre	1997	Rural gay/lesbian/bisexual youth
Williamsport	1997	Young people of mixed race/ethnicity, although predominantly African-American

Since their inception, the Roundtables have evolved in purpose to assist not only in the ongoing statewide HIV prevention needs assessment, but also in the development of interventions targeting young people and in the facilitation of youth participation in the community planning process. This past year, the Roundtables sponsored a statewide youth summit attended by about 80 young people from all regions of Pennsylvania. Resulting from this summit was a Youth Consensus Statement discussing prevention needs of youth and barriers to prevention, as well as recommendations for statewide HIV prevention planning

(provided in the Appendix). The Planning Committee accepted this Consensus Statement and implemented elements from the statement in prevention planning.

University of Pittsburgh staff, with the guidance and support of the Division and the Committee, will have coordinated and facilitated six meetings of each Roundtable by the end of 1998. Each Roundtable is attended by at least one Committee member mentor who serves as liaison between the Planning Committee and the Roundtable and mentor to the young adults. The Roundtable Executive Committee, comprised of two elected Representatives from each group, elects three Co-chairs from among the group who then serve as full Committee members. Three alternate Co-chairs are also elected to replace the Co-chairs if necessary. The Roundtable Executive Committee Co-chairs convene regularly for teleconferences and the entire Executive Committee attends two meetings in Harrisburg (in conjunction with Committee meetings) each year.

"I'm a new member I joined to make me more aware of AIDS/HIV and for my daughter and unborn child."
Roundtable participant

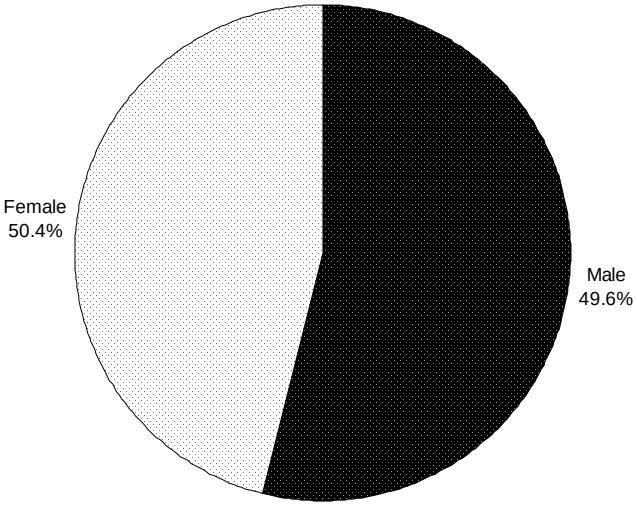
1997 Roundtable goals emerged from formative and process evaluation data obtained from: (1) questionnaires completed by each Roundtable participant at initial meetings this year, (2) surveys of the Roundtable Executive Committee and statewide Planning Committee members, and (3) planned discussions and feedback sessions at Executive Committee meetings and Roundtable meetings. Evaluations showed a high level of satisfaction with implementation and effectiveness of Roundtables, a high level of commitment of Roundtable members, and a belief among these members that their voices were represented in the statewide prevention planning process.

The following goals were established for 1998 Roundtables:

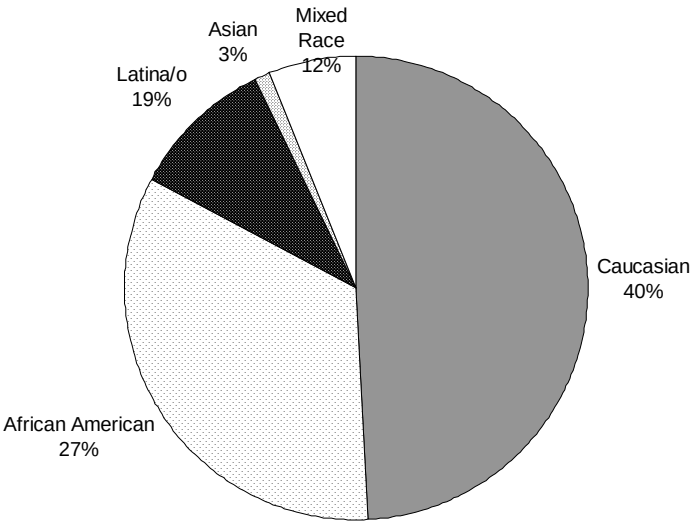
- continue HIV/AIDS education
- provide data for state-wide needs assessment
- increase communication between Roundtable groups
- provide opportunities for peer-education training
- interface Roundtables with local AIDS prevention activities
- increase Planning Committee's awareness of diversity among Roundtable members
- transfer greater control of Roundtable organization to young people
- identify and evaluate HIV prevention materials
- address directives from Roundtable members
- address directives from Planning Committee and Division
- coordinate a statewide Youth Summit in March
- develop a Youth Consensus Statement
- increase Latino membership in the project to at least 15%

Currently, 119 young people participate in the seven Roundtables. Participants range in age from 12 to 29 with a median age of 17. The following demographic data were collected from anonymous questionnaires completed by Roundtable participants at this year's initial meetings.

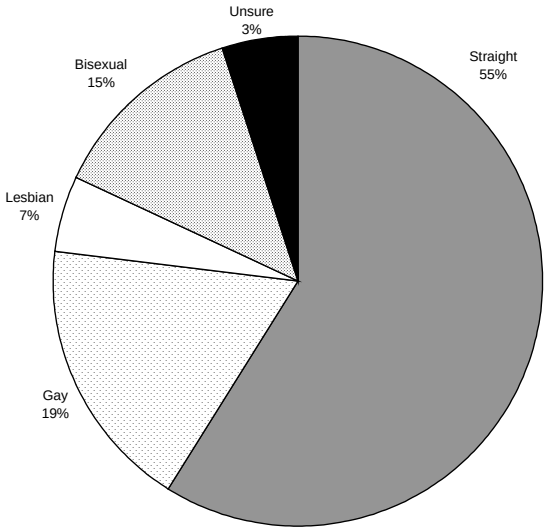
Pennsylvania Young Adult Roundtable Participants
by Sex



Pennsylvania Young Adult Roundtable Participants
by Race/Ethnicity



Pennsylvania Youth Roundtable Participants
by Sexual Orientation



One of the highlights of Roundtable activities in 1998, as stated above, was the first Young Adult Summit Roundtable in Harrisburg on March 13th and 14th, as well as the resulting Consensus Statement. Also in 1998, five Roundtable members completed the Red Cross AIDS education program which qualifies them as peer educators.

"…I just want all of you to know that I respect you tremendously for what you've gone through,…and your commitment to trying to stop the spread of this terrible disease."

"…and I also hope, in the future, a lot more people will be able to say that they don't have a personal story having to do with AIDS. An I think if we start action, a lot more people will be able to do that."

Roundtable participants

Semi-annually, *Roundtable News* is distributed to all Roundtable, Division of HIV/AIDS and Planning Committee members. This publication, with articles written by Roundtable members, helps to increase awareness of activities and goals of each of the Roundtables.

The Pennsylvania Young Adult Roundtable Web Site went on-line as planned in March 1998. The web site concept emerged as Roundtable Representatives voiced a need for on-line communication across the state. Prior to the web site's debut, three young Roundtable participants met with the University of Pittsburgh staff to discuss and design the Web page. This site provides both open and closed access areas, thereby enabling communication exclusively among Roundtable members and with other young people on the Internet who are not Roundtable participants.

The Roundtables empower young people by providing them with a voice in Pennsylvania's HIV prevention planning process. The groups also provide a forum for young people to discuss life issues pertinent to HIV prevention.

The Mentoring Project: This project was initiated in June 1996 as the "African-American Male Mentoring Project," describing the population it then reached. Although the initiative has been made available to a more widely defined population of young people, as described below, the project has always been implemented to assist young adults to adopt behaviors that reduce the risk of HIV infection. It is a structured program that has been reviewed and approved by both the CDC and Pennsylvania Department of Health. In 1996, seven mentors from across the state were trained in a curriculum entitled, *Be Proud, Be Responsible!,* developed by faculty at the University of Pennsylvania. This curriculum trains individuals to serve as mentors of young people to provide the latter with knowledge, motivation, and the skills necessary to change behaviors in ways that will reduce the risk of contracting HIV and other sexually transmitted diseases.

The Mentoring Project is based on a theory of health behavior change that draws on a larger body of community-change theory. This theory stipulates that effective and lasting changes in health behaviors are related to community-wide buy-in and involvement in change processes. As such, leaders who are indigenous to communities and who have positive relationships with both community groups and individuals—especially with those targeted by a behavior-change initiative—are the best persons to present programs. In this case, community leaders knowledgeable and in good standing with community AIDS service organizations (ASO's) and other related agencies, and who are also respected by adolescents targeted by the Mentoring Project as well as their parents, make the best Mentors.

In accordance with this theoretical framework, Mentors have been recruited in their communities at the recommendation of leaders of ASOs and related agencies and have, in turn, recruited participants for the Project workshops using their own community contacts, such as administrators and staff of community-based organizations serving adolescents, churches, and other community leaders. Once a list of names of potential participants is derived by each mentor, the Mentor contacts these individuals and their parents/guardians by phone or in person.

At the project's onset, mentors were trained over two and a half days in Philadelphia, and each year thereafter, they have received (and will continue to receive) an annual "refresher" training at designated sites in the state. Since the initiation of the program, the Mentors have determined that the curriculum should address HIV prevention of all youth, not just African-Americans. Therefore, in the Project's second iteration between January and December 1997,

youth recruited for the project included 75% males and 87% African-Americans (8% Latinos/as, and 5% Caucasians). In the current year, the population of participants will be even more diverse, and, for the first time, will include implementation of pre-, post-, and post-post tests of curriculum and sessions. This year, five mentors will each conduct five groups within their communities. With 8 to 12 adolescent participants per group, a maximum of 240 participants are expected to be enrolled.

Community-Wide Planning Groups: Having gained a significant amount of expertise in the development and implementation of a statewide HIV prevention plan, Committee members agreed that this expertise should be offered to local communities. By developing a local HIV prevention plan, communities could be better prepared to compete for funding of prevention initiatives. In 1997, the eight communities that participated in the Community Leadership Development initiative (discussed previously) were offered the opportunity to participate in a Community-Wide Planning Initiative. University of Pittsburgh staff provided technical assistance to local groups and aided in the development of a community HIV prevention plan, which could then be used to support particular funding priorities.

Two communities, Erie and Williamsport, have developed active planning groups and hope to have developed community plans including epidemiological profiles, community needs assessments, and prevention program priorities, by the end of the year. Each group has approximately 25 members and has met five times. Groups in York and the Lehigh Valley have met, however they have been somewhat slower in their development process. The remaining communities have chosen not to participate in this initiative.

University of Pittsburgh staff has provided the groups participating in the Community-Wide Planning initiative with initial facilitation of meetings and advice in the development of epidemiological profiles and needs assessment. Further, as funding sources are identified, Pitt staff is available to assist these groups in the development of grant proposals.

The success of these community efforts is attested to by the following accomplishments: (1) The Erie Community-Wide Planning Group received funds from the Northwest Rural AIDS Alliance for a street outreach program targeting Lationo(a)s, African-American males/females, and youth and young adults at risk for HIV infection; (2) the York Community-Wide Planning Group received funds from the South Central AIDS Planning Coalition targeting economically disadvantaged minority women between the ages of 9 and 13. Erie and York groups both had extensive technical assistance and support from the University of Pittsburgh staff.

Public Information Activities: The Division of HIIV/AIDS engages in many public information activities that support Health Education and Risk Reduction programs. One such activity is the toll free AIDS Factline, which provides bilingual and TTY HIV/AIDS information and referral statewide. Also available is the World Wide Web site operated by the University of Pittsburgh (http://www.stophiv.com). Information available at the web site, in part, includes eligibility criteria and an application for Pennsylvania's AIDS Drug Assistance Program (ADAP), The Special Pharmaceutical Benefits Program (SPBP); the Comprehensive HIV Prevention Community Plan; and a youth and young adult site. Most recently an electronic bulletin board for AIDS case managers in Pennsylvania went on-line free to verified users. The AIDS Community Alliance and the University of Pittsburgh consultants have been awarded a grant from the National Library of Medicine to distribute free computers to AIDS service organizations, in order to improve access to HIV/AIDS- related information via the Internet. This technology integration will enable case managers and prevention specialists to have greater access to information resources by way to the Internet, thus, increasing the quality of advanced care and prevention being offered to their

clients. A strong link between primary and secondary HIV prevention has been forged as the Pennsylvania Prevention Project has collaborated with the Pennsylvania AIDS Education and Training Center to provide internet access between HIV/IAIDS primary care providers in Pennsylvania and University of Pittsburgh and University of Pittsburgh Medical Center researchers and clinicians.

The Division of HIV/AIDS maintains a system that trains drug and alcohol treatment counselors on HIV/AIDS issues. The Division has also produced Human Immunodeficiency Virus (HIV) Guidelines for Drug and Alcohol Abuse Treatment Programs. Updated in 1996, this is a comprehensive manual on HIV related issues for drug and alcohol treatment providers statewide. The Bureau of Drug and Alcohol Programs licensing of drug and alcohol prevention and treatment providers requires six hours of training on HIV for drug and alcohol treatment staff. The independent drug and alcohol certification process requires HIV/AIDS education as part of its basic certification process of drug and alcohol counselors. The state HIV/AIDS Factline maintains an updated list of drug and alcohol treatment resources. In addition, the Bureau of Drug and Alcohol Programs encourages all Drug and Alcohol Single County Authorities to become involved with their respective Ryan White HIV/AIDS Regional Planning Coalitions and the Bureau has appointed a liaison to the HIV Prevention Community Planning Committee.

Field staff of the Division of HIV/AIDS deliver education programs in the county and municipal jails. In general, the program consists of two tracks, one track for inmates and one track for staff. The staff track provides instruction on basic HIV transmission, prevention and universal precautions. The inmate track provides a modified version of the HIV pre-test protocols which Division staff use in their regular HIV antibody testing and counseling duties. In addition, the Governor has mandated basic HIV education for all state employees under his jurisdiction. Such education consists of basic AIDS education provided by the American Red Cross for most employees. Advanced HIV/AIDS education is provided by the Pennsylvania AIDS Education and Training Center. Such advanced HIV/AIDS training has been provided to the staffs of the state correctional institutions of the Pennsylvania Bureau of Corrections, state hospitals, and children, families, and youth facilities and public assistance staff of the Pennsylvania Department of Public Welfare.

Other Activities to Enhance HIV Prevention Community Planning

Community Needs Assessment: A full summary of all needs assessment activities is described in the evaluation section of this Plan. To enhance and inform the needs assessment data, Pennsylvania Department of Health's epidemiologists and University of Pittsburgh staff develop an annual epidemiological profile (described in detail later).

Summary of evaluation activities conducted between July 1, 1997 and June 30, 1998:

Community Planning Process Evaluation: Evaluation methods included small-group, guided discussions consisting of Committee members, and an anonymous written survey. Highlights from the findings include members' appreciation of Sub-Committees work between Committee meetings and recommendations for future Sub-Committee use and planning; recommendations for future needs assessments and collection of data leading to an epidemiological profile; satisfaction with current diversity represented on the Committee and suggestions for continued ethnic minority representation and future Asian-American representation and inclusion of "representative voices" for populations which are not able to provide actual Committee members, e.g., homeless and prisoners; satisfaction with linkages

between the Plan and CDC Application for funding, and suggestions for continued linkages with Ryan White Coalitions and use of technical assistance fostering linkages; and high marks for the planning process itself, with suggestions for methods of ensuring that members' personal or agency agendas are kept in check during planning.

Evaluations of Community-Based Health Education/Risk Reduction Programs: *Process monitoring and process evaluations* have occurred as part of all community-based initiatives, including the two outreach demonstration projects, statewide community leadership development outreach, and the statewide young adult mentoring project. Process monitoring occurred through regular contact (informal, scheduled phone, and face-to-face contact) between project staff and respective PPP staff responsible for coordinating the project. *Process evaluations* involved structured interviews with staff and, when appropriate, clients of the various projects. The mentoring project also incorporated a survey involving participant satisfaction and feedback. Broad findings across all projects include high satisfaction of staff and targeted participants at each of the project sites in the implementation of projects and support from PPP staff and the Department of Health. Respondents believed that respective methods for delivering interventions were adequate and able to be implemented. Barriers typically included community resistance to HIV prevention and, in one case, agency issues which impeded sustained implementation of project activities and goals. A very obvious lesson learned was the need for more systematic attention to and support for individual project staff who (with the exception of demonstration outreach projects) very often participated in projects in addition to regular jobs and other community participation.

Outcome monitoring of each project's objectives also occurred through regular statistical and qualitative reporting on standardized forms submitted to the responsible PPP staff. Data were processed, analyzed, aggregated, and reported to the Department of Health and Prevention Committee on a periodic basis. Findings include numbers and types of contacts outreach staff made in specific neighborhoods, high drug and sex trafficking areas, bars, and other places where people at-risk of HIV congregate. Data also describe outreach staff, who, at both sites, included men and women, African Americans and Latinos/as, and young adults who lived in the targeted communities and reflected the characteristics of the women and men whom they reached.

Additionally, *outcome evaluation* has been implemented involving participants of the Young Adult Mentoring project. A pre- and post-test survey has been developed which includes a section on HIV/AIDS prevention knowledge and attitudes. The survey is given at the beginning and end of the mentoring intervention to test baseline knowledge and attitudes and change in these areas over the course of the project. Findings showed that, while participants typically had basic knowledge of HIV/AIDS at the beginning of the project (e.g., definitions of HIV/AIDS and general information on how HIV is and is not transmitted), they typically did not have specific information about prevention (e.g., the proper use of condoms for lessening risk, ways of negotiating sexual behavior). Post-intervention surveys gave evidence of increased knowledge about HIV/AIDS and, especially, prevention; changes in participants' attitudes regarding the need for risk reduction; and increased confidence in participants' own abilities to implement risk-reduction behaviors.

Evaluation of Prevention Planning Capacity-Building Activities:
Young Adult Roundtables: Process and formative evaluation activities consisted of annual surveys of Roundtable Executive Committee members and statewide Planning Committee members, as well as planned discussion and feedback sessions regarding the achievement of

project goals, objectives, and activities. Highlights of findings include a high level of satisfaction with implementation and effectiveness of Roundtables, a high level of commitment of Roundtable members, and a belief among these members that their voices were represented in the statewide prevention planning process.

Community Wide Planning Groups: Systematic process and outcome monitoring occurred of all Community-Wide Planning Groups using standardized attendance records submitted by each planning group (including demographic information about attendees); the presence of PPP staff at all meetings, as well as submission of minutes of all planning meetings to PPP staff; and regular PPP staff processing of meeting occurrences and meeting minutes and appropriate follow-up with respective planning groups to make certain that each group remained on track for meeting established goals and objectives.

Evaluation of Public Information Programs: The Internet Project facilitates the dissemination of accurate, state-of-the-art HIV prevention and education information to people at risk of HIV infection. The Internet Project maintains an on-line statewide HIV/AIDS service provider's resource directory, treatment and prevention information, and forms that can be downloaded from both the Departments of Public Welfare and Health. Evaluation of the Internet Project primarily consists of monitoring usage and occasional on-line anonymous satisfaction questionnaires.

Prevention Plan Evaluation: The HIV Prevention Community Planning Committee annually reviews the attainment of goals and objectives within the program areas of counseling, testing, referral, and partner notification; heath education/risk reduction/pubic information, and HIV prevention capacity building activities of the Comprehensive HIV Prevention Plan. In addition, the varied Sub-Committees of the Committee are directly involved in the creation and monitoring of many of the goals and objectives of the Plan.

Counseling and Testing Site (CTS) Client Satisfaction Survey: A client satisfaction survey was implemented at 50 randomly selected, publicly funded counseling and testing sites. A total of 1,800 clients completed surveys focusing on their satisfaction with counselors and services after prevention counseling. A second survey will be implemented in 1999, as discussed below. Although results of the survey indicated overall satisfaction with the services provided, nearly all respondents were white and survey forms were not available in Spanish. The next survey will over-sample minorities and make sure the survey form is available in Spanish.

Adolescent HIV Prevention Guidelines: University of Pittsburgh staff, with Division and Committee assistance have developed a set of guidelines to assist those seeking to conduct HIV prevention activities to adolescents. The guidelines are provided in a published brochure.

Prevention Program Standards: Ryan White HIV/AIDS Regional Planning Coalitions have been active in developing HIV/AIDS care and services, education, and prevention standards for Pennsylvania. In 1997, they requested the Committee to review education standards and assist in the development of prevention program standards. Committee recommendations in this regard have been forwarded to the HIV/AIDS Ryan White Regional Planning Coalitions.

PART TWO
EPIDEMIOLOGICAL PROFILE

SUMMARY:

- Numbers of cumulative cases of AIDS (prevalence) are highest for Men Who Have Sex with Men (MSMs) and Whites.
- Percentage increases of cases of AIDS (incidence) are greatest among African Americans and Latino(a)s, and among women in general. In Counseling and Testing data, racial/ethnic minorities show higher rates of HIV infection; and in a survey of HIV seroprevalence in Pennsylvania childbearing women, racial/ethnic minority women show higher rates of HIV infection.
- AIDS surveillance data and Counseling and Testing data both support high numbers of HIV transmission through MSM, with increasing significance of Injection Drug Use (IDU), IDU/MSM, and heterosexual contact as modes of transmission.
- Pennsylvania has one of the highest numbers of reported cases of pediatric AIDS in the U.S., and relatively high numbers even when Philadelphia cases are excluded.
- Twenty percent of persons living with AIDS in Pennsylvania are between 13 and 29; moreover, sexually transmitted disease (STD) and pregnancy data show that young people have the highest incidence rates, indicating higher incidence of high-risk behaviors which are also associated with HIV transmission; and national data show that an inordinate number of new infections of HIV are among adolescents and young adults.

HIGHLIGHTS

Pennsylvania remains a state that does not require reporting of HIV infections, limiting the Committee's ability to conduct planning based on extensive HIV incidence data. In past years, the epidemiological profile for the Plan was derived from reported AIDS cases in defined populations, HIV seroprevalence from various surveys of selected populations (childbearing women and the population receiving publicly funded HIV counseling and testing), and HIV-related mortality data. This year's Plan continues to draw on these data, but also incorporates statewide statistics on STDs and pregnancies; these sources provide surrogate information about populations participating in risk behaviors which are also associated with HIV transmission. Moreover, estimated HIV incidence rates are incorporated in this year's epidemiological profile, based on CDC-recommended methods for making such calculations. In spite of this large body of data, cases of AIDS and HIV are likely under-reported among various populations, primarily because of lack of data collection among, and isolation of, these populations. Therefore, this year's Plan incorporates a section on "best thinking" concerning what we know about these populations, as well ways we might gather information concerning them in the future.

The Prevention Committee has developed recommendations and a consensus statement for Commonwealth officials to consider concerning HIV reportability from the standpoint of the need for better data for planning, while preserving confidentiality of individuals who test seropositive for HIV. In the 1999 planning cycle, the Committee will also benefit from a newly formed expert panel which will study, recommend, and assist the Committee in reaching concensus about further data collection. Such a process will help ensure the Committee's ability to draw an epidemiological profile based on the best available data and methods of analysis.

BACKGROUND

The Bureau of Communicable Diseases, Division of HIV/AIDS (Division) and the Pennsylvania HIV Prevention Community Planning Committee (Committee) are committed to the idea that the most programmatically effective and cost-efficient HIV Prevention Plan requires activities focusing on populations truly at risk of HIV infection. Therefore, the epidemiological profile provided in this section offers some understanding of the factors associated with risk across the state, including race, ethnicity, sexual orientation, sex/gender, age, and place of residence.

The Pennsylvania Department of Health, Bureau of Epidemiology, compiles and provides quarterly updates of HIV/AIDS statistics for Pennsylvania. These data, as well as those from other sources, were used to draw the epidemiological profile of HIV/AIDS in the state. Such a profile is useful for HIV primary and secondary prevention planning.

Sources for epidemiological data include:

- Reported AIDS cases in defined populations.
- HIV seroprevalence data stemming from Pennsylvania's findings from the HIV Seroprevalence Survey in Pennsylvania Childbearing Women and from publicly funded HIV counseling and testing sites (CTS).
- HIV-related mortality data.
- Estimated HIV prevalence (using reported AIDS cases in Pennsylvania and the U.S. and national estimates of HIV prevalence to extrapolate statewide HIV prevalence; and using Pennsylvania data from the survey of childbearing women along with AIDS surveillance and Census data to estimate HIV prevalence in the state).
- STD and pregnancy data, providing information about populations participating in risk behaviors also associated with HIV transmission.

Sources described in the last two bullets were newly introduced in this year's planning process. Other sources of information—namely, reported HIV-infection cases, projected AIDS and HIV cases by population, and HIV risk behavior surveys were not available for developing this profile. They were unavailable simply because these data are not collected or, when they are collected, they are not done so in a uniform, integrated, and/or timely manner. As stated in the Highlights on the cover of this section, plans for examining, encouraging the use of, and implementing other data sources have been established for the 1999 planning cycle. Part of this process will involve consideration of ways of examining incidence and prevalence of HIV/AIDS among populations for which such information is likely under-reported. To this end, this epidemiological profile ends with reflection on such populations.

