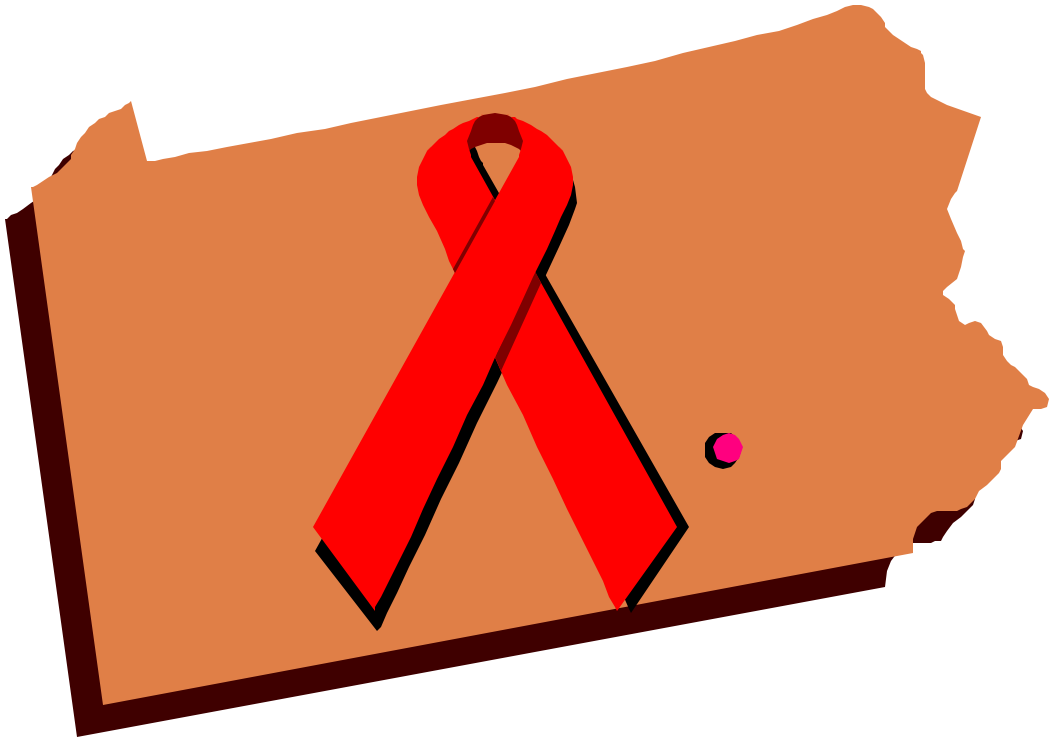
Pennsylvania Community HIV Prevention Plan



September 16, 2002

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Robert S. Zimmerman, Jr., Secretary of Health

HIV Prevention Planning in Pennsylvania:
An Overview

The keynote speaker at the very first meeting of the HIV Community Prevention Planning Committee was a person living with AIDS. He was chosen to reflect loudly and clearly the Pennsylvania Committee's unswerving commitment to meeting the prevention needs of people at risk of infection and those with HIV infection. Since that time Committee members have vigorously resisted allowing cultural differences, agency needs, or personal agendas to influence the planning process. The Committee has principally done this through maintaining a strongly respectful environment, participating in cultural diversity training, encouraging open and honest dialog and by relying on objective and state of the art technologies and methodologies to obtain information needed for planning.

Committee members recognized early on that one of the most effective ways to ensure even handed and objective planning was to use the most effective and rigorous planning tools available. Early in the process it became clear that tools were needed for needs assessment, gap analysis, prioritizing populations, choosing interventions and evaluating existing services and processes. Actually using these tools for planning in Pennsylvania presented varying levels of barriers.

Needs Assessment

Confidentiality concerns, stigma, the invisibility of many at risk, and distrust of those at risk are some of the major barriers in needs assessment. Happily, these were not difficult to overcome in Pennsylvania. Focus groups and interviews were used to gather the data. These methods allowed us to work with participant recruiters, facilitators, and interviewers known and trusted by those at risk. In 1995-96 and 1999-02, the Committee worked to design large needs assessments that involved over 150 groups and dozens of interviews of those at risk of infection, viz., MSM, IDU, and Heterosexual partners of those people. The groups were chosen to reflect the epidemic and reflected the racial, ethnic, age, sex, sexual orientation, and place of residence of people with AIDS in the state. Groups that appeared to be on the growing edge of the epidemic were over sampled and special efforts to made to include subpopulations in special need such as the physically and mentally challenged, transgender people, sex workers, recently incarcerated and others. These data are analyzed and presented to the Committee in different forums and in writing and are the cornerstone of the planning process. (Summary in Appendix)

Some of the most important findings of our recent assessment are described here. The most profound finding was that IDUs were generally very pessimistic about their ability to change behaviors that put them at risk of HIV, explaining that their addiction to drugs was "so strong" so that they would continually and indefinitely put themselves at risk of HIV and other related dangers. This negative effect of addiction was perceived to be "less strong" among young IDUs and adult MSM/IDUs. The negative effect of addiction

was explained to be most strong among (1) rural IDUs, who described themselves as isolated and with less access to free condoms and free needles; and, (2) women in relationships with male IDUs who controlled drugs, sex, and consequently, prevention materials if they were available at all.