Data sources provide a useful picture of the nature and spread of HIV and AIDS in Pennsylvania. With the information provided by these sources, especially by AIDS case reporting, we know:

- The routes of transmission of HIV
- The behaviors related to infection

- The demographic, social, cultural, and geographic characteristics of those most at risk

What remains unknown is the speed at which the virus is being transmitted. However, sufficient information exists for sound judgments about whom to target with prevention efforts.

Organization of the Profile: Rather than organizing information by data sources as in past Plans, data is organized by three large categories which the Committee found to be useful for the eventual prioritization process. These categories are:

- Overview of HIV/AIDS in Pennsylvania (using the CDC's and the state's AIDS surveillance data, estimates of HIV prevalence, and HIV-related mortality data).
- Modes of Transmission (using reported cases of AIDS in defined populations and CTS data).
- Demographic Groups (using the state's AIDS surveillance data; Pennsylvania statistics from the HIV Seroprevalence Survey in Pennsylvania Childbearing Women; and statewide STD, pregnancy, HIV-related mortality, and CTS data).

OVERVIEW OF HIV/AIDS IN PENNSYLVANIA

Summary

Pennsylvania AIDS surveillance data show that:

- ***The highest numbers of AIDS cases among adults continue to be in regions with the largest metropolitan areas, but the highest percentage increase of newly reported cases typically occurs in more rural regions.***
- ***The highest number of pediatric AIDS cases is in the Southcentral region, followed by regions with larger metropolitan areas.***

Estimates of HIV prevalence show that the prevalence of HIV infection in the state is between 22,500 and 30,000, or about 19,000 excluding Philadelphia (4,500 women and 14,500 men).

Pennsylvania mortality data show that:

- ***For the first time since 1987, the ranking of HIV as a leading cause of death among Pennsylvanians increased from the previous year (meaning it is not as high a cause as the previous year); and similar to U.S. statistics, the rate of HIV-related deaths decreased.***

The section below provides detail on these data and methods by which they were compiled.

The CDC's AIDS surveillance data show that Pennsylvania, with 19,323 cases of AIDS reported through December 1997, had the 8th largest number of cumulative cases of AIDS among all U.S. states and territories. Further, Pennsylvania has a high number of newly reported cases of AIDS: in 1997, the Commonwealth had the 7th highest number among males over 12 years of age (1,437), and the 8th highest among females over 12 (443). In terms of rates of newly reported infections per population of 100,000 in 1997, Pennsylvania ranked 17th for males over 12 (30.4 per 100,000), and 18th for females over 12 (8.5 per 100,000). Of all U.S. states and territories, Pennsylvania, had the 4th largest number of newly reported cases of AIDS (n=32) among individuals 12 and under.

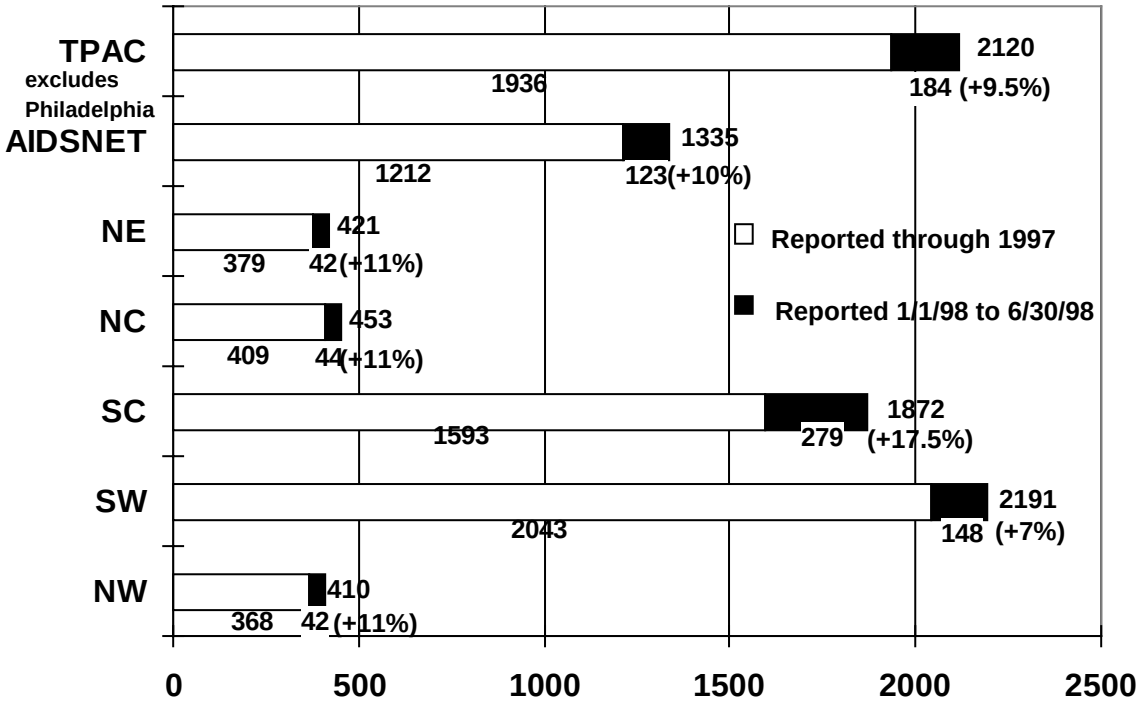
Reported AIDS Cases in Defined Populations: AIDS surveillance data are provided by the Pennsylvania Department of Health's Bureau of Epidemiology for the period January 1, 1987 to June 30, 1998. For this Plan, analysis begins with 1987 data because significant changes were made in the list of medical conditions which could be attributed to HIV infection; therefore, for the sake of consistency regarding AIDS-defining characteristics, we chose to begin with 1987 data. Using a June 30th cut-off date each year, we have been able to compare annual data for updates and planning purposes.

Also unless noted, data pertaining to Philadelphia are *excluded* from these analyses since Philadelphia maintains its own separate HIV prevention planning process because of the large number of cases of HIV infection and AIDS in this city and county.

Note that 1997, 1998, and in some instances, 1995 and 1996 cases were not completely reported at the time data were compiled because of lag-time involved in physician and hospital reporting; 1995 and 1996 data, however, are more complete than information for 1997, and 1997's is more complete than 1998's data.

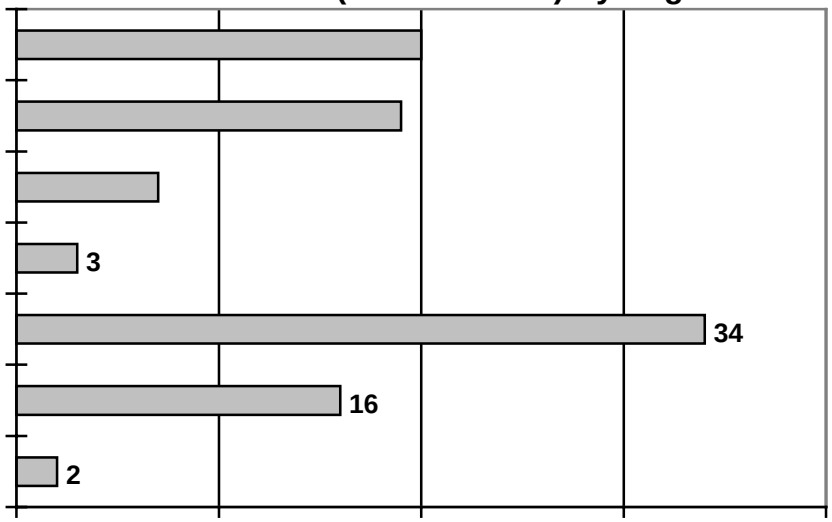
A regional analysis of AIDS surveillance data shows that the highest numbers of AIDS cases among adults continue to be in regions with the largest metropolitan areas [The Philadelphia AIDS Coalition (TPAC) excluding Philadelphia, Southwest Pennsylvania (SW), and AIDSNET]. However, the highest percentage increases of newly reported cases have *typically* occurred in more rural regions [northeast (NE), northcentral (NC), and northwest (NW) Pennsylvania. The southcentral (SC) region, which had the highest annual percentage increase (17.5%), is a wide area of both mid-size cities (e.g., Harrisburg, Lancaster, and York), as well as large expanses of rural areas. Figure O-1 below shows these numbers and increases.

FIGURE O-1:
Adult AIDS Cases (1987-1998) By Region



The largest number of pediatric AIDS cases occurred in the southcentral region, followed by regions with larger metropolitan areas, as shown below.

FIGURE O-2:
Pediatric AIDS Cases (1/1/87-6/30/98) By Region



Estimates of HIV Prevalence: The CDC recommends the use of two formulas to determine HIV prevalence in the states which do not require HIV reportability. These estimates are based on (1) extrapolation of HIV prevalence in the state based on national estimates of HIV prevalence provided by the CDC, and (2) extrapolation of data from the HIV Seroprevalence Survey In Pennsylvania Childbearing Women.

- Estimates of HIV prevalence in Pennsylvania based on national estimates takes the percent of reported AIDS cases in the Commonwealth relative to reported cases nationally (3% in 1997) and multiplies this percentage by national estimates of HIV prevalence (between 750,000 to 1 million people in 1997). Using this formula, the **Estimated Prevalence of HIV infection in Pennsylvania is 22,500 to 30,000 individuals.** This includes Philadelphia.

- Using the Childbearing Women survey data, which is information about actual HIV incidence among Pennsylvanian women between ages 15 and 44 who gave birth to infants between January and June 1997, estimates of HIV prevalence can be made for **all** Pennsylvania women between 15-44 (i.e., beyond only those who actually gave birth during the period of the survey). This was specifically done by multiplying the proportion of infected women in each age category (reported in the Childbearing Women survey) by the corresponding Census

population estimate for each age category. This calculation was done for Philadelphia women and for women in the rest of the state.

Further, by extrapolation, this information can be used to estimate prevalence of HIV infection among females younger than 15 and older than 44. This calculation was done by dividing the seroprevalence estimate of women of childbearing age by the proportion of all AIDS cases diagnosed in 1997 who were 15-44 years of age at the age of diagnosis. This was done for Philadelphia women and those in the rest of the state.

By taking into account an estimate of male:female ratio of HIV infections, which may be approximated from reported AIDS cases, a further extrapolation can be made for HIV prevalence among men. This was done for Philadelphia men and men in the rest of the state.

Combining estimates of HIV prevalence for men and women provides an overall estimate of HIV prevalence. Below are results of these calculations.

Figure O-3:
Estimate of HIV Prevalence Based on Pennsylvania Data from the HIV Seroprevalence Survey in Pennsylvania Childbearing Women

	PA excluding Philadelphia		
Estimated HIV infections in women	4,500		
Estimated HIV infections in men	14,500		
Estimated Total	19,000	Total Male and Female Estimate for Philadelphia = 8,000	Total State Estimate = 27,000*

* Note that the total estimated HIV infections using this approach falls in the middle of the range (22,500 to 30,000) derived by using the national-estimate method above.

State Mortality Data: HIV-related mortality data have been compiled and analyzed for the entire state, including Philadelphia. The last year for which analysis is complete is 1996. Data were gathered from death certificates required by the Pennsylvania Department of Health for all deaths occurring in the state. Immediate cause of death, antecedent conditions, the underlying cause of death, and any contributing conditions

are all recorded in each certificate. Other states in which Pennsylvania residents die provide the Health Department with information under the terms of cooperative agreements, permitting analysis of cause of death for all Pennsylvanians, regardless of where they died.

Since 1987, 11 different codes have been used to describe AIDS and HIV by the International Classification of Diseases--the system used to code death information in Pennsylvania. This code structure does not correspond exactly with the CDC's 1987 list of medical conditions that comprise an AIDS diagnosis. In addition, reporting among physicians is not consistent with respect to ways they describe underlying causes of death or antecedent conditions related to AIDS.

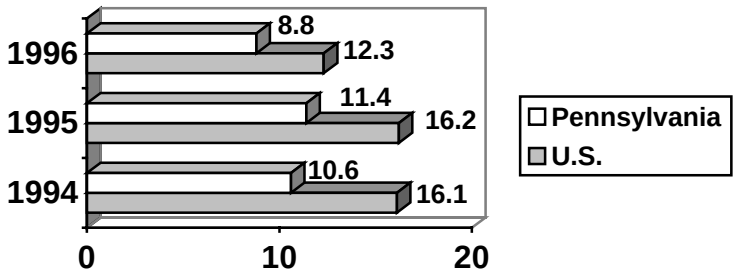
For the first time since 1987, the ranking of HIV as a leading cause of death among Pennsylvanians increased from the previous year (meaning it is not as prevalent a cause as the previous year). The table below shows the decrease in rank (or, increase in prevalence) of HIV infection as a cause of death between 1991 and 1995, as well as the increase in rank (or, decrease in prevalence) between 1995 and 1996.

FIGURE O-4:
Rank of HIV Infection as a Leading Cause of Death in Pennsylvania for Select Years (Including Philadelphia)

	Year			
	1991	**1993**	**1995**	**1996**
Rank	13th	12th	11th	12th

The rate of HIV-related deaths also decreased between 1995 and 1996, similar to the national trend regarding rates of HIV-related mortality. The table below depicts the state and U.S. rates for 1994 to 1996.

FIGURE 0-5
Rates of HIV-Related Mortality Per 100,000 Persons in the U.S. and Pennsylvania (Including Philadelphia), 1994-1996



In spite of the improvement in rank of HIV-related deaths for most age groups in Pennsylvania in 1996, the ranking did not change for 25-44 year olds; for this age group, HIV infection is still the 3rd leading cause of mortality, as discussed in more detail in the section on Demographic Groups.

MODES OF TRANSMISSION

Summary

It is useful to consider data regarding modes of transmission of HIV. Using this approach:

Pennsylvania AIDS surveillance data show that:

- ***The number of cumulative cases of AIDS is highest among MSMs and among Whites.***
- ***Incidence of new cases of AIDS is increasingly reported among African-Americans and Latinos/as and decreasingly reported among Whites. The largest increase of newly reported cases has occurred among African-Americans who have become infected through heterosexual contact and through IDU, and Latino IDUs who also have sex with men.***
- ***Among younger people (10-19 year olds) who are newly diagnosed with AIDS, mode of transmission is highest for heterosexual and MSM transmission; for older age groups, MSM and IDU are the most significant modes of transmission; however heterosexual transmission has increased in significance since last year for most age groups.***

Data from publicly funded CTS show that:

- ***The highest numbers of those testing positive for HIV are MSMs, with increasing significance of IDU/MSM, IDU, and heterosexual contact as modes of transmission.***

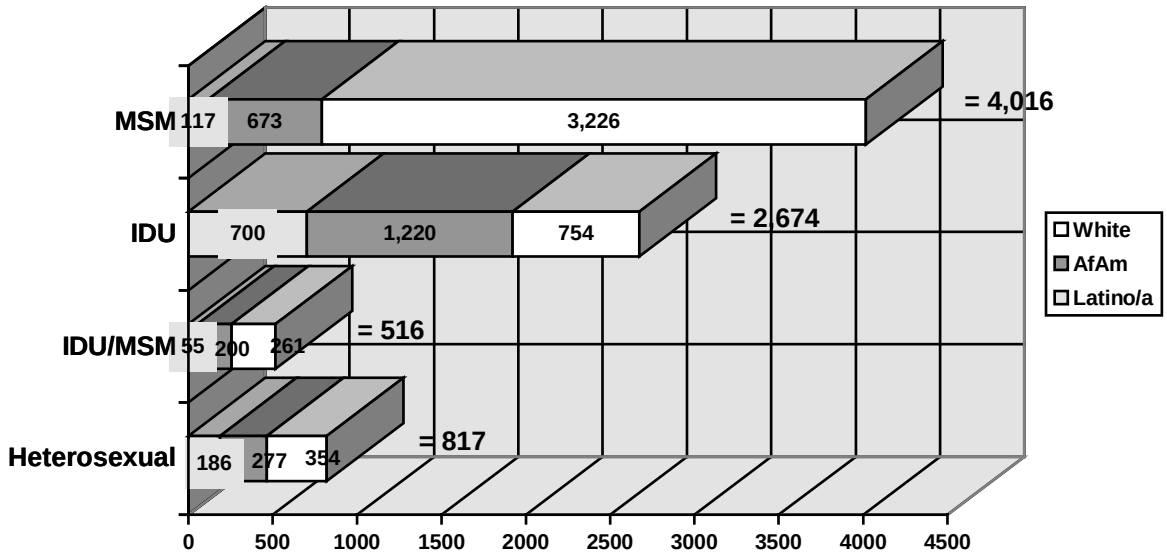
The section below provides detail on these data and methods by which they were compiled.

Reported AIDS Cases in Defined Populations: In AIDS surveillance data (excluding Philadelphia), the number of cumulative cases of AIDS reported between January 1, 1987 and June 30, 1998, is highest among MSMs (4,016 cases) and among Whites (4,595 cases), especially among White MSMs (3,226). Significant numbers of cumulative cases exist among IDUs (2,874) and African-Americans (2,370), especially among African-American IDUs (1,220).

Incidence of new cases of AIDS is increasingly reported among African-Americans and Latinos/as and decreasingly reported among Whites. The largest increases of newly reported cases have occurred among African-Americans who have become infected through heterosexual contact and through IDU, and Latino IDUs who also have sex with men.

The figures below summarize numbers of cumulative cases and percent increases of newly reported cases of AIDS by mode of transmission and race and ethnicity.

Figure M-1:
Adult AIDS Cases by Race/Ethnicity and Mode of Transmission 1987-1998 (Excludes Philadelphia)



IDU includes heterosexual injecting drug users.
IDU/MSM includes males who have sex with males and are injecting drug users.
Heterosexual contact includes persons with a heterosexual partner who is:

Infected with HIV,
A bisexual male,
An injecting drug user, or,
A person with hemophilia.

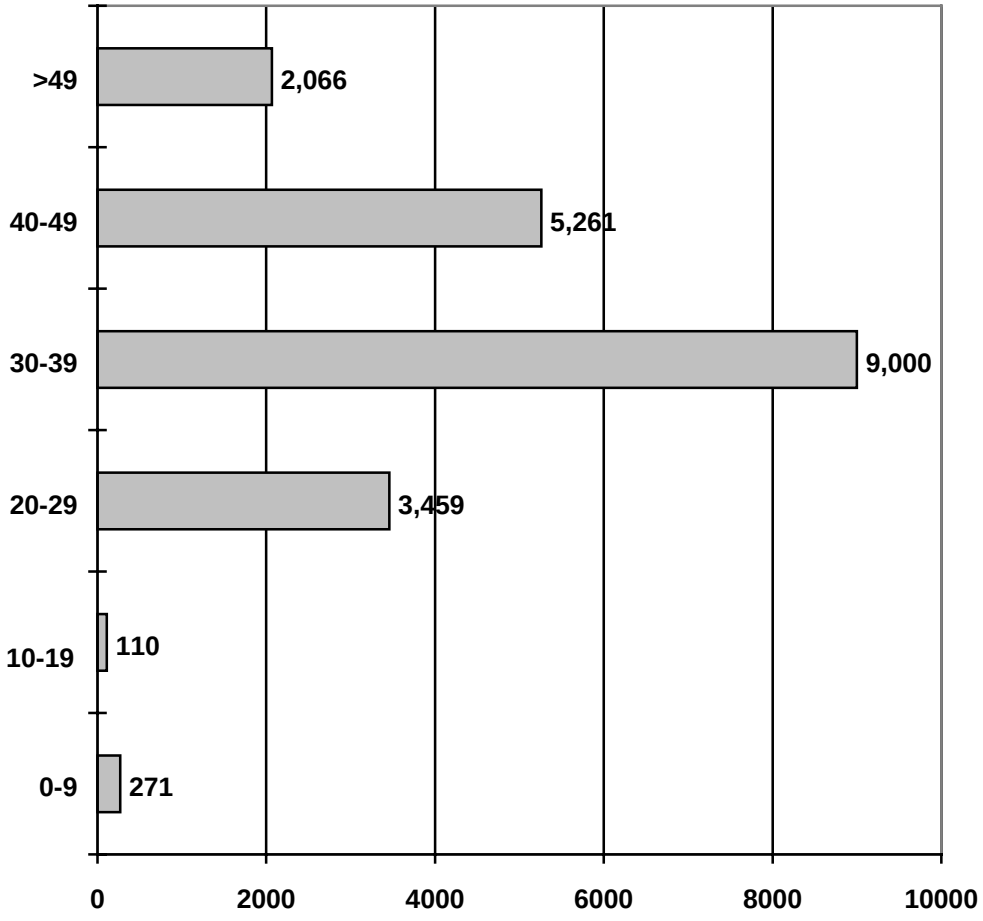
Figure M-2:
Percent Increase of Newly Reported Cases of AIDS Among Adults (>12 years) from 1997 to 1998 by Mode of Transmission and Race/Ethnicity (Excludes Philadelphia)

	All Race/ Ethnicity	Latino/a	African American	White
Heterosexual	**15%**	12%	**19%**	14%
IDU/MSM	9%	**17%**	14%	4%
IDU	**13%**	8%	**16%**	12%
MSM	8%	9%	12%	7%

Percentages in bold denote higher percentage increases.

The below data on age at the time of AIDS diagnosis takes into account both pediatric and adult cases of AIDS and is inclusive of Philadelphia. When considering age at the time of AIDS diagnosis, 30 to 39 year olds account for the largest number, followed by the 40 to 49 year olds and 20 to 29 year olds, respectively (depicted below). It must be remembered, however, that the incubation period between the time HIV infection occurs and a person develops AIDS can be up to 15 years; therefore, the majority of people were infected when they were much younger.

Figure M-3:
Age at Time of AIDS Diagnosis
1/1/80-6/30/98 (Includes Philadelphia)



Among younger persons (10-19 years old) who are newly diagnosed with AIDS, mode of transmission is highest for heterosexual and MSM transmission; for older age groups, MSM and IDU are the most significant modes of transmission; however heterosexual transmission has increased in significance since last year's analysis for most age groups. The table below shows these trends.

FIGURE M-4:
Diagnosed AIDS Cases
by Mode of Transmission and Age
1/1/80 to 6/30/98 (Including Philadelphia)

	MSM	MSM +IDU	IDU	Hetero -sexual	Peri-natal	Coagula-tion Dis.	Trans-fusion	Undeter-mined/ Other	Total
0-9	0%	0%	0%	0%	100%	0%	0%	0%	100 %
10-19	**19%**	3.5%	**12%**	**29%**	18%	13.5%	3%	2%	100 %
20-29	48%	7%	24%	**15%**	0%	2%	1%	3%	100 %
30-39	47%	7%	34%	**9%**	0%	1%	0%	2%	100 %
40-49	43%	5.5%	**40%**	**7.5%**	0%	1%	1%	2%	100 %
>49	47%	2%	24%	12%	0%	2%	7.5%	5.5%	100 %

Highlighted areas denote high percentages relative to the respective age group. Percentages in bold denote an increase in percentage from figures reported last year for the respective age category.

HIV Surveillance Data Reported By Counseling and Testing Sites (CTS): The HIV CTS system is a collection of computer programs and data files developed by the CDC for the collection, management, and analysis of data from CTS programs. The Pennsylvania HIV Counseling, Testing, Referral, and Partner Notification Program makes prevention (pre-test) and results (post-test) counseling and HIV testing available to individuals who are at-risk of infection. Efficient operation of the program requires offering testing at the locations and among the populations which are most severely affected by HIV infection.

The results of testing from publicly funded sites are reported to the Pennsylvania Department of Health along with data on age, sex, ethnicity, reason for testing, and risk behavior. No individual identifiers are reported. Since there is one record for each test, there is no effort to exclude multiple records for singular individuals. Currently in Pennsylvania, reports of HIV testing results are not required of sites which are not funded by the state program.

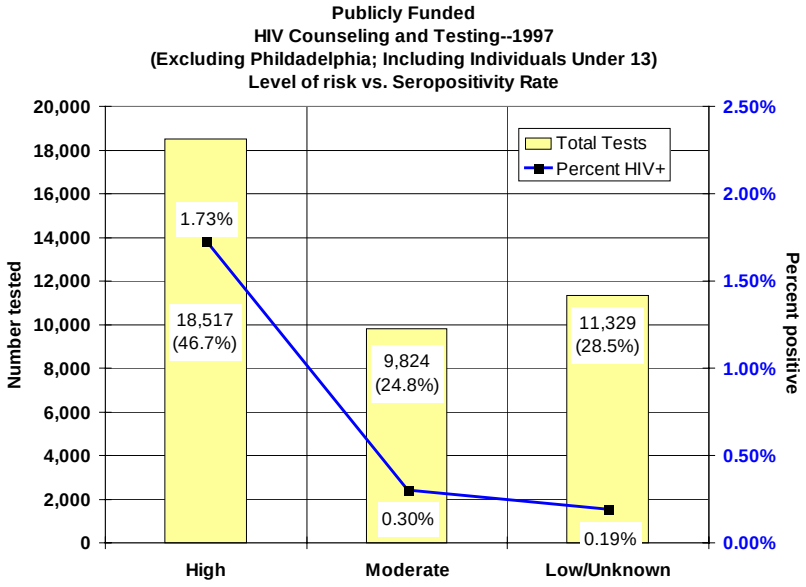
Those who are tested do not comprise a random sample of any particular population. A high number of HIV-positive results for any age, race, or risk-exposure group could indicate that infected individuals from that group are more likely to seek testing. It is possible that a rise in seroprevalence in a certain population may be undetectable by the CTS if that population is not motivated to seek testing.

Although caution must be used when employing CTS data as a basis for statements about HIV seroprevalence, there are advantages in using these data:

- Test sites are located throughout the state, allowing possible geographic comparisons
- The information obtained from each test allows comparisons with other sources of information
- Blood testing detects HIV well before a person develops AIDS, so tests may show a change in the HIV epidemic before the change is reflected in AIDS cases

Because of the limitations of CTS data, these data must be combined with information from other sources to derive a picture of the HIV epidemic.

This section is based on 39,670 tests performed in the state (excluding Philadelphia) at publicly funded test sites between January 1, and December 31, 1997, and reported to the Department of Health by the time of this analysis. The figure below is a graphic illustration of the level of risk, as reported by individuals being tested with reference to their perceived risk behavior, versus seropositivity rates for various risk levels. Those from highest risk categories have a higher rate of sero-positive test results.



HIGH:
MSM/IDU, MSM, Heterosexual IDU, Sex partner of person at risk, Child of woman with HIV/AIDS
MODERATE:
Hemophilia/Blood recipient, Healthcare exposure, STD, Sex for drugs/money, Sexual assault, Sex while using non-injection drugs
LOW/UNKNOWN:
No acknowledged risk, Other, Not specified

The table below gives test results by mode of transmission. The number and percent positive for each category depends, of course, on the number tested as well as the number testing positive. The number tested is affected by how many are at risk for HIV infection, awareness of risk, the availability of testing, and many other factors. Though related to HIV prevalence, the percent testing positive is not a valid indicator of prevalence in that population. The numbers testing positive in each category *may* be related to the seroprevalence in that population. Comparing these numbers will help show which populations are more severely affected by the epidemic.

Data support the fact that the largest numbers of those testing positive for HIV are MSMs, with increasing significance of IDU/MSM, IDU, and heterosexual contact as modes of transmission. The figure below illustrates these trends.

FIGURE M-6:
Publicly Funded HIV Counseling and Testing—1997
(Excluding Philadelphia; Including Individuals Under 13)
Reported Modes of Transmission, Number of Tests and Positive Tests and Percent Positive

Mode Transmission	No. of Tests	No. Positive	% Positive
MSM	3,668	**122**	**3.3%**
MSM/IDU	212	7	**3.3%**
IDU	3,678	**95**	**2.6%**
Sex Partner at Risk	10,932	**95**	.9%
Sex for Drugs/Money	286	3	1.0%
Sex while Using Drugs	5,018	15	.3%
STD Diagnosis	3,441	10	.3%
Hem/Blood Recipient	142	1	.7%
Victim of Sexual Assault	419	0	0
Health Care Exposure	518	0	0
Child of HIV+ Woman	27	1	**3.7%**
No Acknowledged Risk	1,441	5	.3%
Other	9,838	17	.2%
Not Specified	50	0	0
Total	**39,670**	**371**	**.93%**

Highlighted figures in bold denote largest numbers or percentages positive.

DEMOGRAPHIC GROUPS

Summary

It is also useful to approach data which focus on demographics of various populations in the state. Using this approach:

Pennsylvania AIDS Surveillance Data show:

- ***Numbers of newly reported AIDS cases (excluding Philadelphia) are much higher for men than for women, but the percentage increase of newly reported cases is greater for women and has been so for several years now.***
- ***New cases of AIDS are reported at an increasing number among racial/ethnic minorities and at a decreasing number among Whites (inclusive of Philadelphia and pediatrics); the highest number of new cases is among African Americans.***

Pennsylvania HIV Seroprevalence Data:

- ***Data from the HIV Seroprevalence Survey of Pennsylvania Childbearing Women (exclusive of Philadelphia) show that rates of HIV infection among childbearing women were highest for Latinas, followed by African-Americans, and has increased at a high rate for Latinas since the last survey. The highest rates of HIV seroprevalence among childbearing women were among Latina and African-American 25-29 year olds and African-Americans 35 and over.***
- ***Counseling and Testing data show that numbers of individuals testing sero-positive for HIV are much larger for men than for women. However, for 30 to 39 year olds (the age group with highest numbers of positive test results), the ratio of men to women testing positive narrows each year). White and African-American males continue to have the greatest numbers of sero-positive test results. African-American males and Latinas have the greatest percentages of sero-positive test results, followed closely by African-American females and Latinos.***

Surrogate information about risk behavior associated with HIV transmission (i.e., STD and pregnancy data) indicate that:

- ***Higher incidents of unprotected sex among younger age groups, particularly among racial and minority adolescents and young women.***

Mortality data show:

- ***In spite of the improvement in rank of HIV as a leading cause of death for all age groups combined, the ranking has not changed and remains highest for 25 to 44 year olds; has not changed and remains one of the top ten leading causes of deaths for 45 to 64 year olds; and continues to be a leading cause of death for 5 to 24 year olds and under 5-year-old,***

African-American males.

In spite of the large amounts of data available, cases of AIDS and HIV incidence are likely under-reported among various populations due to systematic under-reporting or the lack of data collection among isolated populations. This section also provides a list of such possible populations, as well as explanation about why information may be lacking. This information is useful for planning data collection for deriving epidemiological profiles in the future.

The section below provides detail on these above summarized data and methods by which they were compiled.

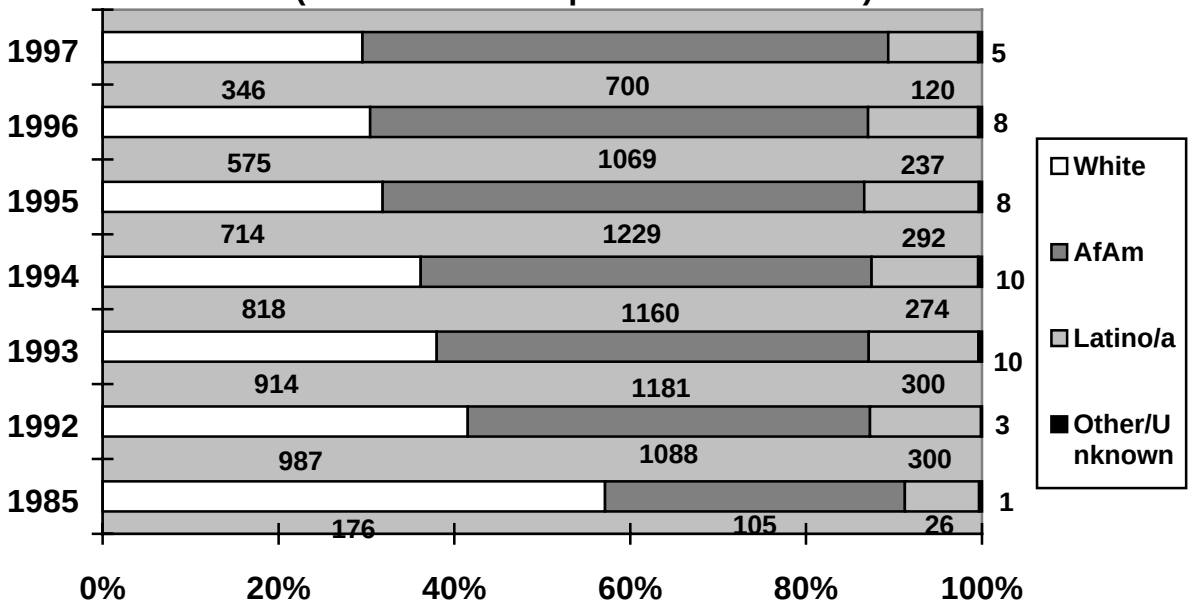
Reported AIDS Cases in Defined Populations: Earlier it was shown that numbers of cumulative reported cases of AIDS among adults is much greater for men than for women. When considering newly reported cases of AIDS among adults by sex (comparing the number of reported cases in last year's analysis with this year's analysis and deriving percentage increases), it is shown that the *percentage increase* of newly reported cases is greater for women than for men and has been so for several years. Figure D-1 below reports these percentage increases by region and the entire state (excluding Philadelphia).

FIGURE D-1
Comparison of Newly Reported Adult/Adolescent Male and Female Cases of AIDS
by Region
Reported Between 6/30/97 and 6/30/98

Region	Newly Reported Cases—MALE	Percent Increase from Last Report (6/97)	Newly Reported Cases—FEMALE	Percent Increase from Last Report (6/97)
TPAC—excluding Phila.	155	9%	39	16%
AIDSNET	83	9%	40	15%
Northeast	34	10%	8	17%
Northcentral	35	11%	9	11%
Southcentral	230	18%	49	15%
Southwest	130	7%	18	8%
Northwest	35	11%	7	13.5%
TOTAL	**702**	**10.5%**	**170**	**14%**

Similarly, when comparing percentage increases of reported cases of from year to year, new cases are reported at an increasing number among racial/ethnic minorities and a decreasing number among Whites (inclusive of Philadelphia and pediatrics). Remembering that reporting lags are greater for more recent years, the greatest numbers of newly reported diagnosed cases of AIDS continues to be among African-Americans compared with Whites and Latinos/as, as shown in Figure D-2 below.

FIGURE D-2
Diagnosed AIDS Cases by Year and Race/Ethnicity
(includes Philadelphia and Pediatrics)



HIV Seroprevalence Data: Several sets of data are available that indicate HIV seroprevalence among selected populations that have been targeted for surveys. The only population-based survey available is that concerning childbearing women. The latest information regarding this population pertains to data collected between January 1 and June 30, 1997. Another data set represents a "sentinel" population (i.e., representative of part of, but not all, members of particular populations.) These data pertain to individuals who have used publicly funded HIV Counseling and Testing Sites.

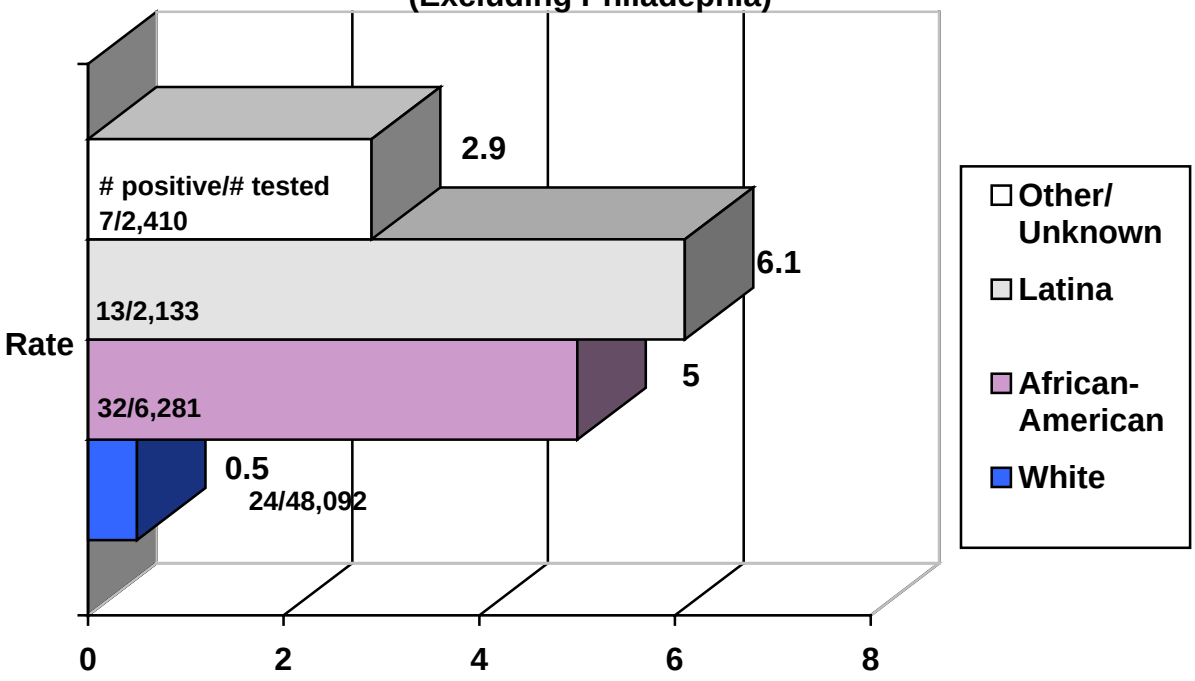
HIV Seroprevalence Data Concerning Childbearing Women: Periodic surveys of HIV infection among childbearing women have been conducted in Pennsylvania in collaboration with the CDC. The objective of the surveys has been to estimate the rate of HIV infection by demographic and geographic subgroups in the population of women giving birth to live children and to monitor the rate over

time. Such a survey was conducted among all Pennsylvania women giving birth between January 1 and June 30, 1997. The survey made use of anonymous, leftover dried blood specimens collected on filter paper for metabolic disease testing of newborns. The specimens are tested for maternal HIV antibody by enzyme immuno assay (EIA). Repeatedly reactive specimens are confirmed by Western Blot.

Of the 70,666 dried blood specimens received during the 6-month period, 92% were suitable for HIV testing. Race/ethnicity and age information was available for 96% of the specimens.

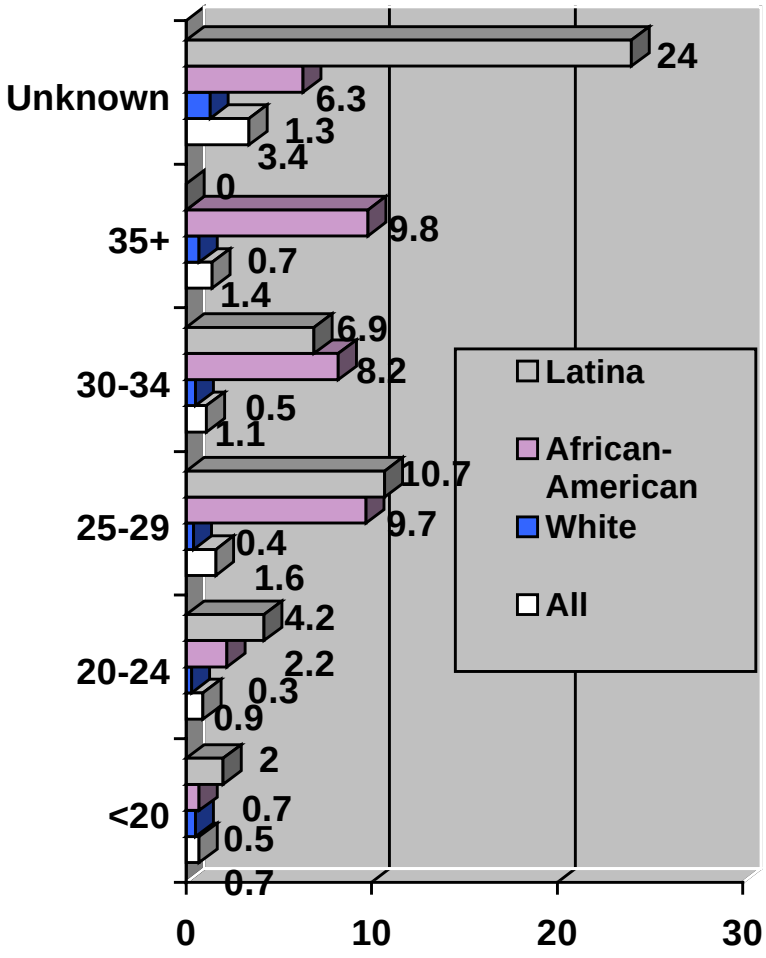
Rates of HIV infection among childbearing women were highest for Latinas (6.1 per 1,000 births), followed by African-Americans (5 per 1,000 births). Rates for White women were considerably lower (.5 per 1,000 births). Actual numbers of HIV infections were highest for African-Americans (32 reported infections), followed by Whites (24 infections), and Latinas (13 infections). These data are graphically depicted in Figure D-3. In comparison to the previous survey in 1995 (exclusive of Philadelphia), the rate of HIV infections per 1,000 births increased from 2.8 to 6.1 for Latinas, stayed the same for African Americans, and increased slightly, from .3 to .5, for Whites.

FIGURE D-3:
Rate (Per 1,000 Births) of HIV Seroprevalence in Childbearing Women by Race/Ethnicity, 1/1/97 to 6/30/97 (Excluding Philadephia)



The highest rates of HIV seroprevalence among childbearing women were among Latinas and African-American 25 to 29 year olds and African Americans who were 35 and older. Age-specific data are shown in Figure D-4.

FIGURE D-4:
Rate (Per 1,000 Births) of HIV Seroprevalence Among Childbearing Women by Age and Race/Ethnicity 1/1/97-6/30/97 (Excluding Philadelphia)



HIV Surveillance Data Reported By Counseling and Testing Sites (CTS): The method of collecting HIV surveillance data by CTS was explained in the previous section regarding Modes of Transmission. The number of individuals testing positive for HIV in 1997 is much larger for men than for women, as shown in Figure D-5. However, for 30 to 39 year olds, the age group with highest numbers of positive test results, the ratio of men to women testing positive narrows each year. In 1995 the ratio of men to women testing positive was 3:1, in 1996, it was 2.3:1, and in 1997, the ratio was 2:1.

FIGURE D-5
Positive HIV Test Results by Sex and Age, 1997
(Excluding Philadelphia)

AGE	**MALE**	**FEMALE**	**RATIO MALE:FEMALE**
<5	0	1	--
5-12	1	0	--
13-19	7	6	1.1:1
20-29	63	29	2.2:1
30-39	100	50	2:1
40-49	68	16	4.25:1
50>	23	5	4.25:1
Unknown	2	0	--
Not Specified	0	0	--

When considering 1997 statistics of those testing sero-positive for HIV by sex and race/ethnicity, White and African-American males continue to have the greatest numbers of sero-positive results (129 for Whites and 105 for African-Americans). However, numbers of White males testing positive decreased by 30 from 1996 numbers, which may be in due, in part, to the lower number of actual tests administered to White males in 1997 (14,539) compared to 1996 (16,747). Numbers of African-American males testing positive increased by 2, and numbers of African-American males actually tested increased in 1997 (4,466) compared to 1996 (4,360). These and other CTS data pertaining to demographic categories appear in Figures D-6 through D-8.

FIGURE D-6
Adult Populations Tested at Publicly Funded CTS
by Sex, Race/Ethnicity, Test Results, and Number Tested
1997 compared with 1996
(Excluding Philadelphia)

(No. Adults Tested for Whom Sex was Determined in Records = 39,496)

	NO. NEGA-TIVE '97	CHANGE FROM '96	NO. POSI-TIVE '97	CHANGE FROM '96	% POSITIVE '97	% POSITIVE '96
WHITE MALES	14,539	(2,208)	**129**	(30)	0.88%	.94%
WHITE FEMALES	13,592	(3,181)	35	(24)	0.26%	.35%
AFRICAN-AMERICAN MALES	4,466	106	**105**	2	**2.30%**	2.30%
AFRICAN-AMERICAN FEMALES	2,722	(133)	47	(21)	**1.70%**	2.33%
LATINO (MALES)	2,125	78	28	(17)	**1.30%**	2.15%
LATINA (FEMALES)	1,130	(63)	23	(2)	**2.00%**	2.05%
OTHER MALES	266	(48)	1	(4)	0.38%	1.55%
OTHER FEMALES	287	(36)	1	1	0.35%	0.00%
TOTAL	39,127	(5,485)	369	(95)	.93%	1.02%

Figures in bold denote higher numbers and percentages in 1997.

FIGURE D-7
Populations With Greater than One Percent Seropositivity Rate and Greater than One HIV-Positive Result Tested at Publicly Funded Sites, 1997 (Excluding Philadelphia)

	Population	No. of Tests	No. Positive	% Positive
By Age and Race/Ethnicity	Latino (Male), 40-49 y.o.	218	11	5.0%
	African-American Male, >50 y.o.	191	9	5.0%
	African-American Female, >50 y.o.	61	3	5.0%
	African-American Male, 40-49 y.o.	644	26	4.0%
	Latina (Female), 30-39 y.o.	339	13	3.8%
	African-American Male, 30-39 y.o.	1,369	47	3.4%
	African-American Female, 30-39 y.o.	875	29	3.3%
	African-American Female, 40-49 y.o.	361	10	3.0%
	Latina (Female), 20-29 y.o.	433	7	1.6%
By Race/Ethnicity	African-American	7,381	152	2.0%
	Latino/a	3,323	52	1.6%
By Age	40-49 y.o.	4,891	84	1.7%
	>50 y.o.	1,730	28	1.6%
	30-39 y.o.	9,835	150	1.5%
By Mode of Transmission	MSM	3,668	222	3.3%
	MSM/IDU	212	7	3.3%
	Heterosexual IDU	3,678	95	2.6%

FIGURE D-8
Populations With One Hundred or More Sero-positive Test Results Tested at Publicly Funded Sites, 1997 (Excluding Philadelphia)

	Population	Number Positive
By Race/Ethnicity	White	165
	African-American	152
By Age	30-39	150
By Mode of Transmission	MSM	122

Surrogate data regarding HIV risk behavior: As discussed earlier, in the absence of HIV reportability, data from other sources dealing with risk behaviors provide good surrogate information about the risk of HIV infection in select populations. STD and pregnancy data are such resources.

STD data: When considering the entire population of individuals tested for STDs, incidence of these diseases is decreasing each year for both men and women and for both chlamydia and gonorrhea. Specifically, the number of reported STDs in Pennsylvania decreased steadily by 8,498 cases between 1995 and 1997. Numbers of reported cases decreased by 6,456 for females between 1995 to 1997, and by 2,042 for males in the same time period. (Incidence of cases of chlamydia decreased from 141.52 in 1995; to 106.10 in 1996; to 89.0 in 1997. Incidence of cases of gonorrhea decreased from 61.55 in 1995; to 41.73 in 1996; to 32.93 in 1997.)

While numbers of cases of STDs are declining each year for both sexes and in all age categories, **numbers remain high among young people, indicating higher incidence of unprotected sex among younger age groups**. Numbers of reported cases for 15 to 29 year olds (both males and females) are significantly higher than numbers for other age groups, as shown in Figure D-9 (for females) and D-10 (for males).

When comparing cases of STDs for females and males, reported cases are significantly higher for 10- to 29-year old females than among males of the same ages; numbers of reported cases decrease more sharply for women than for men after the age of 45. For females, numbers of cases or reported STDs begin to rise noticeably among 13 year olds, reach the highest numbers among 15 to 19 year olds, and begin to decrease from age 20 onward. For males, numbers of cases of reported STDs begin to rise noticeably among 15 year olds, reach the highest numbers among 20 to 24 year olds, and begin to decrease from age 25 onward. These trends are shown in Figure D-9 and D-10.

FIGURE D-9 -- STDs (Chlamydia and Gonorrrhea Among Females)
By Age and Year, 1995 – 1997 (Excluding Philadelphia)

AGE	**1995**	**1996**	**1997**
0-4	16	17	12
5-9	9	8	5
10-14	579	374	272
15-19	**7,304**	**5,222**	**4,432**
20-24	**5,180**	**3,681**	**3,102**
25-29	**1,640**	**1,390**	**1,110**
30-34	703	564	396
35-39	325	233	208
40-44	103	105	78
45-54	62	53	30
55-64	11	4	5
65>	4	5	4

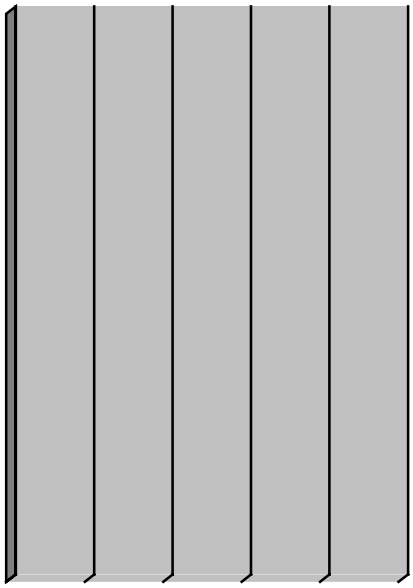
Unknown	362	420	188

FIGURE D-10 -- STDs (Chlamydia and Gonorrrhea Among Males)
By Age and Year, 1995 – 1997 (Excluding Philadelphia)

AGE	**1995**	**1996**	**1997**
0-4	4	18	3
5-9	3	1	1
10-14	24	27	13
15-19	**1,352**	**856**	**721**
20-24	**1,670**	**1,025**	**976**
25-29	**802**	**629**	**512**
30-34	468	370	303
35-39	279	213	157
40-44	130	125	97
45-54	109	106	84
55-64	30	19	20
65>	16	4	6
Unknown	130	70	83

Pregnancy data: Reporting of pregnancies includes the number of live births, non-induced fetal deaths, and induced abortions (as required to be reported by Pennsylvania laws). Records of live births are filed with local Registrars by attending physicians or licensed midwives (or designated persons for unattended births). Fetal deaths are filed with local Registrars by funeral directors or other persons in charge of interment. Local Registrars transmit both of the above types of records to the State. Reports of induced termination of pregnancy are transmitted to the State by facilities registered with the Department of Health to perform induced abortions. Cases of pregnancy among Pennsylvania residents reported in other states are subsequently reported to the Pennsylvania Department of Health under a cooperative agreement among states.