Whether socially open or not open about having sex with men, African-American and Latino MSM felt isolated from larger communities, respective minority communities, and a visible gay community. Both rural and young MSM expressed isolation from an identifiable gay community. Because of the above psycho-social issues, African-American, Latino, rural, and young MSM suggested that most of their peers did not identify as being "gay," and did not attend gay events/institutions. They also described other peers who were gay-identified, but who did not use these resources. Therefore, the majority of MSM is hard-to-reach and would need to be reached with HIV-prevention services in mainly non-gay identified venues. Another finding concerned an "increasing silence" about HIV/AIDS among MSM and a "retreat from HIV prevention" in communities. Because of a growing perception that HIV/AIDS is no longer a significant concern and false idea that AIDS is no longer fatal (especially among young MSM), participants reported less information-sharing about HIV among peers. Further, HIV prevention targeted specifically toward MSM is perceived to be waning in communities where it had once existed. For instance, free condoms, which were once easily available in places like gay bars in the 1990s, were no longer as accessible.

Except for Latina heterosexuals who had received little HIV/AIDS information, participants reported having obtained a fair amount of general information about HIV/AIDS through community agencies and services that they had accessed. They felt, however, that this information was not targeted to specific demographic groups (e.g., African-American women or pregnant women); and that clients typically needed to ask for information they received, rather than having had it routinely provided. The majority of heterosexual participants had received HIV counseling and testing; however, a noticeable minority of African-American men and women had not been tested. More intensive types of HIV-prevention interventions, such as targeted, community outreach and attitude-change and skills-building activities, were rarely provided for any of the subpopulations.

Heterosexual participants described a large number of barriers to HIV prevention, including: stigma related to HIV/AIDS (especially among African-American women and Latinas); lack of provider recognition that clients may have diverse expressions of sexuality (e.g., women who have sex with MSM, bisexuality among women); low self-esteem that interferes with the ability or desire to attend to issues of one's health and risk-reduction activities (among all subpopulations, including African-American men); male-dominated relationships, including sexual relationships, in which women have little voice or control (e.g., women cannot ask their male sexual partners to use condoms without negative and potentially dangerous repercussions); alcohol and drug addiction which interferes with the ability to practice less risky behaviors; physical isolation that makes prevention activities difficult if not impossible to access; and language barriers for Latinas. Condom use ranged from sporadic to non-existent among all subpopulations.

Priority Populations

As with most jurisdictions, limited resources prohibit a full response to all HIV prevention needs. Deciding how to allocate money must be done even handedly and to do so more information needs to be gathered. This Committee had faced that problem squarely and has created a model that incorporates 11 factors and results in actual scores. The 11 factors are:

a. Predominant Risk Behavior
b. Estimated live HIV cases in transmission categories
c. Estimated unadjusted relative risk of death
d. Prevalence of most recent predominant risk behavior
e. Average annual rate of AIDS increase
f. Rate of change in HIV prevalence and direction
g. Fertility Rate
h. Gonorrhea/Syphilis Rates
i. Relative size of risk group
j. Services allocated
k. Socio economic barriers

The model has yielded 12 adult priority populations beginning with Caucasian MSM and ending with Hispanic MSM. The scores range from a high of 165 to a low of 9. The model and factors are under constant monitoring and revisions are made regularly. We expect the model to significantly increase in value once HIV infection data is available in the state.

Evaluation

From its beginning this Committee has valued and supported monitoring and evaluation. Evaluations were required of all programs supported by CDC and other funding sources since early in the process. Our Committee with the strong support of the Pennsylvania Health Department embarked on a major evaluation of the states entire HIV testing program. Client satisfaction surveys for positive and negative users of HIV testing sites, site visits, interviews, and participant observation by actors were all used in the state and have resulted in many changes in HIV testing and counseling services. One of the earliest was the institution of a statewide, internet-based resource directory in response to data showing that some HIV testing personnel were not aware of all the services available to their clients. One of the latest (currently under development) is the design and eventual distribution of palm cards that will tell clients what they should have learned in their session along with a phone number to call for more information.