The total number of reported pregnancies among female residents in Pennsylvania was 185,587 in 1996. This represents a 2.2 percent decrease from 1995. The 1996 reported pregnancy rate was 71.8 per 1,000 female population, ages 15-44 years, a decrease from 72.8 per 1,000 in 1995. The number and rate of reported pregnancies in 1996 were the lowest ever recorded for the state since 1980, when these data were first compiled. In spite of this decline of number and rate**, rates are still high among racial/ethnic minority adolescents and young women between ages 20 and 24, indicating higher incidence of unprotected sex for this population.** Figure D-11 depicts these rates.



State mortality data: The way in which mortality data is gathered and reported is described in the previous Overview section. As discussed in that section, the rank of HIV-related deaths improved for most age groups in Pennsylvania in 1996 (the most recent year for which data is complete). Despite this improvement, the ranking did not change for 25-44 year olds. For this age category, HIV infection was still the third leading cause of mortality. For 25 to 44 year olds (Philadelphia data included), HIV infection continues to rank:

- 1st for African Americans
- 2nd for males

- 4th for females
- 5th for Whites

Other age and demographic categories for whom HIV-related deaths ranked within the top ten leading causes of death in 1996 include:

- African-American youth under 5 years old
- 5-24 year-old (males alone, females alone, and males and females combined)
- 5-24 year-old African Americans and 5-24 year-old Whites
- 45-64 year-old African Americans (male/female combined) and 45-64 year-old men (White and Black combined)

Populations for which Under-reporting of Data is Likely, or Little/No Information is Known with Reference to HIV: In spite of the large amounts of data available to construct an epidemiological profile of HIV/AIDS in Pennsylvania, AIDS and HIV incidence are likely under-reported among various populations due to systematic under-reporting or the lack of data collection among isolated populations. Below is a list of such possible populations in Pennsylvania, as well as a brief explanation about why information may be lacking. Such consideration is important for both prioritizing target populations for HIV prevention, as well as for planning future data collection and reporting strategies:

Racial/Ethnic Minority Young People and Sexual Minority Young People: Though we have better data about racial/ethnic minority young people (ages 13-24) than ever before (information about pregnancy, childbearing women, STDs, Counseling and Testing, and mortality), data are often limited. Further, very little can be interpreted from the data about young people who are sexual minorities. (From CTS data, we know that MSM is a significant mode of transmission for young people). Numbers of HIV infection, high-risk behaviors, and cases of AIDS pertaining to young people, in general, and especially minority youth, often "get lost" in the information about adults.

It is important to remember that 20% of persons living with AIDS in Pennsylvania are between 13 and 29, and we can assume the percentage would be higher if we considered the number of 30 to 39 year olds with AIDS who might have been infected with HIV when they were much younger. National data is also instructive; depending on the source of information, between a quarter and half of all new HIV infections in the U.S. are estimated to be among individuals under 25, and half of these are among individuals under 22. Among adolescents with AIDS, older teens, males, and racial and ethnic minorities are disproportionately affected, although females accounted for 44% of new cases of HIV infection in adolescents in states that report such data (*Source: CDC*).

Latinos/as: Latinos/as often "get lost" in the data, too, since some methods of data collection do not include categories for people of Hispanic origin (they are

either categorized as “White” or “Black”). This year’s information shows, however, that when Latinos/as are distinguished in data collection, they often account for disproportionately high numbers of HIV infection, reported cases of AIDS, and risk-behaviors. Further, evidence exists that a significant number of Latino(a)s may have been diagnosed with AIDS outside of Pennsylvania, largely because of migrant patterns. This fact, coupled with an historic under-use of medical services where HIV-infection might be detected, means that incidence of HIV is very likely to be much higher than reported.

Asians/Pacific Islanders: We have very little information about HIV regarding Asians/Pacific Islanders (APIs). Outside of Philadelphia, only 302 were tested for HIV in publicly funded sites, and only one individual tested positive. AIDS cases among this population are reported in very low numbers. Nationally, the numbers are relatively low. A total of 4,370 cases of AIDS in this population had been reported to the CDC by June 1997. Yet, rates of new AIDS cases among Asian/Pacific Islander MSMs increased by 55% between 1989 and 1995. Researchers, who are Asians/Pacific Islanders themselves, have found that API communities and government officials tend to focus on the relatively low numbers of APIs with AIDS, resulting in complacency about the problem of HIV seroprevalence in this population. Yet, because of geographic and social isolation of many Asian and Pacific Islander American communities, the effect of HIV is magnified once it takes hold. Much more ethnic-specific data is necessary to identify HIV trends in this population. (*Source: Sy, Chng, Choi and Wong.)*

Native Americans: Reported numbers of HIV infections and cases of AIDS are extremely low among Native Americans. Like APIs, this population tends to be socially and geographically isolated and under-uses medical and other services where HIV might be detected or focused on.

Prisoners: What we know about HIV among individuals in prisons/jails in Pennsylvania stems from limited publicly funded counseling and testing which takes place at such sites. Though numbers of tests administered are lower than for some other populations, HIV tests in prisons/jails yield one of the highest percentages of sero-positive results of populations tested.

PART THREE
PRIORITY POPULATIONS
GOALS, OBJECTIVES, AND ACTIONS

SUMMARY:
Prioritizing HIV prevention needs is a critical part of program planning. In order to establish priority populations for HIV prevention in the Commonwealth of Pennsylvania excluding Philadelphia, the Pennsylvania HIV Prevention Community Planning Committee followed a logical, evidence-based process.

The process commenced with the Committee's being provided with the following reference materials:

- Current HIV/AIDS epidemiological profile for Pennsylvania
- Sexually transmitted disease data by county
- HIV antibody testing and counseling data within each of the seven Ryan White HIV/AIDS Regional Planning Coalitions
- Status of previous objectives and action steps
- Statewide HIV prevention snapshot
- HIV prevention efforts funded by the Pennsylvania Department of Health not utilizing the Centers for Disease Control and Prevention funding
- HIV prevention efforts conducted by the independent county and municipal health departments
- Previous needs assessment data from 96 focus groups with almost 700 participants and 138 key informant interviews
- Counseling, testing, referral, and partner notification evaluation recommendations
- Young Adult Roundtable Consensus Statement

A matrix, which numerically rates HIV risk-related behaviors and categories with four HIV prevention criteria (riskiness of behavior, difficulty in meeting the need, emerging issues, and resources needed) was created by the University of Pittsburgh to better insure that HIV prevention planning efforts are based within HIV risk-related behavior. The matrix and instructions were mailed to the 40 Committee members. Sixty-three percent (25) of the forms were returned in the self-addressed stamped envelope. Committee members were also offered additional opportunities to communicate their opinions about priority populations.

The results, which rank ordered 44 HIV risk-related behaviors/categories, were distributed to the Committee for discussion. The high, medium, and low numerical ranking by 25 respondents created a possible total score of 300. The final range of scores was from (1) African-American women injection drug users with 271 points to (44) occupational-related HIV exposure with 70 points.

The following are the top 13 priority populations established by the Committee:

(1) African-American female injection drug users
(2) Young injection drug users
(3) Latino injection drug users
(4) Sexually active Latinas
(5) Latina injection drug users
(6) African-American male injection drug users
(7) Heterosexual sexual partners of injection drug users
(8) Latino men who have sex with men
(9) Young men who have sex with men
(10) Injection drug users who are men who have sex with men
(11) Pregnant Latinas
(12) African-American sexually active women
(13) Pregnant African-Americans

Population: Unless specified P*riority Populations* are defined in two broad HIV transmission mode categories: **(1)** Injection Drug Users (IDU's) and **(2)** Those who engage in HIV risk-related sexual behavior. The following rank order is to be utilized when appropriate: *African American, Latino(a), Youth and Young Adult Injection Drug Users and Their Sexual Partners and/or Young Men Who Have Sex With Men, Sexually Active Youth and Young Adults, Sexually Active Latino(a)s, and African-American and Latino Men Who Have Sex With Men.*

Due to regional variations throughout the Commonwealth it may be appropriate to justify reaching further down the priority population list to address HIV prevention concerns; however HIV prevention efforts should be addressed with the next available rank-order priority population. The Pennsylvania Comprehensive HIV Prevention Plan serves as a guide for Community-Based AIDS Service Organizations, Ryan White HIV/AIDS Regional Planning Coalitions, Independent County/Municipal Health Departments, and others in developing HIV prevention individual-, group-, and community-level interventions. HIV prevention programs that receive either state or federal CDC prevention funds must comply with the Commonwealth's HIV Prevention standards as well as the Comprehensive HIV Prevention Plan. For example, a Ryan White HIV/AIDS Regional Planning Coalition plans to utilize state HIV prevention funds to subcontract with a community-based AIDS Service Organization (CBO). The potential CBO must meet HIV prevention standards and proposed HIV prevention interventions must target the priority population identified within the Comprehensive HIV Prevention Community Plan. The current Comprehensive HIV Prevention Community Plan establishes the basis for communities to expand their capacity to develop and provide effective HIV prevention interventions. *Priority populations* within this plan are defined in the broader categories of injection drug users and those who engage in HIV risk-related sexual behavior. However, HIV prevention efforts directed at injection drug users must target, where appropriate, first African-American women, second Latino(a)s, third youth and young adults, and so forth.

Intervention Goals, Objectives, and Activities

Counseling, Testing, Referral, and Partner Notification

Priority Population: **I**njection **D**rug **U**ser**s** and **those who engage in HIV risk-related sexual behavior**.

Goal CT-1: Ensure and annually assess that free, anonymous and confidential counseling and voluntary testing services are available and accessible for *priority populations* in all counties in the Commonwealth of Pennsylvania.

CT 1 Objective-1 Continue the Secondary Prevention Resource Development Initiative to include a directory of resources available for people living with HIV/AIDS to all counseling and testing sites and other HIV/AIDS service providers.

Activities: The Division of HIV/AIDS will assess the ability of publicly funded counseling and testing sites to access the stophiv.com Web-site-maintained resource directory by 31 October 1999.

Activities: The Division of HIV/AIDS in conjunction with the seven Ryan White HIV/AIDS Regional Planning Coalitions will assess the ability of HIV/AIDS service providers to access the stophiv.com Web-site-maintained resource directory by 31 October 1999.

Activities: Continue to work with the seven Ryan White HIV/AIDS Regional Planning Coalitions to update the resource directory at least twice a year.

Activities: On an annual basis, update and distribute to HIV individual counselors time-specific regional referral resource guides that include: medical, women's health services, STD, mental health and drug and alcohol resources for the *priority populations*.

CT 1 Objective-2 On a continual basis, recognize the possibility of any community stigma directed at HIV/AIDS facilities, and annually discuss, document and implement a process aimed toward the elimination of the stigma for *priority populations*.

Activities: The HIV Prevention Community Planning Committee, the Division of HIV/AIDS, and the seven Ryan White HIV/AIDS Regional Planning Coalitions will explore stigma-related barriers to accessing HIV/AIDS prevention services by 31 October 1999.

Activities: Develop a supervised bulletin board at the stophiv.com Web site where individuals can enter their personal HIV prevention stigma-related concerns by 31 December 1999.

CT 1 Objective-3 To facilitate at least one meeting with the PA Department of Insurance to discuss methods for promoting coverage for HIV/AIDS prevention counseling and HIV antibody testing services in provider facilities and drug and alcohol treatment by 31 December 1999.

Activities: The Division of HIV/AIDS will convene a meeting of drug and alcohol providers, HIV and drug/alcohol consumers, insurers and other experienced and knowledgeable individuals to develop a plan and assessment tool(s) to assess the adequacy of treatment under managed care by 31 October 1999.

CT 1 Objective-4 Expand the accessibility of HIV non-blood testing processes for *priority populations* into at least 25% of the public HIV counseling and testing sites by 31 December 1999.

Activities: The Counseling and Testing Sub-Committee of the HIV Prevention Community Planning Committee in conjunction with the Division of HIV/AIDS will identify testing and counseling sites where HIV non-blood HIV antibody testing processes may occur for injection drug users and men who have sex with men by 31 October 1999.

Activities: Provide training and appropriate resources to publicly funded counseling and testing sites so that the option of non-blood based HIV antibody testing (oral, urine testing, etc.), when available, is a viable option by 31 December 1999.

CT 1 Objective-5 Develop an instrument to evaluate publicly funded HIV counseling and testing services that addresses the following: confidentiality, use of the client-centered counseling approach, culturally sensitive service delivery, counselor training and evaluation, quality assurance, cost effectiveness and appropriate referrals by 31 December 1999. This instrument will be used to conduct annual evaluations.

Activities: The Counseling and Testing Sub-Committee of the HIV Prevention Community Planning Committee in conjunction with the Division of HIV/AIDS will develop this instrument by 31 October 1999.

Activities: The audit instrument will be piloted in a variety of publicly funded testing and counseling sites for six months from 1 July 1999 through 31 December 1999.

CT 1 Objective-6 Explore the methods of implementing HIV counseling and testing services in county correctional facilities by 31 December 1999.

Activities: The Counseling and Testing Sub-Committee of the HIV Prevention Community Planning Committee will develop an issue paper outlining the related HIV antibody testing and county correctional facilities' concerns by 30 June 1999.

Activities: The Counseling and Testing Sub-Committee of the HIV Prevention Community Planning Committee will work with the Division of HIV/AIDS, as a liaison to the Bureau of Corrections and other appropriate organizations, such as the County Commissioners Association, to establish a meeting to discuss the concerns by 31 December 1999.

CT 1 Objective-7 Continue the evaluation of publicly funded counseling and testing sites initiated in 1996 and determine ongoing evaluation needs to include the following: measure methods intended to demonstrate change in behavior as part of the evaluation of CTRPN effectiveness, examine methods of measuring CTRPN cost effectiveness and include cost effectiveness as part of the evaluation of CTRPN effectiveness, examine the cultural appropriateness of counselors, and determine the ongoing quality of counseling, particularly regarding knowledge of and access to resources for HIV-positive individuals.

Activities: The Counseling and Testing Sub-Committee of the HIV Prevention Community Planning Committee, the Division of HIV/AIDS, and the University of Pittsburgh will discuss what can be accomplished with the continuation of the CTRPN evaluation. This discussion is to occur by 31 October 1999.

CT 1 Objective-8 Develop an ongoing training program and follow-up booster sessions for publicly funded counseling and testing site HIV counselors and counselor-trainers, to include updates on basic HIV/AIDS treatment and care issues, behavior-change models, and drug and alcohol issues, and resources.

Activities: Consider the use of the HealthNet satellite sites across the state to assist in the training of counselors. Include the possibility of videotaping HealthNet programs to be shown at other counseling and testing sites by 31 December 1999.

Priority Population: Latina and African-American women

Goal CT 2: To reduce perinatal transmission of HIV, ensure annually that providers of women's health services comply with the PA State Department of

Health's counseling and testing policies and procedures related to HIV infection and pregnancy, especially for *African American women and Latinas*.

CT 2 Objective-1 Monitor, on an annual basis, the implementation of policies and guidelines regarding the reduction of perinatal HIV transmission through the administration of medications to pregnant women or other appropriate interventions identified in current NIH guidelines.

Activities: The Division of HIV/AIDS should examine the process for monitoring those providers to whom they have responsibility, to insure compliance with the current NIH guidelines regarding perinatal HIV transmission by 31 December 1999.

Activities: Annually review and revise, as appropriate, the policies and procedures regarding HIV infection and pregnancy (as established by the DOH in June 1998) as the standard of practice.

CT 2 Objective-2 Convene regional, diverse work groups of providers, consumers, and community leaders who will identify possible deliveries of service to African-American women and Latinas at highest risk for HIV infection in order to reduce information gaps statewide by 31 December 1999.

Activities: The HIV Prevention Community Planning Committee, the Division of HIV/AIDS, and the seven Ryan White HIV/AIDS Regional Planning Coalitions will develop a process to convene meetings and/or a method to assess the required information by 30 April 1999.

CT 2 Objective-3 Ensure that all facilities (insurance, health care organizations) in PA which provide/impact women's health services, particularly prenatal and obstetrical care, have access to mailings, information and/or teleconferences sponsored by DOH, promoting the accepted standard of practice regarding HIV infection and pregnancy.

Activities: The Division of HIV/AIDS will identify agencies and the method of ensuring that they have access to mailings, information and/or teleconferences sponsored by the DOH by 31 December 1999.

CT 2 Objective-4 Develop highly visible, culturally sensitive, marketing strategies in collaboration with a broad partnership network that encourages teens, Latina, and African-American women to seek early prenatal HIV screening and information.

Activities: The Division of HIV/AIDS will develop a media campaign encouraging teens, Latina, and African-American women to seek early prenatal HIV screening and information by 30 June 1999.

CT 2 Objective-5 Assess providers of women's health services (random checks, surveys, interviews, etc.) to assure compliance with PA DOH standards of practice regarding appropriately trained staff, necessary supplies and annual training and information updates.

Activities: The Division of HIV/AIDS will explore possible methods to assess providers of women's health by 31 October 1999.

Priority Population: **I**njection **D**rug **U**ser**s** and **those who engage in HIV risk-related sexual behavior**.

Goal CT 3: All Counseling and Testing sites will have implemented a comprehensive Quality Assurance Program.

CT 3 Objective-1 Ensure all publicly funded HIV antibody testing and counseling providers have implemented a Quality Assurance program by 31 January 2002.

Activities: Develop, in collaboration with a broad range of diverse providers, experts and consumers, standards for a comprehensive Quality Assurance program for HIV counseling and testing sites.

Activities: Explore and assess current marketplace practices regarding Quality Assurance programs/systems by 30 June 1999.

Activities: Create a mechanism (i.e. forum, teleconference, etc.) for establishing best practices for counseling and testing services by 30 September 1999.

Activities: Establish three pilot projects-one each representing an urban, suburban, and rural counseling and testing site-that will evaluate the implementation of the Quality Assurance program standards by 31 October 2000.

Activities: Finalize and revise standards of an effective, comprehensive Quality Assurance program by 30 May 2001.

Activities: Distribute guidelines and provide training to all providers of counseling and testing services regarding the finalized Quality Assurance standards by 31 October 2001.

Priority Population: **I**njection **D**rug **U**ser**s** and **those who engage in HIV risk-related sexual behavior**.

Goal CT 4: Increase by 5% each, the numbers of individuals annually accessing HIV prevention counseling and testing services who are injection drug users, those who engage in HIV risk-related sexual behavior, and youth and young adults.

CT 4 Objective-1 The Division of HIV/AIDS will develop, implement, and evaluate a minimum of one peer-based outreach intervention, in the seven Ryan White HIV/AIDS Regional Planning Coalitions, utilizing harm reduction techniques and targeting individuals who engage in injection drug use and their sexual partners, particularly African Americans and Latino(a)s by 30 June 2001.

Activities: The Division of HIV/AIDS will assess and jointly develop peer-based HIV prevention education and outreach program for HIV antibody testing and counseling to injection drug users, targeting, where appropriate, African-Americans and Latino(a)s with the seven Ryan White HIV/AIDS Regional Planning Coalitions by 31 December 1999.

Activities: Peer-based HIV prevention education and outreach program for HIV antibody testing and counseling to injection drug users, targeting where appropriate, African-Americans and Latino(a)s will be developed in four of the seven Ryan White HIV/AIDS Regional Planning Coalitions by 31 December 2000 and the remaining three Ryan White HIV/AIDS Regional Planning Coalitions by 30 June 2001.

CT 4 Objective-2 Ensure ongoing participation of individuals who inject drugs, those who engage in HIV risk-related sexual behavior, and youth and young adults in the Community Leadership Development (CLD) projects and the Young Adult Roundtables (YART) by assessing participants' HIV risk-related behavior with anonymous surveys.

Activities: The University of Pittsburgh, Pennsylvania Prevention Project, will develop an instrument to assess participants' HIV risk-related behavior within Community Leadership Development (CLD) projects and the Young Adult Roundtables (YART) with anonymous surveys by 31 October 1999.

Activities: The University of Pittsburgh, Pennsylvania Prevention Project, will assess participants' HIV risk-related behavior within Community Leadership Development (CLD) projects and the Young Adult Roundtables (YART) with anonymous surveys by 31 December 1998.

CT 4 Objective 3 Recruit and include individuals who were injection drug users, those who engage in HIV risk-related sexual behavior, and youth and young adults to participate in the evaluation of counseling and testing services using methods such as: focus groups, key informant interviews, and client satisfaction surveys.

Activities: The Division of HIV/AIDS will include injection drug users, those who engage in HIV risk-related sexual behavior, and youth and young adults in the development of focus groups, key informant interviews, and/or client satisfaction surveys of publicly funded HIV antibody testing and counseling sites by 31 June 1999.

Activities: Focus groups, key informant interviews, and/or client satisfaction surveys will be implemented in the evaluation of services for injection drug users, those who engage in HIV risk-related sexual behavior, and youth and young adults. They will be completed in 25% of publicly funded HIV antibody testing and counseling sites by 31 October 1999.

CT 4 Objective-4 Use expanded access to voluntary and anonymous HIV antibody testing through such efforts as street outreach and satellite testing of individuals and other innovative outreach strategies to provide access and the opportunity to anonymously test for HIV antibodies to a greater number of individuals who engage in injection drug use, those who engage in HIV risk-related sexual behavior, and youth and young adults.

Activities: The Division of HIV/AIDS will work with publicly funded counseling and testing sites, where appropriate, to develop plans for outreach efforts and satellite testing for injection drug users, those who engage in HIV risk-related sexual behavior and youth and young adults by 31 October 1999.

Activities: The Division of HIV/AIDS will implement the outreach and satellite testing for injection drug users, those who engage in

HIV risk-related sexual behavior, and youth and young adults outreach plan within publicly funded counseling and testing sites, where appropriate by 30 June 2000.

CT 4 Objective-5 Ensure annually that publicly funded HIV prevention education/outreach workers include representation of individuals who are injection drug users, those who engage in HIV risk-related sexual behavior, and youth and young adults.

Activities: The Division of HIV/AIDS will work with the seven Ryan White HIV/AIDS Regional Planning Coalitions to develop an annual process to ensure that prevention education and outreach workers, where appropriate, are representative of individuals who are injection drug users, those who engage in HIV risk-related sexual behavior, and youth and young adults by 31 October 1999.

CT 4 Objective-6 All DOH-contracted counseling and testing sites will offer well-advertised, weekend and/or evening hours twice a month by 31 December 2000.

Activities: The Division of HIV/AIDS will address the logistics of well-advertised, weekend and/or evening hours for HIV antibody testing and counseling at publicly funded sites by 30 June 1999.

Activities: A percentage of the counseling and test sites will be selected to pilot well-advertised, weekend and/or evening hours by 31 December 1999.

Activities: If the pilot effort is successful it will be implemented, where appropriate, at all publicly funded counseling and test sites by 31 December 1999.

CT 4 Objective-7 The Division of HIV/AIDS will develop a regular policy of risk reduction behavior change strategies for youth and young adults in drug and alcohol treatment facilities and related programs by 31 December 1999

Activities: The Division of HIV/AIDS will work with the Bureau of Drug and Alcohol Programs to make recommendations on a routine policy of risk reduction behavior change strategies for youth and young adults in drug and alcohol treatment facilities and related programs by 31 December 1999.

CT 4 Objective-8 Research non-traditional counseling and testing options for youth and young adults.

Activities: Implement three pilot programs utilizing non-traditional counseling and testing options for youth and young adults by December 2000.

Health Education, Risk Reduction, and Public Information

Priority Population: **I**njection **D**rug **U**ser**s** and **those who engage in HIV risk-related sexual behavior**.

Goal HE/RR 1: Give priority to and implement HIV prevention/risk reduction programs funded by the PA Department of Health which target *priority populations.*

HE/RR 1 Objective-1 Provide funding for a series of education and information sharing summits on examples of national and international HIV prevention/risk reduction programs.

Activities: The Division of HIV/AIDS will convene a meeting of appropriate individuals and organizations to develop an action plan for keeping HIV prevention programs updated on current HIV prevention/risk reduction programs by 31 October 1999. (Community-Level Intervention)

Activities: The Division of HIV/AIDS will provide funding for more HIV prevention resources and data collection to include secondary HIV prevention/risk reduction efforts. (Community-Level Intervention)

HE/RR 1 Objective-2 Provide funding to replicate the successful Pennsylvania Prevention Project HIV prevention demonstration projects.

Activities: The Division of HIV/AIDS will explore methods of disseminating successful HIV prevention demonstration models to other areas of need by 30 June 1999. (Community-, Group-, and Individual-Level Interventions)

Activities: The Division shall continue to explore and if feasible implement replication of the IDU and sexually at-risk women's outreach program developed in Chester and Erie over the last three years for application in York from January to December 1999. (Street Outreach and Individual-Level Intervention)

HE/RR 1 Objective-3 Have individuals who are injection drug users and those who engage in HIV risk-related sexual behavior develop a consensus statement, utilizing the Young Adult Roundtable Consensus Statement model.

Activities: The Division of HIV/AIDS will convene a forum of individuals who are injection drug users and those who engage in unprotected sex to develop a consensus statement, utilizing the Young Adult Roundtable Consensus Statement model by 31 December 1999. (Community-Level Intervention)

HE/RR 1 Objective-4 Evaluate current and if necessary develop and adopt an appropriate pilot project involving male and female condom distribution and dissemination of harm reduction materials in schools.

Activities: The Division of HIV/AIDS will convene a meeting of experienced individuals to assess and explore the methods of condom distribution in schools by 31 December 1999. (Community-Level Intervention)

Activities: The Division shall continue to explore and if feasible implement the establishment of four theater groups (based on the Bronx model) of youth at risk in Erie, Pittsburgh and two other sites to deliver HIV prevention programs in schools and other places where youth congregate from January to December 1999. (Community-Level Intervention)

Priority Population: **I**njection **D**rug **U**ser**s** and **those who engage in HIV risk-related sexual behavior**.

Goal HE/RR 2: Support nontraditional approaches and innovative ideas in HIV prevention programs.

HE/RR 2 Objective-1 Identify programs demonstrating successful techniques serving *priority populations*

Activities: Create a paid position in each Ryan White HIV/AIDS Regional Planning Coalition for an individual to work with community groups (that work with *priority populations)* to provide technical assistance and guidance in developing HIV prevention community resources, community organization, and other HIV prevention activities by 31 December 2001. (Infrastructure Development)

Activities: The Division shall continue to support the meetings and prevention activities of the racial and ethnic, and MSM Community

Leadership Development Projects in Scranton/Wilkes-Barre, State College, York, Allentown, Williamsport, Erie, and Pittsburgh from January to December 1999. (Community, Group, and Individual Level Interventions)

Activities: The Division shall continue to support the IDU and minority women at sexual risk outreach prevention program run by Serenity House in Erie from January to July 1999 and to provide assistance to them in seeking other future funding from July to December 1999**.** (Street Outreach and Individual Level Intervention)

Activities: The Division shall continue to support the involvement of IDU, sexually at-high-risk youth, and other youth from Scranton/Wilkes-Barre, Norristown, York, Allentown, Williamsport, Erie, and Pittsburgh the young adult roundtables in peer-led prevention projects from January to December 1999. (Community-, Group-, and Individual-Level Interventions)

HE/RR 2 Objective-2 Explore and investigate key national and international nontraditional and innovative methods with demonstrated effectiveness with *priority populations* and present this information at a special meeting of the Committee, and at private and public forums.

Activities: The Division of HIV/AIDS in conjunction with the Training and Development Sub-Committee of the HIV Prevention Community Planning Committee will research national and international non-traditional and innovative methods with demonstrated effectiveness with *priority populations* to be presented to the Committee by 31 October 1999. (Infrastructure Development)

Activities: The Division will significantly expand from all volunteer to half-time staff in each city its three MSM street and meeting place outreach programs in Pittsburgh (targeting African American MSM), Williamsport (targeting all MSM and particularly MSM who also use injection drugs), and Erie (targeting all MSM particularly youth) from January to December 1999. (Street Outreach and Individual-Level Interventions)

Activities: The Division shall issue a RFP for a demonstration project of a perinatal prevention intervention, accept proposals, and fund the program with appropriate technical assistance and monitoring by 30 June 1999. (Community, Group, and Individual Level Intervention)

HE/RR 2 Objective-3 Evaluate existing drama, plays, and performance-art programs and if necessary, develop a specific performance-art activity or event targeting specific *priority populations*.

> Activities: If research on present dramas, plays, and performance-art programs is positive, the Division of HIV/AIDS will pilot such HIV prevention efforts by 31 October 1999. (Community Level Intervention)

HE/RR 2 Objective-4 Evaluate existing art therapy techniques for HIV prevention and if necessary develop these techniques to be incorporated into specific *priority population* programs.

> Activities: The Division of HIV/AIDS will work with the seven Ryan White HIV/AIDS Regional Planning Coalitions to conduct HIV prevention programs for *priority populations* to be conducted at media centers, video centers, and non-HIV specific community centers by 31 December 1999. (Community- and Group-Level Interventions)

HE/RR 2 Objective-5 Evaluate current and, if necessary, develop curricula for peer education programs, including models for incarcerated *priority populations*, and disseminate that information by 31 December 1999.

> Activities: The Division of HIV/AIDS will examine models of prison peer education such as that developed by the PA AIDS Education and Training Center for possible replication with *priority populations*, particularly within county correctional institutions by 31 December 1999. (Group- and Individual-Level Interventions)

HE/RR 2 Objective-6 Collect data on HIV positive persons through the use of focus groups and key informant interviews within *priority populations* to determine attitudes and perceptions regarding primary and secondary prevention and barriers to care and services.

> Activities: The Division of HIV/AIDS will conduct focus groups and key informant interviews with HIV-infected *priority populations*. (Community-Level Intervention)

HE/RR 2 Objective-7 Continue to advocate for needle exchange programs.

> Activities: Convene work groups of HIV prevention providers, consumers, and community leaders to discuss what is scientifically known of utilizing needle exchange as effective HIV prevention by 30 October 1999. (Community-Level Intervention)

Activities: Encourage community members to promote and coordinate Needle Exchange Information Days by 31 March 1999. (Community-Level Intervention)

Activities: Request that local agencies, who understand the HIV prevention benefits of needle exchange, send their state legislators fact sheets about this subject on the same date by 30 October 1999.

HE/RR 2 Objective-8 Examine the need for access to drug and alcohol treatment for *priority populations*.

Activities: The Division of HIV/AIDS will coordinate a meeting with the Bureau of Drug and Alcohol Programs to review the concerns of drug and alcohol treatment for *priority populations* by 31 March 1999. (Community-Level Intervention)

Activities: A plan to address the concerns of drug and alcohol treatment access for *priority populations* will be developed by 30 June 1999.

HE/RR 2 Objective-9 Create harm reduction pilot projects.

Activities: The Division of HIV/AIDS will develop a forum for the dissemination of information for policy making regarding the range of harm reduction in HIV prevention by 31 October 1999. (Community-Level Intervention)

Activities: The Division of HIV/AIDS will investigate HIV risk-related harm reduction programs for *priority populations* for possible pilot projects by 31 December 1999. (Group- and Individual-Level Interventions)

Priority Population: **I**njection **D**rug **U**ser**s** and **those who engage in HIV risk-related sexual behavior**.

Goal HE/RR 3: Give priority to and implement HIV prevention/risk reduction programs that are culturally sensitive.

HE/RR 3 Objective-1 Identify culturally-specific training programs and criteria for training programs and identify a group of trainers by December 31, 1999.

Activities: Implement culturally-specific training within three Ryan White HIV/AIDS Regional Planning Coalitions by 30 June 2000. (Community-Level Intervention)

Activities: Modify existing HIV prevention programs to address subcultures within cultures (e.g. drag queens not going to leather bars, not having “mainstream” Latina women going into crack houses). Incorporate the addressing of subcultures within criteria for training programs. (Community- and Group-Level Interventions)

HE/RR 3 Objective-2 Investigate, evaluate and utilize non-traditional cultural diversity training for the Committee and HIV prevention service providers, (e.g., go beyond race and sexual orientation).

Activities: The Division of HIV/AIDS and the Training and Development Sub-Committee of the HIV Prevention Community Planning Committee will investigate non-traditional cultural diversity training and report information to the Committee by 31 March 1999. (Infrastructure Development)

Activities: The Committee will receive non-traditional cultural diversity training by 31 December 1999. (Community-Level Intervention)

Activities: The information gathered relative to non-traditional cultural diversity training will be disseminated to HIV prevention projects by 31 December 1999. (Community-Level Intervention)

HE/RR 3 Objective-3 Evaluate existing curriculum and if necessary develop a cultural competency curriculum to teach HIV prevention to *priority populations*, for example, novelitas (soap operas).

Activities: Develop a manual of innovative HIV prevention programs and trainers to be disseminated to HIV prevention projects by 31 December 1999. (Infrastructure Development)

Activities: Provide support for fun stations (ethnically attractive booth) at HIV prevention project endeavors. (Community- and Group-Level Interventions)

HE/RR 3 Objective-4 Provide technical assistance to assure that provider staff possess the appropriate knowledge and skills in working with persons from other cultures.

Activities: The Division of HIV/AIDS will assess the needs for and the provision of technical assistance with the seven Ryan White HIV/AIDS Regional Planning Coalitions by 31 December 1999. Where feasible, technical assistance staff should represent the p*riority populations* being served. (Community-Level Intervention)

Activities: To insure that providers have the appropriate knowledge and skills, the Division of HIV/AIDS will conduct consumer key informant interviews by 31 March 2000.

HE/RR 3 Objective-5 Provide access to the TTY/TTD AIDS Factline for *priority populations*.

Activities: The Division of HIV/AIDS will insure that staff of the TTY AIDS Factline are culturally competent and aware of *priority populations* by 31 December 1999. (Individual-Level Intervention)

HE/RR 3 Objective-6 Develop and disseminate literature that is culturally and linguistically appropriate for *priority populations*.

Activities: The Division of HIV/AIDS will insure that the statewide HIV/AIDS Factline, counseling and test sites, and publicly funded HIV prevention programs have brochures, etc., that are culturally and linguistically appropriate for *priority populations* by 31 December 1999. (Individual-Level Intervention)

Priority Population: **I**njection **D**rug **U**ser**s** and **those who engage in HIV risk-related sexual behavior**.

Goal HE/RR 4: Encourage and assist HIV education and awareness integration for non HIV-specific community based organizations' existing programs that interact with priority populations.

HE/RR 4 Objective-1 The Division of HIV/AIDS will invite individuals with operational responsibility within non HIV-specific organizations that provide services to p*riority populations* to a meeting at the state level by 31 December 1999.

Activities: The Division of HIV/AIDS will identify the statewide non HIV-specific organizations by 31 March 1999. (Infrastructure Development)

Activities: A plan of how to convene a meeting of necessary participants will be developed by 30 June 1999. (The intent of this

gathering is to encourage collaboration and gain input regarding development of HIV prevention community interventions. The discussion should focus upon how assessing HIV prevention needs can benefit their clients). (Community-Level Intervention)

Activities: A menu of HIV prevention resources will be developed by 31 October 1999. (Infrastructure Development)

HE/RR 4 Objective-2 Facilitate HIV-specific CBOs establishing relationships with non-HIV specific CBOs and increase sharing and networking of resources.

Activities: The Division of HIV/AIDS will work with the seven Ryan White HIV/AIDS Regional Planning Coalitions to assess the needs and develop a plan for establishing relationships with non HIV-specific CBOs by 31 December 1999. (Community-Level Intervention)

Activities: Provide non HIV-specific CBOs with training to better enable them to provide basic HIV education and to enable the CBOs to refer *priority populations* to AIDS service organizations (ASO) for comprehensive HIV prevention information by 31 December 1999. (Community-, Group-, and Individual-Level Intervention)

Activities: Insure that non HIV-specific CBOs are aware of the [stophiv.com] web-site HIV/AIDS resource directory by 31 December 1999. (Infrastructure Development)

HIV Prevention Capacity Building Activities

Priority Population: **I**njection **D**rug **U**ser**s** and **those who engage in HIV risk-related sexual behavior**.

Goal CB 1: Provide technical assistance to community-based organizations, AIDS service organizations, the Ryan White HIV/AIDS Regional Planning Coalitions, and County/Municipal Health Departments to reduce barriers to accessing HIV prevention services.

CB 1 Objective-1 Provide technical assistance to community-based organizations, AIDS service organizations, the Ryan White HIV/AIDS Regional Planning Coalitions, and County/Municipal Health Departments in identifying, addressing, and overcoming barriers to accessing HIV prevention services by 31 December 1999.

Activities: Define and assess the potential problems of HIV-related stigma with representatives from the seven Ryan White HIV/AIDS Planning Coalitions and County/Municipal Health Departments by 30 June 1999.

Activities: Develop a technical assistance plan that addresses the identified HIV-related stigma by 31 October 1999.

CB 1 Objective-2 Assist community-based organizations, AIDS service organizations, the Ryan White HIV/AIDS Regional Planning Coalitions, and County/Municipal Health Departments in meeting statewide HIV prevention standards.

Activities: Develop and implement a technical assistance plan that will assist the Ryan White HIV/AIDS Regional Planning Coalitions, and County/Municipal Health Departments in meeting statewide HIV prevention standards by 31 December 1999.

Activities: The Division shall continue to support to develop local HIV prevention planning groups in Erie, Williamsport, and York which include HIV positive people, members of at-risk groups, and representatives from CBOs, minority and ethnic, and MSM Community Leadership Groups, health departments, civic groups and other related organizations to refine their local plans and to generate proposals for new programs that conform to the state plan from January to December 1999.

Activities: The Division shall continue to convene Young Adult Roundtables in seven Pennsylvania cities and towns to develop recommendations for the state prevention plan and to carry out interventions from January to December 1999.

Activities: The Division shall convene a summit meeting of all members of the Young Adult Roundtables and to revise their 1998 consensus statement and to develop a work plan for 1999 by April 1999.

Activities: The Division shall convene a training conference for all outreach staff of CDC funded projects and members of the minority and ethnic, and MSM Community Leadership Development projects in eight cities and the Community-Wide Planning Groups in three cities by 31 December 1999.

Priority Population: **I**njection **D**rug **U**ser**s** and **those who engage in HIV risk-related sexual behavior**.

Goal CB 2: Advocate and promote the accessibility of drug and alcohol treatment services, including, but not limited to harm reduction strategies, to priority populations and people living with HIV/AIDS.

CB 2 Objective-1 Provide education to community-based organizations, AIDS service organizations, the Ryan White HIV/AIDS Regional Planning Coalitions, and County/Municipal Health Departments about available drug and alcohol resources and services.

Activities: In collaboration with the Bureau of Drug and Alcohol Programs develop a plan to widely disseminate drug and alcohol treatment resources by 30 June 1999.

CB 2 Objective-2 Assist community-based organizations, AIDS service organizations, the Ryan White HIV/AIDS Regional Planning Coalitions, and County/Municipal Health Departments to assess, provide, and integrate HIV/AIDS, STD, TB, Hepatitis B and C, and other blood-borne illness prevention with drug and alcohol prevention and treatment services.

Activities: In collaboration with the Bureau of Drug and Alcohol Programs develop a plan that assess the possible methods to integrate HIV/AIDS, STD, TB, Hepatitis C and other blood-borne illness prevention with drug and alcohol prevention and treatment services by 20 June 1999.

CB 2 Objective-3 Enhance the on-line resource directory to include drug and alcohol prevention and treatment services.

Activities: The PA Prevention Project will ensure that the drug and alcohol resources maintained by the statewide Factline are linked to the [stophiv.com] web-site by 31 March 1999.

Priority Population: **I**njection **D**rug **U**ser**s** and **those who engage in HIV risk-related sexual behavior**.

Goal CB 3: Assist state, county, and local adult and youth correctional facilities in the development and implementation of HIV prevention/risk reduction programs and curricula for inmates, administration, and staff.

CB 3 Objective-1 Facilitate a dialogue between the County Wardens Association and/or County Commissioners Association, private correctional providers and the Ryan White HIV/AIDS Regional Planning Coalitions, to collaborate with community-based organizations to implement effective training and resource programs for HIV prevention which would include counseling and testing resources.

Activities: Establish a meeting with the County Wardens Association, County Commissioners Association and/or private correctional providers to discuss the concerns relative to HIV prevention services within county prisons by 31 October 1999.

Activities: Create a plan of action in conjunction with the Ryan White HIV/AIDS Regional Planning Coalitions, and County/Municipal Health Departments to implement HIV prevention services within county prisons by 31 December 1999.

Priority Population: **I**njection **D**rug **U**ser**s** and **those who engage in HIV risk-related sexual behavior**.

Goal CB 4: Assist community-based organizations, AIDS service organizations, the Ryan White HIV/AIDS Regional Planning Coalitions, and County/Municipal Health Departments with increasing the availability of technical assistance to improve the community needs assessment process as well as HIV prevention program planning, operations, and evaluation.

CB 4 Objective-1 Encourage community-based organizations, AIDS service organizations, the Ryan White HIV/AIDS Regional Planning Coalitions, and County/Municipal Health Departments to collaborate with one another in order to integrate the provision of HIV prevention services and avoid duplication.

Activities: Develop an action plan that will facilitate a dialogue and/or meetings of the Ryan White HIV/AIDS Regional Planning Coalitions, and County/Municipal Health Departments to coordinate HIV prevention services by 31 December 1999.

Priority Population: **I**njection **D**rug **U**ser**s** and **those who engage in HIV risk-related sexual behavior**.

Goal CB 5: Assist community-based organizations, AIDS service organizations, the Ryan White HIV/AIDS Regional Planning Coalitions, and County/Municipal Health Departments to assist with their capacity in the provision of HIV prevention services to, for, and by young adults.

CB 5 Objective-1 Provide technical assistance to community-based organizations, AIDS service organizations, the Ryan White HIV/AIDS Regional Planning Coalitions, and County/Municipal Health Departments on how to collaborate with young adults in developing and providing HIV services such as peer education, personal perspectives and profiles, and one-to-one peer outreach to youth and young adults.

Activities: Develop a technical assistance plan in collaboration with the Ryan White HIV/AIDS Regional Planning Coalitions, County/Municipal Health Departments, and youth and young adults to provide HIV prevention services by 31 December 1999.

Linkages

In addition the Pennsylvania Department of Health has created a number of goals and objectives to enhance linkages between primary and secondary HIV prevention activities, other prevention related activities, and coordination of HIV prevention services and programs.

Linkages between primary and secondary HIV prevention services will be enhanced by closer coordination between the Department of Health funded primary prevention providers and secondary prevention providers.

Goal: Develop a “seamless” system to insure that HIV positive individuals transition effectively from primary to secondary prevention services.

Objective: Assess current status of referrals from publicly funded C&T sites to determine barriers to secondary prevention services by 15 November 1999.

Objective: Analyze referral and follow-up data from field staff and central office records to determine the percent of clients referred who have complete referrals to case managers or local AIDS service providers by 30 June 1999.

Objective: Analyze preliminary data from focus groups being conducted with Ryan White funding to determine barriers to access for and treatment compliance by HIV-positive individuals by 30 September 1999.

Objective: Develop and implement mechanisms to overcome the barriers preventing access to and utilization of secondary prevention services by HIV-positive individuals identified at publicly funded testing sites by 31 December 1999.

Objective: Determine the ongoing quality of counseling with respect to knowledge of and access to resources for HIV-positive individuals through interviews with Division of HIV/AIDS field staff and positive results counselors of the independent county and municipal health departments by 30 June 1999.

Objective: Produce and disseminate a directory of resources for Persons Living With AIDS (PLWA) to all publicly funded counseling and testing sites and other appropriate service providers by 31 October 1999.

Objective: Conduct training for division field staff and positive results counselors of the independent county and municipal health departments in barriers and access issues and linking with appropriate staff of local AIDS service organizations by 30 November 1999.

Objective: Conduct training for Ryan White funded case managers and appropriate staff of local AIDS service organizations about access issues, secondary prevention education and "linking" with appropriate staff positive results counselors within their local referral area by 30 November 1999.

The State Health Department has formed a Perinatal Transmission Working Group composed of representatives from the Pennsylvania AIDS Education and Training Center, Department of Health, consumers, relevant Department of Health contracted agencies and County and Municipal Health Departments.

Goal: Reduce the perinatal transmission of HIV.

Objective: Develop an information/resource packet regarding the perinatal transmission of HIV to include updates on counseling and prevention recommendations for distribution to health professionals that impact on women's health services by 31 December 1999.

Objective: The PA AIDS Education and Training Center will compile an information/resource packet and submit it to the State Health Department's Perinatal Transmission Work Group for review by 31 March 1999.

Objective: Prepare the final packet and update the women's health professionals mailing list by 30 September 1999 and mail the packets by 31 December 1999.

Coordination among governmental and non-governmental agencies providing HIV prevention services will be enhanced so that the particular expertise and strengths of both can be brought to bear in a coordinated fashion on the HIV epidemic locally.

Goal: Develop a coordinated system of HIV prevention services that reduces direct service delivery by governmental agencies and maximizes governmental agency cooperation by utilizing governmental agencies as funding conduits and sources of technical assistance and support to non-governmental agencies.

Objective: Identify effective prevention models which readily lend themselves to local adoption and/or adaptation, which are not dependent upon direct services by governmental agencies by 30 June 1999.

Objective: Analyze the results of the demonstration projects in Chester and Erie to determine their suitability for replication in other communities by 31 December 1999.

Objective: Identify other existing culturally appropriate and successful models and programs and select two for replication by 30 June 1999.

Objective: Identify sources of funding and technical assistance to implement chosen programs by 30 June 1999.

Objective: Solicit proposals from local governmental agencies interested in acting as conduits for funding to local non-governmental HIV prevention service providers by 30 August 1999.

Objective: Execute contracts or contract amendments to implement programs in the year 2000 with selected governmental agencies by 31 December 1999.

Evaluation Objectives

Evaluation activities to be conducted between 1 July 1998 through 30 June 1999:

- Development of a comprehensive evaluation plan.
- Community planning process evaluation, to be conducted in November 1998 of the 1998 planning process (using past years' methods, but incorporating the CDC's survey, to be completed by Committee co-chairs and each Committee member).
- Continued process monitoring evaluation and outcome monitoring of community-based health education/risk reduction programs, prevention planning capacity-building activities, and the Internet project.
  These evaluation activities already incorporate the majority of variables listed in the CDC's Evaluation Guidance (Chapter 3, Variables for Intervention Plans and Process Evaluations); however, all protocols will be reviewed for variable inclusion and will be prepared in a manner that reports aggregate

data grouped by target population and intervention type when CDC aggregate forms become available.

- Continued outcome evaluation of the Young Adult Mentoring Project, with a behavior and behavior-change component added to the attitude and knowledge-base components; and a 6-month post-test to measure participants' abilities to retain attitudes and knowledge, and to assess behavior change.
- A Risk-Behavior Change Survey will be piloted at the Serenity Hall SHOUT Outreach project in Erie, Pennsylvania, which provides prevention outreach for active intravenous drug users.
- Continued evaluation of the implementation of the Comprehensive HIV Prevention Community Plan.
- As a next step in assessing client satisfaction of publicly funded CTS, a survey will be implemented involving clients who receive prevention and results counseling at 50 sites across the state. It is expected that 1,000 clients at these sites will complete surveys, including Spanish-speaking clients who will complete a translated version of the survey.

Other activities that will also assist evaluation include:

- Convening an expert panel to review data for incorporation in the epidemiological profile. While this activity directly contributes to needs assessment and planning, but not evaluation, this panel will also be mindful of needs for eventually using epidemiological data for assessment of *impact* of HIV prevention interventions on populations. Therefore, the panel will also provide advice on data collection and analysis for evaluation purposes.
- Gap analysis scanning current programs across the state which address HIV prevention but are not underwritten by CDC funding. This data will assist need assessments and Prevention Committee planning, but will also provide background data for evaluation purposes.

Comprehensive Evaluation Plan

As shown above, many of the evaluation activities required during the next 5-year period (described in CDC's Announcement 99004, A.8. *Evaluation of Major Program Activities*) are already implemented. In the next 12-month period, however, CDC requirements for evaluation, as stated in the CDC's Guidance for evaluating HIV prevention programs, will be weighed against current activities. Where appropriate, current data collection, reporting approaches, and instruments will be revised to incorporate requirements. Such review will be a part of activities leading to a comprehensive evaluation plan.

Below is an explanation of steps that will be taken to devise such a plan. Additionally, the Department of Health has submitted an application to the CDC for funding that would supplement the State's capacity to conduct evaluation of HIV prevention activities. [An enhanced capacity would incorporate a system for equipping agencies at various statewide, regional, and community levels to

address outcome evaluation through shared understandings of and approaches to evaluation and shared resources (such as technical assistance and data collection, analysis, and reporting tools and instruments). An enhanced capacity would also incorporate the ability to conduct cross-community and cross-regional comparisons leading to evaluation of impact of prevention interventions on at-risk populations]. If supplemental funding is awarded, steps for constructing a comprehensive evaluation plan would be integrated with the activities leading to an enhanced capacity for prevention evaluation, as indicated below.

The Health Department will contract with the PPP in facilitating activities leading to this comprehensive evaluation plan. The Health Department will oversee and issue approval of the overall procedures and time table for issuing a plan. To begin the planning process, a training and consensus-building session will be held in December 1998. This session will include members of the Prevention Planning and Evaluation Sub-Committee of the Prevention Committee, which will keep the larger Committee apprised of ongoing development of the evaluation plan. Also participating will be appropriate members of the Department of Health's Division of HIV/AIDS and PPP staff.

This session, coordinated by the Director of Evaluative Research at Pitt and presented by experts in evaluation and consensus building, will present basic information about program and systems evaluation, including definitions and examples of various evaluation approaches (e.g., process, outcome, and impact evaluation); present an overview and description of current evaluation activities already undertaken or planned, including resources for conducting such assessments; review CDC requirements and guidelines for evaluation; and begin a consensus-building process for determining evaluation goals and strategies to be incorporated in the comprehensive plan. (With supplemental funding, this session would also serve as a "kick-off" function for building a statewide infrastructure for evaluation. As such, it would also include site staff of current prevention outreach demonstration projects who would serve as technical consultants to future prevention intervention projects incorporating evaluation activities; other outside experts who would be expected to provide evaluation technical assistance to regional and site-specific agencies across the state in the future; and representatives of the Ryan White coalitions to address shared and integrated approaches and resources for conducting evaluations.)