The CDC Five-Year, Strategic Evaluation Plan that the Committee has adopted has six components, each describing a distinct type of evaluation:

1. Evaluation of the community planning process and prevention plan development.
2. Establishment of Intervention Plans.
3. Evaluation of linkages between the Comprehensive HIV Prevention Plan and application for funds, and between the Comprehensive HIV Prevention Plan and resource allocation.
4. Process monitoring.
5. Outcome monitoring and process evaluation.
6. Outcome evaluation.

Items 1, 2, 4, and 5 are all functioning well and yielding information that is used to inform decision-making. The 6th item, our outcome evaluation is in its fourth year of implementation. The outcome evaluation has been initiated for a Perinatal/Young Adult (male and female) HIV-Prevention Demonstration Project. An outside evaluator has been identified and a contract has been established with this evaluator to work with the administering agency in completing design and implementing an outcome evaluation. The larger evaluation design includes assistance to the provider agency in appropriately monitoring outcome and process evaluation. This process evaluation addresses reasons why clients may choose some levels and types of interventions over other types and levels within the multi-intervention project; it also assesses client satisfaction and project staff and, when appropriate, clients' families' impressions of the project. The outcome evaluation assesses risk behaviors at baseline and changes in intent to change behavior and actual behavior change over time intervals. A time-series design is used so that changes among individual clients is assessed over time. Additionally, "natural" comparison groups may exist in the project; that is, outcomes of clients choosing to receive lower intensity of interventions may be compared to those choosing to receive higher intensity and multiple interventions over time.

We are still working on item 4, the linkage between the plan and resource allocation. Early on, we tried to do this linkage which we called gap analysis but found that we could not readily get information on all of the prevention programs around the state and that the data we did gather were not comparable. For example, agencies funded by HRSA collected different data and used different categories than did agencies funded by SAMHSA, foundations and other sources.

So the Committee proceeded on two fronts. First, the state health department mandated that all agencies receiving any money from or through the state needed to adhere to the Committee's Prevention Plan. In support of that, the Committee wrote the prevention standards used by all agencies funded by Ryan White funds. These standards also address cultural competency and sensitivity. Second, the state has started an ambitious uniform data collection program for all publicly funded programs. As a result, all state-funded programs will use risk group categories, the same demographic categories, and the same definitions of those variables, and will analyze the data the same way. Local health departments and all Ryan White funded agencies have made the changes, been trained, and are sending the data in for analysis. The Spanish Speaking Council is still being trained and will be on board in the next 6 months. This program will need monitoring and occasional retooling as new questions emerge and as new agencies are funded. However, soon the Committee will be able to look at data from all publicly funded programs around the state and have a deeper understanding of how those programs are responding to the needs, priorities, and resources in the state. The Committee has yet to develop a method to gather information about privately funded initiatives and is likely to approach the CDC for technical assistance in this area.

Accomplishment Highlights

When the Committee began in 1994, most so-called prevention programs were simply doing AIDS 101 education to any group that was accessible. Since then major strides have been made. The providers, the consumers, and the community now understand the need for targeting, culturally appropriate prevention, and true interventions. These changes have been institutionalized by the Health Departments mandate that our Plan be used in designing all programs funded by them, by the creation of Committee designed prevention standards and their implementation by Ryan White funded agencies, by the extensive evaluations of HIV testing sites and revisions in HIV testing programs.

The following is a brief listing of some of our major accomplishments:

HIV Counseling and Testing Evaluations: Since HIV prevention counseling and testing is the most common intervention for primary and secondary prevention with more than 400 publicly funded sites in Pennsylvania. The Department has steadily increased testing program in community-based settings that are often more successful in reaching high-risk clients. The number of such agencies increased from none in 2001 to 33 in 2002. Twenty of these sites are at community based agencies (3 of which are at Spanish speaking agencies), 5 at drug treatment facilities, and 8 are at community medical centers. Agency surveys, site visits, participant observation (actors posing as patients), and client satisfaction surveys have been completed. Random sites continue to be monitored using client satisfaction surveys in Spanish and English.

HIV/AIDS Factline 1-800-662-6080: Disease-related information and referrals to medical and psychosocial services, including the location of anonymous and confidential HIV counseling and testing sites is provided.

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

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

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

HIV testing with the OraSure method of specimen collection: The Department began promoting the use of oral fluid testing (OraSure) as an alternative to blood testing in 1998. This non-invasive process of specimen collection has been widely accepted and is

being used increasingly by drug and alcohol providers, prisons, community based organizations and other providers involved in the Department's publicly-funded HIV Counseling and Testing Program. In 1998, 781 HIV OraSure specimens were tested. Since 1998, OraSure use has increased each year; 1999 – 6,089 specimens tested, 2000 – 9,656 specimens tested, 2001 – 11,597 specimens tested. In 2002, it's estimated that approximately 15,000 specimens will be tested.

Anonymous HIV testing: A long-term objective of this Committee was to see that anonymous testing sites existed in each of Pennsylvania's 67 counties. This year that became policy and all sites are open or on their way to being operational in the very near future.

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

Statewide HIV-related training: Training is provided on site and through satellite down-links for substance abuse treatment program staff.

Peer Education in State Correctional Institutions: The Department has worked with the Pennsylvania HIV/AIDS Education and Training Center and the American Red Cross to adapt their models for use in Pennsylvania prisons. The curriculum was developed and plans are underway for their implementation.

Congressional Black Caucus (CBC) Initiative: Pennsylvania received Federal CBC funding for a second consecutive year. With less restrictive requirements on the use of these funds, the Division of HIV/AIDS intends to expand CBC initiative services to additional regions of the Commonwealth. In addition to increasing the number of minorities participating in the AIDS Drug Assistance Program (Special Pharmaceutical Benefits Program), the funds will also be used to increase participation in care and supportive services.

Demonstration Projects in 2002:

> Outreach to Minority Women: This project provides street outreach and prevention interventions to economically disadvantaged women of color and their infants. Outreach workers are trained in state-of-the art prevention interventions and a rigorous evaluation program has been instituted.
>
> Outreach to MSM: A small city project is aimed at reaching young MSM and MSM of color. The project works in conjunction with local gay community leaders and groups.

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

HIV/AIDS pamphlets, brochures and information sheets: These are available by calling the Pennsylvania Department of Health Research and Information Clearinghouse (PADOHRIC) at 1-800-582-7746.

Young Adult Roundtables: The Roundtables have been designed to provide young people, ranging in age from 13 to 24, a voice in HIV prevention planning. Roundtables, each comprised of up to 15 young adults from diverse communities across the state, convene in 10 cities. The objectives of the Roundtables include:

a. Giving voice to young adults in statewide HIV prevention planning;
b. Having participants evaluate HIV prevention materials that target young people;
C. Having participants interact with local leaders and AIDS service organizations;
d. Promoting sensitivity for people living with HIV disease;
e. Disseminating accurate information about HIV/AIDS;
f. Providing the group with local HIV peer-education training opportunities;
g. Creating a safe forum in which HIV prevention issues can be openly discussed;
i. Developing a web page for communication among youth in various cities;

The PA Young Adult Roundtable Executive Committee, consisting of two elected representatives from each of the eight groups, has provided a conduit through which four young people have been elected by their peers to be sitting members of the PA HIV Prevention Community Planning Committee.

Young Adult Advisory Team: A team of 18 young adults 16 to 24 years old and comprised of Roundtable members and peer educators is designing an original HIV prevention intervention for sexually active young adults.

Internet Project [stophiv.com]: The Internet Project facilitates the dissemination of accurate, state-of-the-art prevention and education information and capacity building assistance to people at risk of HIV infection and agency personnel. The Internet Project maintains an on-line statewide HIV/AIDS service provider resource directory, treatment and prevention information, and forms that can be downloaded from the PA Department of Public Welfare. Since the beginning of this 5 year planning cycle, our Internet page has had 1,279,482 hits. More than 500,000 of them have occurred since January 2002.

Stophiv.com Awards

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

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

- *Pennsylvania Site of the Day Destination*

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

- *American Public Health Association*

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

Objectives of the Internet Project are to:

a. Reduce the incidence of HIV infection and morbidity and mortality related to it
b. Provide clear, accurate information in a unique, non-judgmental, and interactive public forum;
c. Formulate healthy attitudes;
d. Develop appropriate prevention skills;
e. Link those infected to medical resources
f. Furnish information on prophylaxis; and
g. Improve the quality of life.

In September 2002, a community calendar was added to the stophiv.com internet site as a result of community/agency requests. This feature allows community agencies to post events, trainings, and meetings on the web site for public view.

In an effort to improve interactivity of the stophiv.com web site, an interactive poll was added to the site. This allows viewers of the site to respond to topics regarding HIV/AIDS and other STDs. A summary of the results are posted on the site.