Continued information and consensus-building sessions will occur throughout the year involving the Sub-Committee members and the Division of HIV/AIDS and PPP staff. Consensus reached by this group will be reported to the Prevention Committee at various intervals for further revision and consensus by this Committee. (With supplemental funding, planning for an integrated infrastructure for evaluation would also occur throughout the year and would incorporate information and decisions reached by the body forming the comprehensive evaluation plan.)

A timeline for developing a comprehensive evaluation plan follows:

- December 3-4, 1998: Initial training and consensus-building session to "kick-off" production of a plan.
- December through January 1999: Continued information and consensus-building activities. By the end of this time, Steps 1 through 4 of the CDC's Guidance for establishing an evaluation plan (identify goals; assess current resources and capacity for evaluation; describe past current and planned evaluations; and identify evaluation activities required by CDC that are not adequately covered) will be complete. This information will be conveyed to the Prevention Committee for feedback.
- February through May 1999: "Drafts" of Steps 5 and 6 of guidance will be completed (i.e., determine when each type of evaluation will be implemented during the five-year period and when data will be reported; determine how data will be collected, managed, and monitored for each type of evaluation). Prevention Committee will be provided with periodic updates.
- June through August 1999: Revisions to Steps 5 and 6 with Prevention Committee and final draft of comprehensive evaluation plan.
- September 1999: Final Prevention Committee acceptance of comprehensive evaluation plan.

Technical Assistance

Technical assistance activities occur at two levels: (1) The Pennsylvania Department of Health and/or its subcontractors provide technical assistance for various HIV prevention service providers throughout the state and (2) technical assistance is provided to the HIV Prevention Community Planning Committee so that members may be well equipped to carry out decision making activities related to HIV prevention planning.

For example, the HIV Prevention Community Planning Committee has an ongoing commitment to have cultural competency training for Committee members. In addition the Committee has requested technical assistance in comprehending the concepts of harm reduction.

As a subcontractor, the University of Pittsburgh staff will continue to provide technical assistance in eight communities and others as identified, for the community-wide HIV prevention planning initiatives and community leadership development program in order to create a community infrastructure to both develop and sustain HIV prevention initiatives.

The proposed HIV prevention plan requires extensive technical assistance to the seven Ryan White HIV/AIDS Regional Planning Coalitions and County/Municipal Heath Departments, to meet the Pennsylvania HIV prevention standards, to conduct program evaluations, to explore harm reduction techniques, and to become more culturally sensitive and aware.

In Pennsylvania traditionally, the CDC has supported the Counseling and Testing efforts, while state funds have been used predominately for prevention education. The following is a partial list of such efforts supported by state funds: (1) The Council on Spanish Speaking Organizations oversees street outreach programs in Harrisburg, Reading, Lancaster, and Bethlehem, (2) on-site education to migrants and seasonal farm workers, who are largely African-American and Latino(a), is conducted in the six counties with the largest population of migrants, (3) all nine county/municipal health departments are funded to provide HIV prevention services within their jurisdictions, and (4) several drug and alcohol treatment facilities are participating in a pilot project to test the efficacy of OraSure.

The creation of HIV risk-related priority populations was a significant challenge for the HIV Prevention Community Planning Committee. The Division of HIV AIDS and the HIV Prevention Community Planning Committee is committed to the continual refinement of this process to reduce HIV risk-related behaviors in priority populations. In addition, the development of measurable goals and objectives create a process that identifies the specific activities necessary to accomplish the goals and objectives. The Committee will continue to refine the process for the development of measurable and time specific goals and objectives through a complex system of contractual services of the Department of Health. The Pennsylvania HIV Prevention Community Planning Committee perceives itself as a planing body that recommends the direction of HIV prevention interventions from multiple funding sources.

APPENDICIES

- Young Adult Roundtable Consensus Statement
- Relating State-Funded Prevention Activities to the Centers for Disease Control and Prevention HIV Prevention Planning Process
- Pennsylvania Prevention Project Staff

1998 Pennsylvania Young Adult Roundtable Consensus Statement:

HIV PREVENTION OBSTACLES, TARGET POPULATIONS AND NEEDS FOR YOUTH IN PENNSYLVANIA

JULY 1998

Introduction

The concept of a Roundtable Youth Summit began in March 1997 with the realization that Roundtable members and Planning Committee members desired meeting one another. Janice Kopelman, then Co-chair of the PA HIV Prevention Community Planning Committee, recommended such a meeting, which was also to include a major planning component. The Youth Empowerment sub-committee, in subsequent teleconferences, further developed the concept of a Summit, broadening its intention to include the development of an HIV prevention consensus statement both for and by youth. Furthermore, the Consensus Statement would be disseminated to state and local officials, and would be used in the PA HIV prevention community planning process.

Fifteen months later a concept became reality. On Saturday and Sunday, 14th and 15th March 1998, the Pennsylvania Department of Health, *Division of HIV/AIDS* funded the first Roundtable Youth Summit in Harrisburg. The Summit was attended by 64 youth from the seven Roundtables across the state: Erie (20%), Lehigh Valley (11%), Norristown (14%), Pittsburgh (16%), Wilkes-Barre/Scranton (9%), Williamsport (20%) and York.(9%). 34 (53%) of the attendees were female and 30 (47%) were male; 31 (48%) identified as Caucasian; 24 (37%) as African American; 5 (8%) as Latino; and 4 (6%) as "other" (mixed race). 6 (9%) Summit attendees identified as bisexual; 8 (13%) as lesbian; 12 (19%) as gay; and 38 (60%) as straight. Attendees ranged in age from 12 to 29, with a median age of 18.

This two-day planning conference, coordinated by the University of Pittsburgh/*Graduate School of Public Health*, consisted of plenary and small group didactic activities which facilitated the generation of data exclusively for this document. Among the Summit sessions were: the presentation of AIDS epidemiologic data, needs assessment data from the 1996 focus groups conducted among PA youth (Appendix A), and data from the 1997 Roundtables; presentations on peer education, risk reduction and outreach; personal perspectives from two individuals living with HIV; and personal statements by Roundtable members (Appendix B). Appendix C contains only a springboard of research, which supports much of the data in this Consensus Statement. The term "youth," as used in this document and as defined by Summit attendees, refers to individuals between the ages of 9 and 25.

The Roundtable Consensus Statement is presented in bulleted, rather than narrative form in order to facilitate its integration with the HIV prevention community planning process. There are four parts to the *Roundtable Consensus Statement*: Part I: The AIDS Epidemic: A Youth Perspective; Part II: HIV Prevention Obstacles; Part III: HIV Prevention Target Populations; and Part IV: HIV Prevention Needs. Within topical areas II, III and IV are two sub-categories, the first of which presents information from small-group, brainstorming sessions on those three topics. The second sub-category is a prioritized list of information for that topical area. These prioritized lists were developed, through consensus, using only

emerging data from a plenary session at which youth from each of the Roundtables were present. ***It is the hope of Roundtable members that these three prioritized lists in shaded boxes at the conclusion of parts II, III and IV will be utilized in the 1998 HIV prevention community planning process.***

In February 1997 the National Institutes of Health, in collaboration with international experts, consumers and others in HIV prevention, drafted a Consensus Statement entitled: *Interventions to Prevent HIV Risk Behaviors*. The following are among the conclusions and recommendations found in the NIH Consensus Statement:

> The epidemic in the United States is shifting to young people, particularly those who are gay and who are members of ethnic minority groups. New research must focus on these emerging risk groups. Interventions must be developed and perfected, and special attention must be given to long-term maintenance of effects…. Legislative barriers that discourage effective programs aimed at youth must be eliminated. Although sexual abstinence is a desirable objective, programs must include instruction in safe sex behavior, including condom use…. The catastrophic breach between the behavioral science of HIV/AIDS prevention science and the legislative process must be healed. Citizens, legislators, political leaders, service providers, and scientists must unite so that scientific data may properly inform legislative process.

HIV prevention expert Ralph J. DiClemente, Ph.D., author of *Adolescents and AIDS: A Generation in Jeopardy* (Sage, 1992), recently noted in the *JAMA* (20 May 1998, p.1575):

> Given the weight of scientific evidence demonstrating the efficacy of safer-sex interventions and the absence of clear and compelling data demonstrating a significant and consistent treatment advantage for abstinence programs, it is difficult to understand the logic behind the decision to earmark funds specifically for abstinence programs. Unfortunately, much of the public health policy debate appears to have been ideologically motivated rather than empirically driven… Any public health policy that constrains the range of STI [sexually transmitted infections]/HIV-intervention options severely reduces the programmatic flexibility needed to design and implement effective programs…. To promote the health of adolescents, public health policy should be empirically driven, not ideologically motivated. Ideologically motivated policy decisions may inadvertently cause a grave disservice to our youth, many of whom are ill-equipped with the knowledge and skills necessary to reduce high-risk sexual behaviors. In the end, we risk jeopardizing the health and well-being of a generation of youth.

This conclusion is echoed by the Joint United Nations Programme on HIV/AIDS (UNAIDS), which reported in October 1997 that, "failing to provide appropriate and timely information to young people for fear of encouraging sexual activity is not now a viable option."

In reading the following Consensus Statement, please keep in mind its purpose. As one PA HIV Prevention Community Planning Committee member stated: "The only ones who know how best to serve youth are youth. The old heads have tried and failed, and now they need to listen to the youth. We asked the youth to do this, now we have to listen and do something about it."

John F. Faber, Director
Pennsylvania Young Adult Roundtables

1998 Pennsylvania Young Adult Roundtable
Consensus Statement:

HIV PREVENTION OBSTACLES, TARGET POPULATIONS AND NEEDS FOR YOUTH IN PENNSYLVANIA

I. The AIDS Epidemic: A Youth Perspective

Every year more and more youth are being infected with HIV. Within this section of our Consensus Statement many statistics are mentioned about youth and AIDS. About 20% of AIDS cases in Pennsylvania are between the ages of 13 and 29. It is also important to look at ages 30-39, since many of these cases were infected with HIV as youth. In order to lower the statistics bulleted in this section everyone must take into perspective the youth and meet our needs.

- There are an estimated 8.4 million cases of AIDS worldwide, and 30 million people infected with HIV. HIV/AIDS affects all types of young people all over the world. Of the estimated 7,500 new infections of HIV per day among people 13 and older, the majority of these new infections are among 15 to 24 year olds.

- HIV infection is related to behaviors that, if changed, could prevent infection. Most HIV infections worldwide, including those among young people, are caused by unprotected sexual intercourse. Young people practicing particular behaviors (sex without latex protection, sharing needles in intravenous drug use) are more at risk of HIV infection than others.

- There is a cumulative total of 581,429 reported cases of AIDS in the U.S., and more than 216,000 currently **living** with AIDS. There are an estimated 650,000 to 900,000 Americans living with HIV, and about 3% of these (or, between 19,500 and 27,000) live in Pennsylvania.

- Half of all new HIV infections in the U.S. are among individuals under 25, and half of these are among individuals under 22.

- Since 1980, all counties in Pennsylvania have reported cases of AIDS, and all 7 regions of the state and most counties continue to report new cases of AIDS.

- About 20% of persons living with AIDS in Pennsylvania are between 13 and 29, but it is important to look at statistics for 30 to 39 year olds also, since many of them were infected with HIV as young people. African-American young people have the highest numbers of AIDS in the 13-19, 20-29 (as well as 30-39) age groups. But, whites and Latinos/as have significantly high numbers also.

- HIV and AIDS are not affecting just one risk category of young people in Pennsylvania, but a number of risk categories are prevalent. Men who have sex with men, intravenous drug use, and sexual contact among heterosexuals are all significant modes of transmission among young people in Pennsylvania.

- HIV-related conditions make up the 6th leading cause of deaths among 5 to 24 year olds in Pennsylvania (also reflective of U.S. statistics). HIV-related deaths rank third (behind accidents and homicide) among Pennsylvania's African-Americans between 5 and 24, and seventh among white youth.

- STD and pregnancy data show high amounts of unprotected sexual activity (which can also lead to HIV infection) among young people relative to other age categories.

- Data regarding HIV testing and counseling of young people at publicly funded sites show relatively low numbers of young people testing HIV-positive, very likely indicating that young people at highest risk are not being tested at these sites. HIV testing and counseling among high-risk populations may be important for getting people who test HIV-negative to change their risk behaviors, thereby preventing new infections, as well as encouraging individuals found to be HIV-positive to practice safer behavior to prevent reinfection and the spread of HIV.

- Leaders in communities can devise a local profile of HIV/AIDS and its effects on young people in their areas by compiling local data on:
  - Numbers of cases of young people with AIDS
  - Estimates of HIV infection among young people
  - STD and pregnancy data pertaining to young people
  - Counseling and Testing data concerning young people

II. Obstacles To Effective HIV Prevention For Youth In Pennsylvania

Anyone involved in HIV prevention knows that many obstacles exist in effectively reaching certain populations. Whether it be language barriers, lack of funds or taboos, obstacles certainly exist everywhere! As ***young people***, we are one of the major target populations. What could be more effective than to ask us directly what we feel the barriers are in reaching us? As you will see in the following section, we have identified various obstacles. We could have gone on forever! Some may be familiar to you, others you may have never recognized. All of the items listed are of extreme importance to us. In submitting this document to you, we hope that you will take each item into careful consideration. We have been dedicated to complete this. For some it was difficult to feel encouraged enough to voice their opinions. Now that we've had this chance we are genuinely appreciative of this opportunity to convey this information to you. Here it is, followed by our prioritized list!

- required parental consent (in schools, churches, community centers, etc.) for youth to attend sexuality and HIV/AIDS education classes, etc.
- schools don't allow talking about condoms, AIDS, sex, sexuality, or STDs; or limit discussions to abstinence only
- parental avoidance of discussing sex, STDs, HIV, etc.

- government policies regarding schools (abstinence only programs and no condoms) and drug use/needle exchange
- lack of adequate funding for prevention
- religion – doesn't allow for talking about condoms, sex, sexuality, HIV, STDs
- discrimination/prejudice – only "they" can get it (racism/homophobia)
- lack of prevention services (e.g. only planned parenthood in York with a program targeting youth)
- people don't know how to talk about sex
- embarrassment to ask about condoms
- denial that I'm at risk
- scared to make changes (behavioral)
- some men won't use condoms
- language barriers
- battering/abusing women
- getting high (drugs/alcohol) and then not taking care of self
- mental health problems
- pretending that prevention is easy
- pretending that young people don't have sex
- prostitutes who don't practice safer sex or who don't get tested
- stigma of rape: shame in seeking counseling/HIV testing/treatment
- disability – these people excluded from others or not being able to read/write
- poor self-esteem – why take care of myself if I don't like myself
- fear - of being identified as HIV+ and therefore avoiding counseling and testing, avoiding treatment, avoiding talking about it
- fear of being rejected by important others (partners, family, employer, etc.)
- not knowing how to clean or to properly share needles
- lack of clean needles
- lack of condoms
- not knowing how to reach out to IVDUs, MSMs, young people
- embarrassment/stigma of IVDU, gay, poor
- laws that prevent IVDU activities
- few people willing to do prevention
- poverty – lack of welfare resulting in increased personal problems and resulting in decreased concern for HIV. (For example: Parents who can't feed their kids will do anything [prostitution, etc.] to survive.)
- people scared of needles who won't get tested

Ranked Obstacles to HIV Prevention for Youth:

1. lack of cultural competency among service providers, etc.
2. lack of resources/money for prevention services
3. poverty
4. stigma – fear of being identified as "gay" or "drug user," etc.
5. government laws and policies (against needle exchange and condom distribution, for example)
6. drug and alcohol abuse

7. not knowing how to reach IVDUs, MSMs, youth
8. rape/abuse
9. poor self-esteem
10. parental and family attitudes

III. Target (Youth) Populations

Approached with what, at first, is an easy question, "what populations are at-risk for contracting HIV?" soon grew into a passionate debate. But once the list was started, it grew and grew until everyone was included. When the issue of a prioritized list was presented to roundtable members at the Summit, another idea was presented: Why use target populations when this approach has proved to be ineffective? Why not propose an alternative to prioritized lists? Everyone struggled over this issue. What you are about to read is the result of heated debates, energy and frustration; but it is a solid account of the work of the "Target Populations" group and of all the Roundtables as a whole.

young people 9-13 yrs old
males
people ages 14-25
iv drug users
men who have sex with men
poor people
bisexuals
people who attend raves, clubs, and underground parties
sex offenders/rapists
people in drug rehab
people who have or have had STDs
sex workers
people w/ mental problems
people w/ low self-esteem
people who go to bath houses, X-rated movies theaters, etc.
heterosexuals
minorities (Af.Amer, Latino, immigrants)
urban youth
suburban youth
rural youth
people with multiple sex partners
sex addicts
non-minorities
massage parlors
women's shelters
college students
anyone who has unprotected sex
runaways
incarcerated youth
pregnant teens
group home residents
people going through puberty

Prioritized List of Target Youth Populations*:

- Youth between the ages of 9 and 25:
  - gay males
  - racial minorities
  - females

*There is need to approach the issue of target populations differently. As rates of HIV infection continue to rise among youth, it is clear that target populations or prevention efforts to reach these populations (or both) are clearly ineffective as currently defined.. Furthermore, current approaches to identify "target populations" serve only to perpetuate stereotypes, which further stigmatize these groups (e.g., young gay teens). A different approach – perhaps identifying risks

only (e.g., “youth who have sex” or “youth who exchange needles”) is recommended.

IV. HIV Prevention Needs for Youth in PA

This list is proof positive against any argument that the youth of America are lazy slackers who could care less about anything, much less our health. We argued, we debated, we agreed, we discussed, we disagreed. What was left is not an iron-clad list; it is, however, a very good start, and we hope that you take it seriously. Read the list carefully, then read it again. You will see that many of the things we have listed are unusual—they are not things normally discussed concerning HIV prevention. Advocacy? Uncensored information? Local government involvement? These things have rarely, if ever been discussed; perhaps this is part of the problem.

- Youth need to first recognize the HIV/AIDS problem and take ownership (*do something* in communities for prevention).
- Information should be distributed in a way that is Fun and Educational.
- HIV/AIDS Education should begin early (middle school).
- HIV testing and counseling needs to be more available to suit the schedules of young people (not your average 9 to 5, M-F).
- There should be more anonymous and safer ways to get information.
- HIV testing should be offered anonymously.
- Information should focus on everyone (Community mentors and family members – not just youth).
- We need more support from Community Leaders (legislative leaders – Governor and Mayors); they need to be vocal about the issues. There needs to be increased lobbying and more advocacy by these community leaders.
- Need for more information in the schools.
- Condoms should be distributed in the schools together with the information. Condoms will also need to be both male and female condoms – both sexes need the information and tools.
- Staff who deliver HIV prevention messages need to be better trained.
- Teachers need to have training on HIV/AIDS. It should not only be Gym Teachers that do this education.
- There is a need for a new school curriculum that is designed to provide up-to-date, accurate information and prevention education specific to HIV/AIDS.
- Peer Education should be offered in the schools, peers who can teach others about HIV/AIDS.
- The education needs to be UNCENSORED.
- Needs for more peer education and outreach outside of the schools.
- The need for more and better education in the college universities and education in the dormitories.
- Prevention messages need to be consistent and repeated over and over.
- Prevention messages should be targeted and media can be used to really get the messages out.
- Increase in outreach interventions – more one-to-one interactions which set examples for youth.
- increased support to those young individuals who are doing the HIV/AIDS work
- more role models who are effective at delivering the messages to youth

- Give a face to the numbers.
- properly trained counselors and facilitators to properly provide harm reduction techniques
- Give information to youth in a format that is comfortable to them and that is safe.
- Use multi-media outlets that are attractive and focused at youth.
- Give incentives to get youth into HIV counseling and testing.
- More electronic media outlets to youth.
- increased “hands-on” community outlets to increase enthusiasm among youth
- Have youth working in the clinic settings and in HIV counseling and testing sites.
- Have teens working a Hot-line, so other young adults can talk to people like themselves.
- Have a condom mobile.
- Support educational programs that offer options other than just abstinence based, such as risk reduction and other issues (self-esteem enhancement)
- Showcase conferences (Ryan White Conference) more of these ways (Summit) to go to these events to learn and interact with other youth, talk about ideas and increase networks and opportunities to plan and discuss activities.

Prioritized HIV Prevention Needs:

#1 Advocacy and Education

- more advocacy and education by leaders in the roles of:
  - politicians
  - school boards (representatives)
  - city council members
  - other governmental institutions
- education in jails, correctional facilities and juvenile detention centers
- education in community centers
- education should be culturally competent
- education should use non-traditional forms of prevention
- advocate for more HIV testing

#2 Cultural Competency

- increase education in this area of cultural competency
- use it to meet needs in each community by assessing the needs of each community
- educational materials should relate to the diversity of the community
- recognize and be more aware of the differences among racial and ethnic groups, and cultures
- HIV prevention programs should be adapted to diversity
- learn the language and speak the dialect of the community

(continued)

#3 Prevention

advocating for HIV prevention efforts to use non-traditional ways in doing prevention programs such as:

- harm reduction
- needle exchange
- offer options (ex: abstinence, risk reduction, self-esteem)
- educate about reproductive health issues
- increase prevention education
- more peers educating peers, using personal perspectives and personal profiles (stories)
- outreach (peer and one-to-one outreach, etc.)

#4 Increase in HIV testing and counseling

- this will assist in prevention
- use it to educate youth
- advocate for more accessibility to testing sites in different communities, better hours offered
- offer more information in communities (be culturally competent)
- have youth involved in pre/post test counseling
- use alternative ways of testing (ex. orasure)
- have a youth-line, phone-line bases at the testing site, for youth to call in and ask questions

Notice that the main list of Needs (1-4) high priority are located within each sub-category. So although high-priority #1 is advocacy and education, underneath high-priority #1 is the need to a) be culturally competent, b) educate in non-traditional ways in prevention, and c) advocate for more HIV testing.

V. Declaration

We are your sons and daughters. We are still getting infected. We are chained to your fears. We are still getting sick. We are having sex. We are the future. We are exhausted by your silence. We are tired of your excuses. We are still dying. How many more infections do we have to count before you listen to us? Are 5,000 not enough? Are 50,000 too many? We are demanding that you help us. We are hoping that you will help us. Please ACT on what you have read.

On behalf of all Roundtable members, we, the undersigned youth representatives, present this document to the Pennsylvania HIV Prevention Community Planning Committee on this 15th day of July 1998. The information contained in this document was gathered at the 1998 Roundtable Youth Summit and represents the collective perspective of Roundtable members from across the state. We believe that if HIV prevention is to be made effective for the youth of our state, then the strengths of current interventions must be acknowledged and the weaknesses of others must be addressed.

Erie:

_____

_____

Sarita Rodriguez Mara Johnson

Lehigh Valley:

_____

_____

Steven Tabb Byron Morris

Norristown:

_____

_____

Stephanie Doane Rachel Balick

Pittsburgh:

_____

_____

Gene Artman Darnell Christian

Wilkes-Barre:

_____

_____

Thomas Harrington Steve Wallace

Williamsport:

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Emily Clark Lou Shar Robinson

York:

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_____

Leonarda Vazquez Lois Winston

All data in Parts II, III and IV of this Consensus Statement were generated by Roundtable members during the Roundtable Summit. This document was prepared and edited by: Gene Artman, Steve Wallace, Sarita Rodriguez (Roundtable Executive Committee Co-chairs); Emily Clark (Roundtable Executive Committee and Planning Committee Alternate); the members of the 1998 PA Young Adult Roundtables; John Faber (Director of the Roundtables); and Michael Shankle, Matthew Moyer, Mark Friedman and Jan Ivery (Roundtable staff). Epidemiologic data were presented by John Encandela (PPP). This document would not exist without the collaborative support of the PA Department of Health, Division of HIV/AIDS*; the PA HIV Prevention Community Planning Committee; and the University of Pittsburgh,* Graduate School of Public Health*.*

APPENDIX A

Public High School Students
1996 Focus Groups
n = 8

Participants were asked to rate on scale from 0 to 10 (0 being "absolutely none and 10 being "a lot") the amount of information about HIV/AIDS that they obtained from their public schools.

- A majority of the participants rated the amount of information that they received from their schools between 1 to 5. In general, the participants did not think that they received a large amount of information from the schools and desired more information about HIV prevention.

- Participants noted that the amount of information varied from school to school and was dependent on the teacher's ability and willingness to present the information. In addition, participants recalled information being presented only once in either grade school or junior high; this initial presentation was usually not reinforced in later grades, such as high school.

Participants were asked to rate on scale from 0 to 10 (0 being "absolutely none and 10 being "a lot") the usefulness of the HIV/AIDS information that they received from their public schools.

- There was wide variance regarding the usefulness of the information received: 1/3 of the participants rated the usefulness between 1 and 3; 1/3 rated the usefulness between 4 and 6; and 1/3 rated the usefulness between 7 and 10.

- Participants who rated the usefulness between 7 and 10 noted that the information they obtained addressed specific sexual risks and was applicable to their situation. Participants who rated the usefulness as low (between 1 and 3) discussed that the school avoided the subject of HIV/AIDS, teachers were not comfortable discussing adolescent sexuality, the HIV prevention message was limited to abstinence, and/or the information was focused to a heterosexual group with a pregnancy prevention message.