HIV Prevention through Public Schools: Young adults from the Roundtables encouraged the Committee to add objectives in the 2001 Plan to focus more attention and resources around educating young people in Pennsylvania's public schools. As a result, a new program has begun that is gathering information about what education is occurring, organized a web page with resource information for teachers, parents, and Board members, and gathering information from around the country on best practices. That information will be presented to the Committee in November 2002 and next steps will be planned.

Secondary HIV Prevention: The 2001 Plan recognizes HIV+ persons as a target for HIV education and prevention. These efforts should help in reducing the risk of HIV transmission to others and reducing the risk of acquiring re-infection and other sexually transmitted infections that may further compromise the health of HIV+ persons. Pennsylvania Prevention Project staff has embarked upon assessing the history and current capacity of HIV primary clinics to accept assistance and to implement HIV prevention programs for their patients. They will identify HIV primary prevention curriculum, models, and other resources relevant to HIV+ individuals and the primary care workers that serve them. Staff would develop and distribute HIV primary curriculum models, and other resources to HIV primary care providers and HIV prevention counseling and testing staff. Focus groups and consumer surveys will also be developed and utilized to inform staff of secondary HIV prevention concerns. In addition, in support of the Plan Health Education and Risk Reduction Goals I and II to promote effective education and prevention strategies and to increase usage of risk/harm reduction approaches for inmates of state and county correctional facilities and those recently released from incarceration.

Perinatal HIV Prevention Project: Pennsylvania was one of seven states selected to participate in a federally sponsored Action Learning Lab to explore methods for combating perinatal transmission utilizing a variety of government and private sector partners. An extension of this project will be a physician outreach program in York.

Standardized Data Collection: University faculty are working with the state and agencies to generate and analyze standardized HIV prevention related data so that gaps in services can be identified and addressed.

A radio and print media campaign was developed in 2002 to reduce the stigma associated with AIDS. The primary message emphasized at-risk behaviors.

One on One HIV prevention counseling: Over 15,000 substance abusers in treatment received one-on-one HIV prevention counseling. Approximately 10,000 substance abusers in treatment were tested for HIV antibodies; and 167 were identified as HIV-positive and linked to health and social services.

Rural Task Group: A small group of Committee members has organized to generate a literature search on HIV prevention in rural areas, seek technical assistance from the CDC, and bring experts to present at Committee meetings.

Limitations

While moving ahead with planning in order to meet the immediate needs in the field, this Committee has been building a state of the art planning infrastructure that includes ongoing and thorough needs assessments, uniform data collection for gap analysis, an objective and sound system for identifying priority populations as change occurs, identifying and implementing effective interventions and ensuring sound evaluation and program monitoring. This system is almost complete. With TA from the CDC this year, we expect to implement a priority interventions system in 2003. At the same time, uniform data from all of our publicly funded prevention programs will begin to provide vital information for our planning. And so, we expect our infrastructure for planning to be complete by the end of 2003. We also expect that the infrastructure will need refining and retooling on an ongoing basis. However, this system will allow a level of HIV prevention planning that has not been seen in Pennsylvania up till now.

2003 Plan Update

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

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

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

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

The 2003 Plan Update commences with a brief demographic overview of Pennsylvania. Next the Pennsylvania HIV Prevention Community Planning Committee is described, as well as the process for selecting members, structure and process evaluation are described. The HIV/AIDS Epidemiological profile for Pennsylvania provides a glimpse of trends and emerging populations. The needs of at-risk populations are determined through needs assessments as well as through Pennsylvania's nationally recognized Young Adult Roundtables. Evaluations ranging from process evaluations on the operation and development of the Committee and interventions to outcome evaluations of HIV prevention interventions are outlined in the Five-Year Strategic Evaluation Plan. Thirteen priority populations have been developed through a methodical process. The Committee is developing priority interventions that will be reflected in the next plan cycle (2004-2008), however several current interventions are reflected in this section of the Plan Update. The final section addresses linkages between the Plan Update and the Department of Health grant application and illuminates efforts being enhanced by state HIV prevention resources.

Co-Chairs from the Pennsylvania Department of Health and HIV Prevention Community Planning Committee have had conversations and sessions with the CDC Federal Project Officer relative to the Special Situations Team review of the 2002 Plan Update. Technical assistance was sought and attained concerning initiating the development of priority interventions as well as information on gap analysis. The Committee is dedicated to continuing to improve and seek technical assistance on the basics of PIR, needs assessments, epidemiology, gap analysis, resource inventory, and prioritization of populations. We strongly believe that this groundwork has been laid to develop a comprehensive Plan for Pennsylvania citizens in the CY 2004-2008 cycle.

Pennsylvania Department of Health
Pennsylvania HIV Prevention Community Planning Committee
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Brief Description of Pennsylvania

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

Pennsylvania's population demographics can fluctuate greatly from region to region. Where feasible this analysis does not include residents of Philadelphia as this Plan Update relates to the remainder of the Commonwealth. There are 10,763,504 persons residing in Pennsylvania outside of Philadelphia of which 4,587,556 (48.5%) are male and 5,538,948 (51.5%) are female.

Table 1
Pennsylvania Residents not including Philadelphia

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

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

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

Table 3
152,159 Asian Pennsylvania Residents not including Philadelphia

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

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

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

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

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

The Committee

The current Calendar Year (CY) 2002 Pennsylvania HIV Prevention Community Planning Committee (Committee) is composed of 37 members. Since its inception in 1994 the Committee has appointed some voting members because of their unique expertise in prevention planning, policy experience, or familiarity with systems. However, an appointment process tends to skew the categories of gender, race/ethnicity, and geographic distribution. Members from the Pennsylvania Departments of Education and Corrections are appointed to the Committee. A member from the Ryan White HIV/AIDS Regional Planning Coalitions is appointed. Four young adults are appointed by the Young Adult Roundtable Executive Committee. The Philadelphia AIDS Consortium has appointed a representative from the HIV prevention community-planning group. Five of the six women and two of the three men appointed are Caucasian. In addition, members of the Pennsylvania Bureaus of Drug & Alcohol Programs and Epidemiology, and Division of HIV/AIDS regularly attend and participate at Committee meetings.

The CY 2003 Committee is expected to remain in the 40-member range with attrition requiring new members to be selected as well as maintaining the aforementioned appointed categories. Following the September 2002 meeting Co-Chairs and an ad hoc group will review attendance and participation records of Committee members and those no longer capable of participation will be removed. The Committee decided in 1999 that members can have excused absences; however, no matter the circumstances, if they are not present for a significant amount of time for planning, their ability to commit and participate should be examined. For example, an individual who attended one meeting in 2001 was removed from the Committee. However, because of their unique expertise they provide input to the Committee upon request, as well as review materials. Absent members are sent all materials distributed at the meetings along with a request to communicate with the Co-Chairs if they have problems with participation .

Committee members can serve two consecutive three-year terms as dictated through bylaws. It is a continual balancing act to maintain members who have the experience and history of the process as well as add new members. Fifty-eight-percent (22/38) of those Committee members serving in 1999 are no longer with the Committee. The vast majority departed due to employment changes or moving, others

were unable to maintain the original commitment, some were removed due to lack of attendance, and one member died in a car accident. In January 2002 seven new Committee members were appointed to the Committee. One did not attend the Orientation and subsequently dropped from the Committee unable to maintain a commitment. Five Committee members on the roster in January were consequently dropped from the Committee. Two males departed with no forwarding information, one male relapsed, and two females were no longer able to participate due to employment changes. In the succeeding months one male and one female Committee member resigned due to employment status changes.

At the beginning of this five-year planning cycle in 1999 there were 38 Committee members and Richard Shaw was Community Co-Chair from 1999 through 2000. He departed due to employment changes. Renee Hartford has been Community Co-Chair since 2000 and completes one two-year term at the end of 2002. Elections will be conducted in November 2002 for the 2003 and 2004 calendar years. Co-Chairs may serve two consecutive two-year terms.

Table 4 2002 Committee

	Total Members/Minus Appointments		
Ryan White Coalition Area	**Females** 23/17	**Males** 14/12	**Totals** 37/29
Northeast	2/2	3/3	5/5
North Central	1/1	1/1	2/2
Northwest	1/1	2/2	3/3
Southwest	3/2	3/2	6/4
South Central	5/3	2/1	7/4
AIDSNET	6/5	2/2	8/7
TPAC	5/3	1/1	6/4

Table 5 2002 Committee

Race Ethnicity			
	Female (17)	Male (12)	Total (29)
Caucasian	7 (41%)	6 (50%)	13 (45%)
African American	6 (35%)	2 (17%)	8 (28%)
Latino(a)	2 (12%)	4 (33%)	6 (21%)
American Indian	1 (6%)		1 (3%)
Asian/Pacific Islander	1 (6%)		1 (3%)

Table 6 2002Committee

HIV Infected Males	HIV Infected Females
5 (33%)	3 (13%)

A total of 8 (18%) of the Committee are HIV infected and represent HIV transmission categories of injection drug use (IDU), men who have sex with men (MSM), and heterosexual HIV transmission.