Students noted that information about HIV/AIDS was presented to them in the following ways:

- video tapes in classroom followed by a written test
- health class or science class presentation
- guest speaker from an area AIDS organization

- two groups recalled puppet shows about HIV/AIDS

Participants emphasized that HIV prevention was usually provided in one class during grade school or junior high and then usually not repeated during high school. If the information was presented during high school, then the information was usually the same information. A majority of the groups noted that the information was usually facts about HIV/AIDS (such as current statistics) and not specific information addressing sexual activities, sexual orientation, and risks associated with needle sharing.

In general, **the HIV prevention information was not specific - meaning the information did not address specific risk activities and specific way to prevent HIV.** The information was discussed in relation to heterosexual couples and not in relation to men who have sex with men. If homosexuality was mentioned, homosexuality was portrayed as dangerous and something that the youth should not do.

Participants in two groups discussed that their teachers told them that specific information could not be provided by the school since parents would become upset or the school did not allow teachers to discuss specific information.

HIV prevention information is not consistent between schools. For example, participants from different schools within the same district noted that one school may discuss and demonstrate condom use while another school will not.

The ways that students received HIV prevention information in the schools varied. For example, participants in one group discussed that one area high school has a whole week of classroom and school activities that address HIV prevention and AIDS. A majority of groups, though, noted that HIV prevention is provided in one health class (approximately 2 hours in length) during junior high and the information is not repeated.

Participants in all the groups generally agreed that the health classes were not effective in providing HIV prevention education. Most groups described the health classes as boring and the information presented was not relevant to their needs. Participants noted that the gym teacher may not be the best person to present information on HIV prevention.

Two groups noted that HIV prevention information was presented with other information about sexually transmitted diseases and thus students did not know that sharing needles and injection drug use are risk activities, also.

The information available through the schools was dependent upon the students' initiative to ask for information, the teachers' willingness to provide information, and the principal's leadership in arranging for information and activities.

A majority of the groups reported that, as students, they had limited HIV-related activities or assignments outside of any classroom presentations about HIV/AIDS. One group discussed that student organizations will support an AIDS walk, but there was resistance from other students since the AIDS walk was viewed as a gay event and some students are not accepting of people who are gay. Two groups noted their school brought part of the AIDS quilt to the school. Participants in two groups discussed that they wanted to write term papers about HIV/AIDS, but they were discouraged by their teachers. Another group noted that they were supposed to have a field trip to an AIDS event but the principal canceled the event with the explanation that AIDS is associated with homosexuality and drug use and these two activities were not acceptable in the community.

The participants recalled receiving the following HIV prevention information from their schools:

The emphasis was about statistics, such as how many people have AIDS and what the terms 'HIV' and 'AIDS' mean. Content also included ways you cannot get HIV, such as toilet seats and casual contact. Some groups thought one could contract HIV from kissing, while other groups did not think one could become infected through kissing.

All groups stressed that they were told not to touch blood. Participants noted that students could not participate in sports/physical education if they were bleeding and gym teachers would clear the basketball court if there was blood on the floor.

The main prevention message that the students received was to abstain from sex. Participants recalled that abstinence was emphasized since sexual activity among adolescents is considered wrong. Students noted that the abstinence message is not realistic since many students are sexually active. Alternatives to abstinence are not discussed , nor are 'alternative lifestyles' - such as lesbianism, homosexuality, or bisexuality.

All the groups recalled hearing that one needed to wear a condom to prevent sexually transmitted diseases and HIV during sexual activity. The only sexual activity discussed was vaginal intercourse. Most of the teachers did not discuss anal or oral intercourse and participants noted that both these activities occur among adolescents. Three groups noted that teachers were not comfortable discussing sexuality or specific sexual activities such as oral sex. Only one group mentioned a discussion occurred regarding dental dams.

Two groups noted that teachers at two different schools demonstrated how to use a condom by using a cucumber or banana.

Participants in one group recalled hearing from a teacher that AIDS is from gay people and gay people give it to you.

Some participants in the groups noted that they were told not to use injection drugs or use other people's needles.

One group recalled attending a skit about the stigma of having HIV.
One group reported that they received information about how drugs and alcohol may affect your judgment and place you at risk for HIV infection.

In general, information received had little impact since the information was too general, the message was not realistic (abstinence), and the students did not think the information pertained to them. One gay group noted that 'straights' in their schools perceive HIV as only a gay disease and will not consider or change their risk behaviors.
Participants reported that they would like the schools to provide the following information:

Overall, a majority of the groups requested sex education information. Participants noted that they would like to receive sex education information from their parents - but many parents do not want to discuss sex with their children. In addition, the schools won't address sex education since the schools think it is the parents' responsibility to teach this information.

Participants emphasized that students need specific and detailed information about sexual issues, including the prevention of HIV, so students could make informed decisions regarding their health. Participants noted that not all students are abstinent and not all students are heterosexual, so the information is needed so students can prevent disease and death. In addition, students need negotiation skills so they can know how to deal with pressures that may place them in an at-risk situation.

HIV prevention information should start in the middle schools and be presented each year. The information should be increased each year and address the following: specific activities that can place one at risk for HIV infection, specific ways to prevent HIV infection (including how to use a condom and information about the female condom), information about HIV testing, and birth control methods.
Participants in the groups discussed the need for condoms and suggested condom distribution and birth control methods be available in school.

Information presented in the classroom needs to be supplemented by outside activities and assignments.

All groups wanted a ‘more personal perspective’, meaning presentations by people who are HIV positive. Participants noted, though, that the people should be like the groups that they are presenting to - meaning young adults close to the age and experiences of the groups they are presenting to. Participants suggested that the speaker needs to be as close to the audience as possible since most students perceive HIV/AIDS as only a gay disease.

Some participants noted that they would prefer a small group discussion with a person who is HIV positive instead of a large assembly since information is not heard at an assembly and students cannot ask questions..

Three groups discussed that they would like information on the following: transmission through blood products, risk of kissing, risk of oral sex, sex between gay people, and if HIV is present in saliva, and if lesbians are at risk for HIV.

Two groups would like information on the following: not discriminating if someone has HIV, new findings and treatments for HIV, how someone who has HIV progresses to AIDS, and more information about how the virus started (one group wondered if the virus started because a monkey was infected).

Other groups cited that they would like the schools to address HIV with the same intensity that they address other subjects, such as alcohol, drugs, car accidents, and date rape.

Information was requested about ‘alternatives lifestyles’, meaning information about being gay, lesbian, and bisexual. One group noted that they thought it was good for straight people to know about ‘alternative lifestyles’, also.

Participants recommended the following ways to get HIV prevention information to students:

Use outside speakers since outside speakers may be able to present more information in the classroom than teachers can. Outside speakers do not have to follow the school’s regulations as closely as teachers. Outside speakers may be more informed than teachers who are providing HIV prevention in the schools.

Most groups thought that adolescents would respond to speakers who are like them, including speakers who are HIV positive since they can give the message that ‘if it happened to me, then it can happen to you’.

Use speakers who are comfortable with the topic of HIV/AIDS and sexuality, especially sexual activities such as oral sex. Presenters should be able to discuss a subject without labeling the topic as unacceptable.

Four groups recommended establishing peer education programs. Peers or older youth would be trained to teach HIV prevention to students. One group cited a peer education program their school offered that addressed postponing sexual involvement.

Establish a new health curriculum with new ideas and new materials. Make health education a priority in the schools.

The gay, lesbian, and bisexual groups discussed the need for teachers who are 'out' so the students who are lesbian/gay/bisexual will have role models and resources regarding sexual orientation.

Do not use videos since people will not listen and some videos do not seem 'real' and are not effective. Do not only use pamphlets since information is thrown out. Participants noted that they would prefer group work and speakers instead of just giving out pamphlets.

All groups cited that they get the best information from the following sources:

1. TV - such as MTV (especially the series with 'Pedro'), news programs, soap operas, popular prime time shows, public service announcements, and talk shows. Three groups discussed 'Channel one' - but not all participants have access to Channel one.

2. Magazines like Time and Life; magazines about celebrities that will do a story about a celebrity with HIV.

3. Movies - such as Philadelphia, The Band Played On.

4. Someone they met or family members they know who are HIV positive.

Additional sources that were cited by participants within groups:

1. School for general information and individuals that are seen as trusted, credible sources within the school, such as health teachers, counselors, and school nurses.
2. Family physician or therapist

Three groups noted that their parents provided the best information, especially if the parents were health care professionals (such as doctors and nurses) and the participants had access to the parents' reading materials (medical journals).

The gay, lesbian, and bisexual participants cited peers, gay literature (such as gay newspapers, magazines), and AIDS events and sources.

Other sources cited by 2 or less groups:

Local religious organization
Community groups through volunteer work
Lollapalooza rock concert
Friends 'on the street'
Youth roundtables - especially the discussions at the Roundtables
Camp counselor job

Participants cited that the following factors prevent students from receiving HIV prevention information in the schools:

Teachers are not comfortable discussing the subject or are not interested in the subject . The focus in the classroom is teaching topics that are on the schedule, and not teaching anything outside of the scheduled topics.

Teachers are not allowed to provide specific information about HIV prevention. Teachers not allowed to address gay, bisexual, or lesbian issues. Teachers who are gay have to be careful since may be accused or "recruiting" students.

Parents do not want schools to discuss HIV prevention or sexual issues - especially condom use. Parents will claim that youth need to learn the information at home, but parents will not discuss the information, either.

Parents are scared of AIDS and do not want to address the issue. Parents do not know how to address the sexuality and HIV with children.

General resistance in society to discuss homosexuality.

School clinics are limited in what they can provide students. For example, participants in one group discussed that a student can get a pregnancy test at one school clinic but cannot get condoms, information about HIV or HIV testing, or birth control.

School boards and politicians do not want HIV prevention information presented in the schools.

APPENDIX B

1998 Roundtable Youth Summit
Personal Statements

The following personal statements were voluntarily offered on day-two of the Summit. Names have been omitted from each statement in order to protect the confidentiality of the individual. Several individuals chose not to speak at the podium, but rather to submit written statements. These are found at the end of this section on page 14.

…I'm from the Erie Roundtable… I think that education is very important with everything in life… Because when you don't know something you're gonna have a more likelihood of being afraid of what you don't know, like fear of the unknown and things like that. And I think it's important to educate yourself and to understand basically AIDS, racism, anything. But right now we're talking about AIDS… I think education is important. I think that it needs to come from not just from peers but it has to come from adults in society and things like that… It's a dilemma we have right now and it's something that's not going to go away… more than likely it can get worse... So I think it's important that… we all educate ourselves about it and that we offer that information to people who don't know, to the ignorant people or the people that are afraid of what they don't know… I think it's important that we all work together as one and try to educate each other because we all have the same goal. We all wouldn't be here if we didn't have the same goal… We all want to get through this. Do something to help this AIDS dilemma that we have right now. That's basically all I have. Thank you.

I'm… from Erie. Basically it's kind of like to reinforce what [N.] said: We need adult support. We need people in the community that we can look to for advice. Mentors, that type of thing. I think that we need to take control ourselves because a lot of times there is not that many leaders and a lot of followers. So most of us in here are very empowered; we take control... And that's what we need to do and try to keep the energy level high to get everybody else involved, not be exclusive. Try to meet everybody. Try to get everything together. I think that they need to involve more teenagers in clinics, HIV pre- and post-test counseling. That type of thing because a lot of times you'll feel more comfortable talking to someone, you know, that you can relate to. Also, provide incentives for those who are in a less, how do I say this, in a lower income/housing... lower income or that are disadvantaged youths. That type of thing. What else? Education. Condom distribution in schools. Having people prepared to answer questions just in case. If important authority people in schools and communities prepared to answer some of these questions so that the youth can feel like it's not bad. If you want to know something then, ask. That's basically what I have to say for now.

Hi… I'm from Erie. Mine's just a simple and straight to the point. OK, number one is definitely education. Two would be hands-on experience, such as getting out into the community and doing something and not just out here saying we're going to do something about it. And number three would be importance to reinforce the use of

people from community organizations to work in collaboration and to attend the roundtable meetings. Thank you.

Hi… from Pittsburgh. My opinion is that we've been talking a lot about obstacles, like how we would overcome them. There is not one obstacle that we've mentioned that cannot be overcome. The biggest obstacle that we have to face yet is ourselves… Keep doing what you're doing. Just work harder at like trying to prevent and keep prevention around. Just keep up the good work. That's all I can say.

… from Pittsburgh. It said that we could share a personal experience. When I was in high school, my sophomore year, all our students in students counsel decided that…school education isn't working and we need more education about AIDS. We decided to have an AIDS awareness week. We got the approval of the school. We got approval of the principal who was very supportive. We got approval of the teachers. We thought that would be enough. There was a lot of info from outside agencies cause it was a big city. But the questions was bringing it all in to the school. We knew we couldn't bring in condoms. We couldn't pass them out even on the sidewalks next to the building cause it was still school property. Next was getting the money for it. We wanted to bring in some patches for the Quilt. We wanted to bring in speakers. There was a supplemental school grant, $500 that was given out by the Alumni Association and by the Parent Teacher Association. There were usually eight available that year. We applied. They gave out six. We were people who didn't get it. Our Principal managed to allocate $50 for us. So what do you do when you can't get your own patches from Quilt? You make your own quilt. We bought material. We made Clubs make their own little patches with their messages. Right now there's four quilts hanging in high school. My first year we wanted to raise some money for the Pittsburgh AIDS Task Force and also our first year coincided with the first AIDS walk in Pittsburgh. So we went as a unit and our Principal went with us. Every news camera that was there, every channel, shot us. Every newspaper shot us. Only one paper published it. Our school newspaper the next month's issue had three positive responses to cap the week off with a candle-walk through the school. We stopped all the classes. We actually stopped turned out all the lights in the rooms and we had the school choir follow the group of people who were involved with the project. And every news crew showed it. When we went to the AIDS Walk we didn't have the money for the T-shirts so we actually just went to K-Mart and bought white T-shirts and stenciled our school name on them. Second year, we had all the money we wanted. Third year, we had all the money we wanted. Fourth year, which is coming up right now, they're having a kick-ass program. Don't give up cause that's the only way you're gonna get the funding and you're gonna get the job done.

OK. I wrote mine out. HIV/AIDS prevention begins with giving youth the tools they need to learn and grow from their mistakes. We must work to give youth a purpose, support and acceptance to do whatever is right for them in this life. I believe the answer lies in us, in our youth. In order to prevent the spread of HIV and AIDS we must be educated. With that education we empower ourselves and our peers. As educated and empowered youth through our communities and relationships of trust we can offer choices, safer choices, to those at risk. All of us.

Hi… I'm from Pittsburgh. I've been involved in this program since the very beginning, actively. But I'd like to… say that I'm glad to see where it's going and that efforts aren't wasted. We have a serious disease out there and I'm glad to see people my age and younger are actually involved and care… I wish that the disease never was, but it is. And the only thing I can say, I'm really glad everyone's here. Keep up the good work. But when you leave I just charge you all to question yourself not on what you've done but what you haven't done yet.

I'm… from Williamsport. We've done a lot of talking about obstacles this weekend. We've posted them on the walls. We talked about them before we got here in our own Roundtables at home. Part of removing the obstacles is to acknowledge them and we've done that. Several times now. So it's time to move on to the next step, I think, for the people in this room. Now that we know the obstacles – we know that we have problems with our parents and, the adults at home; we know that our schools are a big obstacle; we know that money's an obstacle – we've also heard how that can be overcome. So it's time for us to take the initiative, time for us to go home and start talking to our parents. Don't be afraid to stand up and tell them what you want. Go to your school board and tell them you want condoms in your schools. That's the only way it's gonna happen because nobody's gonna do it for you. We have the information. It's been provided for us. We know who supports us. We know that the State Department of Health is there for us. We know who in our community we can talk to. In each of our communities there's obviously somebody that cares or we wouldn't be here today. So go back to those people and encourage them to speak up as well.

Hi… I'm from the Wilkes-Barre roundtable group. Personally I have a great perspective on us right here now. To think that we're the first state that is actually having a young adult roundtable meeting and actually getting youth involved in our communities and our State to help in planning HIV prevention is great. I've never had that outlook on HIV education in general with schools and all. I came from a high school that was very actively involved with HIV/AIDS education with youth and peer education among other classmates. I just think that what we're doing now is what really counts and what will make us go far and farther. And what everyone else has said prior to me, that as long as we keep trying and keep doing what we know is right and keep bugging our parents and bugging our adults on what we want done will eventually get done. And right here, right now is a good sign to show that because we asked for this last year and we now have it. It may take a little time to get things done but they are getting done, and hopefully everyone here will see more things that we will get done throughout our roundtable, if you want to call it a career. It's very time-consuming and it's a great challenge that we are facing and hope everyone else tends to stay with it as long as they can.

Hello, I'm… from Allentown, Lehigh Valley. My statement is about the lack of condoms, about the lack of condom use. A lot of people know about HIV and AIDS. A lot of people don't know about HIV and AIDS. But I think a lot of people do know. …It seems like people don't value their lives enough to wear a condom or take the proper precautions

they should. It seems that people don't understand that the same way you get pregnant or the same way you get STD's is the same way you get AIDS. I don't understand. I mean, I don't understand. So, OK. Like I said, you can tell people about HIV and AIDS and you can tell them that they really need to use condoms or they need to do this but you can't strap on the condom for them. You can't bleach their needles for them or whatever, or change their needles or whatever. So I mean, the question that I have is how do you get through to people like that? I mean, I don't understand. If you tell someone over and over again that yeah, you need to use a condom, this, this and that and they ignore it, how do you get through to them? I think, I think self-esteem has a lot to do with HIV prevention because if people don't feel good about themselves or they don't value their life, they're not gonna take the necessary precaution because they don't care. And that's it. That's all I got to say.

Hi, …I'm from the Wilkes-Barre roundtable. I have a personal short little story to share with you. Earlier this year, a friend of mine, my closest friend since high school, I lost him to AIDS. He was about 24 years old. He came out in his high school years, his early high school years, had no support from his parents. Had no outlets. Felt he didn't have a choice in life. Felt that the only way he was going to meet someone and the only way he was going to be able to live as a gay man was to go to the clubs, go to the bathhouses. He didn't think he had a right to love, to pursue the kind of life that we all wish to have. And the truth of the matter is I wish he could see all of us here today because we're all here by choice and there are some of us here that are pursuing long-term relationships. And whether you're straight or gay or bisexual or whatever we all have the right to the quality of life that our parents had. They had obstacles. We have obstacles and we can get through this. Thank you.

… I'm from Pittsburgh. I've been involved with HIV and AIDS prevention work for about four or five years now… and I'm in the Roundtables… and I do outreach in Pittsburgh. And everyone who knows me know that I do this work. Yet in the past two months two friends of mine have just told me that they have tested positive. And I'm feeling very frustrated right now that I'm doing all this work and it doesn't seem to come to fruition half the time. And I'm frustrated that people know better or know what they can do to prevent getting infected and they're not doing it. And I'm frustrated for a lot of reasons. I feel like, there are a lot of people who are doing this work but I feel like I'm still by myself a lot of the time. And I feel that there's no support from the gay community anymore because it's a "treatable disease". And I feel very angry… And I'm angry about all these things and I don't know, I don't know what to do about it. I don't know how to stop being angry. I don't know how to stop my friends from getting infected. I've done all that I know that I can do and I'm really upset. I just want you guys to just remember why you're here and when you go back home just do what you can and just remember that it's the best you can do. Thanks.

OK. I'm… from Erie. I don't have a lot to say but no one's getting up here so I'll say something. I think that we just need to emphasize more, I mean if we're not gonna have, you know, the condoms in schools or, you know, parents don't want to talk about it, that we, ourselves, need to get out there and make sure other people know what the options

are. You don't get out, get your own rubbers, you know what I mean. Family Health Council, they give out six, six a week, I think to somebody. Or if you ask for more you can get..., but they'll give you six. You walk in they'll give you six. You know what I mean? That's just in Erie. I just think we need to emphasize (my voice is shaking I'm not good). Just emphasize that far. That's all.

…I'm a member of the Wilkes-Barre roundtable group. I don't have a lot of experience working with people with HIV and AIDS. In fact, this has been my first experience becoming a member of the roundtable group. And I must admit to you it's been extremely rewarding and I feel like I'm really making a difference. I believe that we've talked a lot over the past day or the past several months about target audiences to reach, who we should be looking at. I believe the target audience we have to be looking at is today's youth. We have a strong group of people here. People here that are taking the initiatives to educate themselves and pass it on to others. And since no one else is really doing it I think it's up to us to do it. However, I also believe that our most insurmountable challenge facing us is changing existing attitudes, particularly those of prior generations. We have a very strong network of people here and I just think we should work together to stop this spread of this horrible disease. And hopefully, you know, the next few years, if we're lucky, maybe we won't be here working on it anymore. Thank you.

I'm… from the Lehigh Valley. I think we need to focus on the group that has the highest risk. People need to be educated. People also need to get more involved. The more that we as a whole get together and educate others the easier it will be to decrease the AIDS population. Once we let others know that we are serious about stopping the AIDS epidemic, they might stop and think, "Hey, maybe together, we can change the world".

Hello, I'm… from the Norristown group. As a college student I see campus and dorm life as an important target audience. On my campus, one in six students has an STD, which has to do with the fact that it's one of the top drinking schools in the state. This means that HIV virus could be running rampant on the campus, also. The education on campus, so far, is basically in pamphlets that are at the Health Center that no one reads and a basket of condoms that you have to ask the nurse to have. I've tried to do some programs on AIDS and I got peer educated training, but I believe that you have to try and reach out to people more. I think colleges should spend more time in classes talking about prevention of disease other than just health class which people just skip. They should give out condoms as well as information and they should be made available in the dorms. And often forgotten but as important is info on drinking safely and alcohol abuse prevention. But the main thing that probably needs to be done in colleges to scare the hell out of the students with the truth and see the effect of the AIDS. Because as much as they'd like to think, college students are not invincible.

… I was feeling a lot of frustration. Not necessarily concerned with the Roundtables but with the outreach work that I do. And I'm so glad that I came, just to meet Christopher and Terry [two individuals living with AIDS who spoke at the Summit], who are people that through my outreach I would never have come in contact with but have really kind

of inspired me to keep doing them. A lot of times I wonder if these people don't care about themselves, I don't care about them. Why am I going there, putting myself through a horrible nightclub that I hate anyway. But now I have the inspiration to keep doing that. And for that I'm glad. You know cause when I was sixteen my biggest concern was like when does the mall close on Sunday? So that kind of put things into perspective for me. This thing is very, very nerve-wracking. But that's all I have to say and I did it under a minute. Good for me. Thanks.

… I'm from the Pittsburgh group. I just wanted everybody to just think about your own unique situations and the people that you know that others might not know or might not get a chance to talk to. For example, I work at a daycare. So one thing that I might be able to do, it would be difficult to just come out to the parents and just bring up the AIDS issue, but what I could do is, they had coloring books for children and, you know, maybe I could present those to the parents and ask them if they have children that are at the age where they should be learning about it, maybe they could give them the coloring books. Another thing is being vegetarian, I know a lot of people that are against animal testing, so I can maybe pass out condoms that aren't tested on animals to them because that's something that I can do for that group. So if everybody could just take the rest of my two minutes to think about unique situations that you have and people that you know, just think about what you can do in your own community. And, you know, the people that you know aren't necessarily the people that everybody else knows.

I'll go again… I'm from the Pittsburgh group. And once again, yeah, work we are doing here is important. … I'm bisexual and I've known it my whole life. But coming out to my parents was tough. And my mother always educated me about safe sex and protection and everything. Like she offered to buy me condoms. And my response to her when she offered to buy me condoms was, "Mom, if I can't go and buy them myself, I'm not ready to have sex". When I started getting involved with AIDS-work, it was after the first time I saw a movie about the quilt. And I said, "I don't want to be one of those patches. I DON'T WANT TO BE A PATCH. I DON'T WANT TO BE A NAME ON A PIECE OF CLOTH". Make sure that none of your friends are, and make sure you don't end up as one.

Hi, I'm… from Wilkes-Barre. Basically what I have to say is everybody knows we need responsibility, community commitment. But I think, most importantly, you need the courage to be a friend. Think about a person that you dislike or disrespect, maybe for actions they take or the values they disregard. My advice is to take them under your wing, because they are the people who need you the most. Within all of these people exists a void filled only with self-hatred and lack of love. Low self-esteem is one of the leading causes of drug use and promiscuity, and therefore, AIDS. So my piece of advice is to motivate others to care and to love and to simply find someone who you least likely would consider a friend and do just that. Be a friend.

Hi. I'm… from Norristown. And in my opinion, I think people are still ignorant, especially in my high school. And I find it really frustrating cause they have the mentality of that, "Oh, it can't happen to me". And I think to change that we need better education. And do

to that we need to change legislation because how can you talk about issues if you aren't allowed to talk about certain subjects and you're not allowed to show them certain things or like give them condoms or just something that they need and a lot of people are embarrassed about discussing. And we also need to stop placing blame. And we can't look at this as a sexual preference or race issue because the truth is that everyone is at risk and I don't think people realize this. They think that , you know, it just can't happen to me because, you know, I'm not gay or I'm not like this and I'm not that. And that's not true. It could happen to anybody. That's it.