Selecting New Members

In November Co Chairs and an ad hoc group of the Committee review applications and make recommendations to the Health Department on new Committee members. Those applicants are contacted and if willing to commit to the process invited to a one-day orientation in January 2003 followed the next day by their first Committee meeting. In addition, each new Committee member is assigned an experienced Committee member to act as his or her mentor into and throughout the process of serving on the Committee.

Mentor Job Description

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

At Orientation new Committee members receive a three-ring binder with pertinent information to the HIV prevention planning process. The following day they attend their first full Committee meeting.

Three Ring Binder

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

The full Committee meets from 9 AM to 2:15 PM and the Steering Committee meets from 2:15 PM to 3 PM. The 2003 Committee Orientation will take place on Tuesday 14 January and the full Committee will meet on Wednesday 15 January. Committee meetings for the remainder of 2003: 19 & 20 March, 21 & 22 May, 15 & 16 July, 20 August, 17 September, and 19 November. The Committee meets at the Best Western Inn and Suites of Middletown/Harrisburg. Committee members are provided a hotel voucher and if necessary, a travel voucher for flights. Otherwise they are reimbursed for mileage for meal expenses a continental breakfast and lunch is served at meetings.

The Committee operates on a consensus basis. In 2000 a Committee member skilled in negotiation provided technical assistance to the Committee relative to developing group consensus. The mere nodding of a head or show of hands does not necessarily indicate consensus. People commit at different levels ranging from (1) not willing to support an effort in any manner—(2) not agreeing with a situation, but likewise not standing in its way—(3) all-out support with taking action to insure something occurs. This process more accurately reflects the commitment of the Committee in support of HIV prevention concepts and efforts. In addition to seeking consensus with such a large and diverse group, this Committee member also provided some technical assistance relative to respectful engagement during consensus development. For example, if a Committee member feels aggrieved they indicate so by saying, "ouch" to the individual that they believe made the "hurtful" statement. That individual responds with an "oops" and the two briefly dialogue with each other on their intent and meaning of statements. This process also fosters greater understanding among all members of the Committee.

Rules for Respectful Engagement (developed in 2000)

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

Structure

In 1999 the Committee operated with 11 standing subcommittees. Subcommittees met quarterly on telephone conference calls and occasionally at Committee meetings. Pennsylvania Prevention Project staff arranged for calls, created the agendas, and maintained the notes. The Committee had determined in 1996 that they did not want to appoint subcommittee chairs and have the responsibility of taking notes. At the end of 2000 it was apparent that this operation of subcommittees was no longer viable. Few subcommittees had quorums and subcommittees appeared to lose focus and failed to complete tasks. An ad hoc group was created to examine the operation of subcommittees and made recommendations which essentially reduced the number of subcommittees and created more flexibility for each subcommittee to determine how best to accomplish their tasks. At the conclusion of CY 2001 another work group recommended that subcommittees be created to reflect the Plan development work groups

operationalized that year. The Committee adopted the Health Education and Risk Reduction, Counseling and Testing, Priority Populations and Interventions, and Linkages and Public Information subcommittees.

In January 2002 the Committee eliminated existing subcommittees and created four new subcommittees: (1) Needs assessment, (2) Evaluation, (3) Epidemiology, and (4) Interventions. Each subcommittee selects a Chair and Alternate and they are responsible for running meetings and maintaining notes. Subcommittees may recruit appropriate experts (including former members) to fill in gaps of expertise, but such participants would not have voting power. The efforts of subcommittees need to be clearly communicated between each other and share needed information in order to minimize duplication of efforts.

Thus each Subcommittee Chair and Alternate along with the Committee Co-chairs form a Steering Committee. Alternates are encouraged to attend the Steering Committee, but have no vote unless their Chair is absent. Subcommittees meet from 10 AM to Noon and report to the full Committee in the afternoon. The Steering Committee meets at the end of the day to better insure that the individual work of subcommittees is progressing and specific needs are being met. It was made clear that this was not an Executive Committee and its sole role was to promote and insure communication between subcommittees. Due to their unique position of knowing the technical assistance needs of the Committee an additional role would be to point out the training or technical assistance needs of the Committee. Health Department staff supports each subcommittee.

Process Evaluation

A Committee process evaluation is conducted in November of each year. The Committee is randomly divided into two groups and facilitators not familiar with the Committee are employed to ask structured questions. The Centers for Disease Control and Prevention (CDC) Evaluation handbook format and questions are utilized which primarily relate to the five-core objectives of Community HIV prevention planning.