I don't know how to do this but I'm gonna say a little something something …. I don't know how to speak up on no mike. First time for everything. Sure enough. No doubt. OK. Alright. … I'm a young mother from York, PA roundtable. I'm here to speak in my own words about how I feel. And the way I feel is that it's very important to me to help out in any way about the AIDS and HIV and to give out information that I know to help out other people and to help stop the spread of HIV and AIDS. We must allow ourselves to be persistent in what we are here to achieve. But in reality, spreading the word of knowledge out to others is very important to me because I have two kids and they're young. And as they're young, I feel as though it's my responsibility to talk to my kids when they old enough to understand what's going on in this world before it's too late... And I think it's very important to me. What I'm getting from here is good information that I can take back to my two and to the other meetings that I go to. So, I'm just here to say that I love being here and I enjoyed myself... Thank you.

Hello, ... I'm from Pittsburgh. I just wanted to talk about treatment and support services for people who already have HIV. I think that there's a huge gap there. Like, we learned yesterday that heterosexual transmission, like male to female, is what like 70% of new cases? But then in typical HIV drug trials women make up only 13% of people that are tested, that the drugs are tested on. I think that's a huge problem because it just like a way that sexism is working in our society because women aren't used because they have children and blah, blah, blah, and they work and they do all the things that women have to do to survive in this country in the 90's. And I think that's something that we need to deal with that there has to be something else for women to do other than just hope that the drugs will work in their bodies.

Hi… from the Allentown roundtable. I feel we need to focus a lot on self-confidence. Not just to say no to sexual intercourse or other high risk behaviors, but for individuals to stand up and not worry about what their friends are going to think about them. It's time for everyone to start caring about this virus and put this thing to an end. Thanks.

It's me again, from Allentown… I heard someone mention the drugs and alcohol situation. Yesterday, when I was in the risk-reduction discussion, I heard that you could get high or you could drink responsibly. Just because you get high or drink or whatever, doesn't mean you have to act wild or do things that you know you shouldn't be doing. I just wanted to touch on that and say that you can get high responsibly. That's sounds kind of crazy but you can. You can drink responsibly. Maybe getting high or drinking

may not be the best thing for you but that's another discussion. I mean, I just wanted to touch on that. You don't have to act up because you get high or drunk. That's all.

…Allentown roundtable. I think that was mentioned by other individuals that ignorance is a problem. And I think that people know of the disease but not about the disease. And I think that all the information that we received in these two days with the workshops, all the information that was given to us, I think that's information that we should give to all those individuals who don't know about this disease. People know, people are lack luster to think of how AIDS is easily contracted. And I think that we as Roundtables, as youth, as individuals should let those people know about the situations and how easily AIDS is contracted.

… I'm from the Williamsport roundtable and before I say anything I'd just like to say that, yes, I'm very nervous. And most of all I guess I'm just proud of myself and I'm just happy that I'm a part of something that is positive like this. Because in our community people are very narrow-minded about things that they think don't exist. They're more concerned about politics and about how they can make money for the community than they are about educating youth and doing things for us that, you know, they always say, "You need to do something positive. You need to do something positive". But yet, whenever we try to show some initiative to do something positive, nobody's ever there. Nobody ever wants to fund you. Nobody ever wants to do anything. I just think like now that we are in it, people in our school who know that I am in this group, like our health teacher at our local high school, Miss Whitehill, she is a very bold teacher. And she wants to do different things. And she's trying to write grants and stuff so that our school can have the type of HIV and AIDS prevention. And she found out about the group and she wants to get involved. And I just think that if people are gonna tell us to be positive they need to be there for us when we actually show some initiative to do something.

S'up! … I brought up a piece of paper cause everyone else did. It looks organized. Nothing on it… All's I know is there's a lot of love in this room, man. This is all kind of people. People be smiling... It's cool. But I'm just glad to see all kinds of faces. People I don't know, but people I can go up and give a hug to or shake their hand. Whatever. Feels good. I think there's tables are empty in the back but people that you may not have lost to AIDS just people might be back there even though you can't see them. And I bet you they're pretty proud of all the people here. So, thanks for coming.

Hi, … I'm from Pittsburgh. And what I believe it will take to keep myself and others like me HIV negative is practice what I share with others. Wholeheartedly, determination and dedication to the cause. What I believe it will take to keep those of us living with HIV and AIDS healthy is a lot of positive support, unconditional love and major understanding…. Some people just don't care and some people don't think it can happen to them. But maybe by this information we give they can also be awakened by these stories, just like us. Thank you.

Hello, again… I'm from Pittsburgh. I got a kind of personal story to tell you guys that you might find interesting. I went to high school in Chicago, Illinois, public high school.

Chicago public schools, they're one of the largest systems in the world. Very well-funded. Have all kinds of buildings. Thousands of students per school. Everything. For my Health class. Oh, the school that I went to - about 80% of the kids there were very low income. You guys know what Gabrini Green is? That was a school that's for that district. So, one woman came in and kind of said this is AIDS. It stands for blah, blah, blah. You can't get it from toilet seats. That's pretty much all she said. That's all. Only safer sex education we got in the school. But in the mean time people there, kids there were having children, you know, getting sick, all kinds of stuff. Well, in elementary school, I went to school on a farm, which is kind of weird but it was a farm, literally. And in like second grade or so twice a week for six weeks we did three hour sessions where we talked about safer sex and all kinds of things like that. And I think it's a shame that I got better safer sex education in third grade when there's not much of a chance for me to be having sex than in high school when my friends are getting pregnant. And I think it's a serious problem in this country that a kid who goes to school on a farm and like plays with horses and sheep knows more about STD's than a high schooler. That's all I have to say.

Hi, I'm… from Williamsport. I feel that prevention boils down to one question. It's a question that you ask yourself right before you put yourself at risk. Just say, "How would I live with the full-blown "HIV". "HIV" being HIV. That's it.

I was just sitting here thinking and I remembered what got me involved in HIV and AIDS prevention. And I just wanted to share that cause maybe that's an answer to how some other people can get inspired. I was at a youth group, a sexual minority youth group in Philadelphia. And there was woman there who was going to speak about having AIDS. A young woman. And she sat down and did the activity with me before she talked and we joked and laughed. And then she got up three feet away from me and told me and told her story about how she got AIDS and what it's like living with AIDS. And I just, something hit me. And from that moment I knew it was something I needed to do work with. And I did for a year. And I became a peer educator. And then last January, I found out that my dad was positive. So, it's kind of funny how things happen that everything happens for a reason. And there's nothing that happens that doesn't have a purpose on this world. There's a reason why we're here.

I'm… from Allentown. The AIDS virus is succeeding in killing because of many reasons. Ignorance is a big one. But misinformation or just not knowing enough about the virus is a definite route down death's highway. We need more people talking from experience to show people that we're not lying about AIDS killing, and as you can see, with no discrimination of AIDS. When people see something it's a little different than hearing about it. The more we can learn about this virus and spread it out into the community, the less the virus will succeed. There's a lot of problems in the world and in order to change anything you've got to take action and make those changes happen. Change is in our hands and in other's hearts. But it's our job to exercise their most powerful tool, and that's their mind.

I ain't got a lot to say. All I got to say is if you really want people to listen you have to show them how serious the AIDS virus really is. And you got to show them the people that are dying out there. That's it!

Hi, … I'm from Wilkes-Barre. I've been sitting down and I've been thinking a lot about what [N.] said. And I really would have to agree with him because I'm an officer in an AIDS awareness group on my school where I go to, Wilkes University. And we have a lot of activities through out the year. We have a lot of meetings. And it seems like whenever we have a speaker about ten people show up. And sometimes like that apathy and that just people don't care, like it really scares me. And sometimes I don't know what to do. I don't really know why I'm doing it. It just seems to have no point. And it seems like I've been involved with AIDS-related causes for quite a long time, even throughout my high school years. And I'd really like to start seeing some results. I really would. So I really think that it's important for us to get here and sit down and talk about all these things and put these lists up on the wall. But like what we need to do is take our message and take it on the road. Take it back to your high school. Take it back to your college. Go out there and do something. Anything. Even if only ten people show up, if we can feel like we've touched even one life, I think that everything we're doing here is worthwhile.

Hi. I'm… back, from Erie. OK. Well, my friend over here, the girl with the two kids she inspired me to come back up here, so talk about my son now. But anyway, what it would take for me to stay negative is my son and a very special lady back home who helped organize the roundtable. I've been here since, you know, the roundtable first started, four years, whatever. And if it wasn't for her motivation I wouldn't be an HIV educator or an HIV and AIDS counselor now. And as for my son I would hate to see him miss out on opportunities that we have now, like to make a choice to have sex or abstain from it. Cause I feel by the year 2010 he might not have that choice to engage in sex, cause we all might be HIV positive by then. But that's what makes me, you know, really mad that he won't have that choice if we keep doing what we're doing today. Thank you.

I can't believe we're doing this, cause I don't want to talk but I'm going to. I feel it's important that somebody like me comes up and talks here cause I'm one of those kind of people that we were talking about today. This is what I was afraid of. I'm gonna go sit down. OK. I'm the kind of person that we're dealing with. Like three years ago I was like this. I was the kind of person who didn't care about myself and that messed around with people I didn't know. And didn't realize that I messed around, because what was I doing all the time? I was drinking. I was doing stuff that I thought was right at that time, that I should be doing at that time because everybody else was doing it. So I feel like a hypocrite to be up here and like be a part of this. But at the same time I think you need people like me to be a part of this to share with you because I have that perspective. But I've been totally drug-free and clean for two years now (applause). Well, in like a couple months it will be two years. (laughter) And so I feel good about that, but everyday I think about what I used to do. How I was. And I'm like, Wow. And you guys are doing stuff for like for people like how I used to be. And I'm part of that now and that's why I feel like a hypocrite because that's how I used to be but I'm still glad to be a

part of it. I still want to help out. And I think this is important because I wish I had you guys three years ago to help me out because I didn't see people at Pitt like, I'm from Pittsburgh, I didn't see people at Pitt like there for me doing stuff. But you guys were around, I just didn't notice you because I didn't notice myself. I prepared like a poem because I always feel better when I read a poem. …because it's basically all the same stuff that I just said now. I feel weird about reading it. But I guess I will anyway. Once I calm down I will read it. OK, it goes. All right.

I was alone then. Then I was alone.
Three years ago I wanted a home.
So I found myself with people I did not know.
I gave up my soul to people I did not know.
I wish you had talked to me back then.
I wish I had you three years ago
When I was like that
Not caring about my soul.
But I have you now.
I take responsibility for myself, now.
But not then.
But I wish I had had you then.
But, yes, now, I have you.
And I have myself.

Hello, … I'm one of the young mothers from York. I have something a little different to say. I want to say (**this is spoken in Spanish**). And for those of you who are not that gifted, I'll just translate. I'm a young Latin mother helping the cause that we're all here for. I, as a Latina feel very sad because within my race the numbers of people who are infected are so high. My people are dying and that's why I'm here.

…I'm from Erie. Everybody was talking about personal experiences so I'm gonna talk a little bit about myself. I don't like doing this but I'm gonna do it anyway. What got me into this was that I wasn't always a nice person. I've got in trouble before. I've committed crimes and things like that. And for a while I was locked up. While incarcerated I had met a few people who had AIDS. I had met a, a few speakers had came in and things like that. And then a few people I was around, they had AIDS. And one guy, Norm, I had met him and he had told me a lot about his life, things he did, how out of control his life was and stuff like that. He had said one thing to me. He had said having AIDS to him was maturity in a bottle. He said once he got that, he had to grow up. He could no longer be a young person or act the way he did. He had to grow up and like, I don't know, it was just, it totally changed his whole life. And through like talking to him and being locked up as long as I was, like, I had talked to him and he had, I had came to realize that my life was no where as bad as he was. And it like, it really like, I don't know, it really hurt me. I felt really bad for him. I always talked to him about life in general and things like that. And he's part of the reason why I do what I do now. I took from the community for so long. I robbed people or whatever. When you think of crime. I did that. And now I think it's time that I start giving back. I took so long, I think I owe

the community, society, whatever in general, I owe them something. And even though I did do my time, I still feel I owe them more than that. That's it.

Hi, … I'm from Williamsport. I feel that we need more peer leaders in each county and to start when they're young, around eleven or twelve years old, and teach them about HIV and AIDS. My friend was in sixth grade, getting high, sexually active and drinking. He was infected with AIDS in ninth grade. He couldn't deal with the fact of AIDS, so one day he was huffing butane around a candle and he burned himself from the inside out and died. I feel that if we start at a younger population, we could have a greater impact on prevention. Thank you.

Hi, I'm… from Erie. I'm not a very good speaker so I'm not gonna say much. But one thing I know is that everything I learned here, I'm gonna put it to use when I get back.

I know I was already up here but I guess I'll borrow back the rest of my two minutes. Whenever [N.] was up here, she really inspired me to share my real personal story with everyone. Whenever, I'm eighteen now, whenever I was twelve years old I was raped and it wasn't once, it was continuously throughout middle school. I was the kind of person who didn't have a lot of friends and the one person who I thought I could really confide in turned out to be the person who deteriorated my dreams for three years. Sorry. I can't stress enough how important it really is to reach the younger kids. I mean, I don't know what we could do to really get into those schools and talk to the teachers and talk to the parents and let them know that their children are not too young to know about these things. And even if it is building their self-esteem and then teaching them, I mean, I just can't stress enough how important it really is to talk to people, not only in middle school, it has to be younger than that. I really believe it has to be younger than that. So I just want everybody to, you know, when you go home, think about something that you could do to, you know, push for the officials to really let us teach the younger kids. Thanks.

My last time. I know there's some mothers in this room and probably some fathers, too. I want to share a story about my friend [N.]. My friend, when she was eight or nine years old, she was raped by the man who was dating her mother. He was infected with AIDS at that time. So, therefore, he gave it to her mother and he gave it to her, too. She died last year, her mother died first, and then a couple of months later, she died. I think people, I mean since this isn't a perfect world, we all know this. We all know rape and incest and that does happen. You know what I mean. So, people, like watch your kids. You could trust the person you're with, your mate, or whatever. You could trust that person with your life or whatever. But don't overlook the fact that this ain't a perfect world. We do need to watch our kids. We do need to educate them. And we do need to let them know that if there's something wrong they can speak to us. They can feel comfortable with speaking to us. Because my friend, she didn't have a choice. I miss her now and I wish she were still here. But she's not. And if I can stop this from happening to anybody else or stop this from happening to anyone else's kids, cause it's not right. I'll do anything to do that. And I just thought that I should get up here and let y'all know to please watch your kids. Mothers, fathers, just ….. when it come to your

kids. And let them know that they can talk to you and they can confide in you and that. Just let them know that you love them or whatever. I think a lot of the prevention, like I said, has to do with self-esteem because if a person doesn't feel good about themselves why should they protect themselves, really. I mean why should they care enough to wear a condom or, like I said, clean their needles or whatever. We can't, I don't know, it's just, you just have to be careful. That's all. Like I said, watch your kids...

Hi. ... I'm from the York roundtable. And I'm very new to this program. I just committed myself to this program of HIV prevention in January of 1998. …Sat down one day and talked to me about this program. It sounded very interesting to me. Because of what I don't know I can learn from this meeting. It caught my attention when she said it could spread to anybody no matter what color, size, shape or age. So I feel as though I have a responsibility to reach out to the community with answers to slow the process down because there is no cure for AIDS, just medicine so slow the process down. And I have three kids to teach, too. So it's very important. Thank you.

Hi, I'm… again, from the Wilkes-Barre roundtable. We've been sitting here throughout the past few days doing workshops talking about all the wonderful things, all the logistics of the things that we can do to prevent HIV. We've been talking about education. We've been talking about lecture series and outreach and all of these wonderful things that have been listed very A,B,C,D. And then we're gonna go back to our Roundtables and we're gonna talk about how we're going to implement these programs and how these programs affect whatever particular group that we're working with. And I attended a group yesterday called Outreach that was done by Matt Moyer and Doug Klopp, and I was really inspired by the fact that they seem to do everything from the heart. All their planning, all of the things that they were thinking about were coming directly from the heart. And I think that if we all go back to our individual Roundtables and begin to think about that one universal need that we all have, to love and to be loved unconditionally, to look at the individual as having needs and not just as a statistic or as a target audience but as a human being that needs to be loved and have the quality of life preserved, I don't think we'll have a problem coming up with the answers of the things when we start to recognize them as not just statistics, but as people, cause we all have that universal need. Thank you.

Hi, I'm… from the Norristown roundtable again. And everybody's been coming up here and sharing their personal stories and it's really touching. And I don't have a personal story. And I hope I never will. And I also hope, in the future, a lot more people will be able to say that they don't have a personal story having to do with AIDS. And I think if we start taking action, a lot more people will be able to do that.

… Once again, I'm a member of the Wilkes-Barre area Roundtables. Over the past day, day and a half or so I haven't had an opportunity to meet a lot of you but sitting here for the past hour and a half listening to your personal perspectives has really touched me. And I just want all of you to know that I respect you tremendously for what you've gone through, where you're going right now, and your commitment to trying to stop the spread of this terrible disease. Thank you.

I'm from the Norristown roundtable… I hate microphones. I just wanted to say that my Dad thinks you can get AIDS from like kissing. And my Mom thinks condoms are funny (laughter). I've been bisexual since I hit puberty, but I can never, I've never been able to tell my parents that and I may not cause I don't think they want to know. They don't want to know that. I'd like to think that in the future people will be able to accept that more…

Hello, I'm gonna read my friend [N.'s] speech because she lost her voice. Her name is [N.]. She's from York, PA roundtable. And she's proud to be involved in this roundtable. She learned a lot about HIV and AIDS and it reached her to be more supportive to someone she knows that have HIV positive. In 1982, thirty people was infected with HIV in PA. And now, 17,000 people are diagnosed with HIV. This information is for the people who don't know that America is dying slowly. Real slowly. Day after day. Minute after minute. That's all.

Once again, I'm… from Pittsburgh. And one word that I, sitting there, heard from pretty much …. everyone of you who came up here was community. And somebody who came up here said that community leaders don't care. They care more about improving their communities and stuff. What makes a leader? You're all leaders here. You know why? Cause you care. It's caring that makes a leader. All of you. Each and everyone of you in here is a community leader. When you go back there, make sure you educate about HIV prevention, otherwise you won't have a community to lead.

…My statement is that the reason why I started doing HIV prevention and going to the Roundtables is statistics. I think that each and everyone of those people who's in the statistics has a face put to each. Look at the quilts around you. There's a person that died. Don't let them die in vain. Just keep doing what you're doing. Work hard at it. And you can achieve anything. Thank you.

Written Personal Statements

My issue is on AIDS. Not to long ago I lost my Uncle to Aids. My family didn't really want to tell me. Because they know I would have a nervous breakdown. But to sum it all up I would like to say wake up and look around you and see what's going on in the world. I also have a personal story I've been raped 3 times, also been molested as a child and I never told my mother. And now I still haven't told her about anything that has happened to me. I've also been abuse by my ex-boyfriend.

… From the Allentown roundtable and I am glad to be in this group because I know a lot more about AIDS/HIV now then I did before because they really help me because I know if I don't have a condom I don't have sex and I like to thank the Roundtable.

… from the Erie Roundtable. I feel that we need to go to schools and talk about the roundtable and what we do. Then get their opinions, like grades (6-12) because a lot of teens start to have sexual relationships about 12 or 13. So they know were to get condoms and information about pregnancy and others. We need to get in the school now and try to stop it now instead of letting it get worse.

Fear that they are scared to go get tested in fear that they have the disease. And by not getting tested they are still having unprotected or even protected sex, and they pass the disease to other people that may fell the same way, and they do the same thing. Parental and schools.

Hi ….from Allentown and I think we need to focus on safe sex because I think that a lot of the people having sex don't use condom is because they don't want to. But they know how to use one. So don't get me wrong, probably some people might not know how to use a condom.

Hi! I'm… from York. I'm a new member I joined to make me more aware of AIDS/HIV and for daughter and unborn child.

APPENDIX C

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Relating State-Funded Prevention Activities to the CDC HIV Prevention Planning Process

The Pennsylvania Department of Health using non-CDC (state) monies has funded HIV prevention projects for many years. While those programs have been based on sound principals they are not all necessarily in conformity to the standards developed in light of new research and of CDC guidance related to the beginning of the prevention planning guidance first issued in 1993. In 1996, the Department of Health began a process to develop standards for all HIV care and prevention services. Using the standards developed by the CDC, input from CBOs and the plans of our statewide Planning Committee, the Department developed draft prevention standards in 1997. These standards supported by the unanimous vote of the Planning Committee are currently being used.

In order that technical assistance needs can be identified and in order to complete a analysis of the gaps in HIV prevention in the state, the Department after completing a pilot in 1998 shall be undertaking a more thorough study in 1999. The aim of the study is to ascertain whether non-CDC prevention programs are targeting the priority populations identified by the plan, whether the programs conform to state-of-the-art knowledge about effective interventions and whether there are gaps in programming. The data collected will be used in future planning by the Committee. The following describes existing non-CDC, state funded prevention programs in Pennsylvania.

The Council of Spanish Speaking Organizations of the Lehigh Valley receives funding to oversee street outreach projects in four cities with noticeable Latino populations- Reading, Lancaster, Bethlehem and Harrisburg. ($140,000)

Keystone Health Services receives direct funding from the Department to conduct onsite education in migrant camps in six counties. Largely African-American and Latino, many of the migrants reside in Pennsylvania practically year round. ($100,000)

Several women and children's initiatives are underway in an effort to reduce perinatal HIV transmission. These include the development of audiotapes and literature for providers on best practices, media campaigns encouraging women to seek testing, and surveys of pharmacies to determine if they have the requisite HIV pharmaceuticals in stock. ($300,000)

For the past four years, a statewide technical assistance/skills building conference has been held attracting 300-400 attendees at each event. This past year the focus was on minority empowerment and included topics such as building and expanding coalitions, future of AIDS medical realities, and marketing street outreach. ($100,000)

The Department maintains a toll-free hotline which operates seven days a week and is available to handle calls related to HIV transmission, the location of counseling and testing sites and other calls. ($171,000)

The Pennsylvania AIDS Education and Training Center received state funds to provide one-day prevention counseling trainings to private sector providers. ($50,000)

Intercultural Family Services, Inc., was engaged to undertake a project for the purpose of accessing people of color communities to promote their involvement with the regional Ryan White Coalitions, thereby increasing their influence on how prevention and care dollars are spent in communities. ($870,000).

Each of the seven Ryan White Coalitions receives state funds for community-based prevention services in their respective regions, many of which have a minority focus. Most of the funds are allocated to local providers. Th seven coalitions and the approximate amount of state prevention dollars they receive are as follows: The Philadelphia AIDS Consortium ($1,259,000), South Central Pennsylvania AIDS Planning Coalition ($530,000), AIDSNET ($213,000), Southwestern Pennsylvania AIDS Planning Coalition ($392,000), Northwest Pennsylvania Rural AIDS Alliance ($234,000), North Central District AIDS Coalition ($263,000), and the Northeast Regional HIV Planning Coalition ($288,000).

Finally, all of the nine (soon to be ten) independent County and Municipal Health Departments receive state funds as well as CDC dollars. Traditionally CDC dollars were used for counseling and testing and the state monies for health education/risk reduction activities. There has been some overlap in recent years. The departments are listed in descending order according to the amount of state dollars they received. A brief description of activities is included because unlike the Coalitions, these services generally are performed in-house with the exception of Philadelphia and Allegheny (Pittsburgh) Counties. Philadelphia ($971,000)- A significant portion of their funds is subcontracted to established and grass roots agencies, many of which have a minority focus. Erie County ($67,500) – minority outreach focus; also works with school districts; radio and TV programs; and education and testing for female sex workers. Allegheny County ($51,000) –street outreach; prevention services t the minority community and disadvantaged/incarcerated women through contracts with the Pittsburgh Coalition Regional abuse, the Housing authority and Mon Yough Community Services; education and training on HIV for county prison staff, Pittsburgh police, school health educators and health care workers; and the provision of an annual STD/HIV symposium. York City ($45,000)- outreach to the Latino population; presentations to staff and ‘residents’ of drug treatment programs, the prison and halfway houses for female offenders and the development and distribution of literature. Bucks County ($39,000)- school-based initiatives; prevention in alternative schools and teen specific drug and alcohol facilities; outreach in gay

bars; women's initiatives at women's shelters, homeless shelters and a women specific drug and alcohol facility; and trainings for police, fire companies, emergency room staff and ambulance companies. Chester County ($20,000)- outreach in public housing projects; after school programs; and one on one sessions with soon to be discharged prisoners. Montgomery County ($15,000) – HIV education programs in schools and the county prison; training of drug and alcohol staff; and small group outreach in women's shelters, halfway houses, etc. Allentown City ($15,000) – targeted and general education. Bethlehem City ($13,000) – concentration on outreach to the Latino community and among IV drug users, women, and children.

UNIVERSITY OF PITTSBURGH
GRADUATE SCHOOL OF PUBLIC HEALTH
PENNSYLVANIA PREVENTION PROJECT

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Patricia A. Cordice---Staff Specialist

Deborah E. Miller, M.B.A.---Accountant

Jospeh Pawlak, M.P.A.---Administrative Consultant

Mark Stein, B.A.---Administrative Director

Student Support

Nikhil Parekh
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