National Core Objectives for Community HIV Prevention Planning

(1) Fostering the openness and participatory nature of the community planning process.
(2) Ensure that the CPG reflects the diversity of the epidemic in your jurisdiction and that expertise in Epidemiology, behavioral science, health planning and evaluation are included in the process.
(3) Ensure that priority HIV prevention needs are determined based on an epidemiological profile and needs assessment.
(4) Insure that the interventions are prioritized on explicit consideration of priority needs, outcome effectiveness, cost effectiveness, social and behavioral science theory and community norms and values.
(5) Foster strong logical linkages (i.e., connections) between the community planning process, the comprehensive HIV prevention plan the application for funding, and allocation of HIV prevention resources.

Utilizing this format and guidance permits both the CDC and the Committee uniformity for comparison nationally between funded jurisdictions and locally between years. In 1996 the Committee believed that too many members were either not present for the process evaluation or not all members may feel comfortable participating with their colleagues while sessions were tape-recorded. Therefore, an

anonymous survey asking similar questions is mailed to all Committee members and data is merged into a more comprehensive process evaluation report.

Process Evaluation 2001

- The most recent process evaluation was conducted on November 14, 2001 by facilitators not familiar with the Committee.
- Questions based upon the Five Core Objectives of Community HIV Prevention Planning in which 75% (30/40) of the Committee participated.
- Anonymous Survey of all Committee members in December of which 50% (20/40) of the Committee responded.
- Information is utilized for recruitment of new members in 2002.
- Information informs the Co-Chairs of Committee development needs.

Committee members believe that **membership recruitment, nomination, and selection** work well. The Committee orientation process continues to improve however, several Committee members still believe that the volume of information is overwhelming and the learning curve steep and long. The mentoring process works well, however not consistently for all. Seventy-percent (14/20) of respondents to the survey are satisfied with the selection criteria.

Meeting attendance continues to be a contentious issue with the following two quotes from the small groups appearing to capture the primary opposing sentiments. "Attendance is often talked about, but seldom addressed." "We are not corporate America. One of the target groups that should be a large part of this are the economically disadvantaged." The Committee needs to strive for the balance of enforcing meeting attendance as well as addressing the needs of members to participate.

Few comments reflected on the committee procedures for **conflict resolution.** "The conflict resolution process has come a long way and needs to be ongoing." " I was happy to see that we all did not have to say the same thing and all agree all of the time. That it was okay to have a differing opinion and be of a differing perspective."

Meeting facilitation on the other hand needs to be examined. Participants and respondents both reflect frustration with meetings starting and ending on time, too many side comments during the meeting, members do not respect the break and meal times, and people allowed to speak too long. Sixty-percent (12) respondents are satisfied with meeting facilitation and 10% (2) are neither satisfied nor dissatisfied. Thirty-percent (6) of respondents believe meetings run smoothly while 30% (6) disagree; however, 40% (8) neither agree nor disagree with the statement. Ninety-five-percent (19) of the respondent believe the minutes accurately reflect the meetings.

According to responses **Epidemiology** appears to be a challenge for most to grasp and utilize as well as in the past two years the epidemiological profile has become much more sophisticated. The information is probably as thorough as it can be under the circumstances with all of its limitations. The information is needed earlier in the process to be used for planning. Concern is expressed by both group participants and survey respondents relative to **priorities** in rural Pennsylvania, particularly among the invisible farm labor community. Community values and norms need to be addressed within the African American and Latino(a)/Hispanic communities in establishing viable priorities.

Many group participants expressed concern over not seeing the fruition of their planning efforts They question how the Plan is or if it is utilized at the community-level? What programs exist statewide with other non-public funding?

Many respondents to the **survey** identified the diversity and talent of the Committee as **strengths**. In addition, they identified the informal atmosphere, youth input and participation, levels of commitment and expertise, as well as respect for one another and willingness to meet challenges, and open mindedness of the group, as strengths of the Committee and its process.

In contrast respondents indicated, among a number of **recommended changes**, that they would like to strengthen facilitation, match funding to intervention needs, provide direction to the Plan, and add more rural and injection drug use representation. **Barriers to participation** such as conflict with employment, health, domestic considerations, and expenses were identified.

Epidemiology

Relevance of Epidemiology Input To Prevention Planning

The most basic broad objective of Epidemiology input to HIV Prevention Planning is to analyze HIV/AIDS data, describe the impact of the epidemic in terms of the person (who), place (where) and time (when) attributes of the HIV epidemic, and facilitate the use of Epidemiologic data in the HIV prevention planning process. This descriptive profile of the impact of the epidemic provides a scientific basis for inference on patterns of new HIV infections – and hence, the Epidemiologic Profile is used to inform the process of planning for prevention of new HIV infections.

Methods and Processes of Epidemiology Input To Prevention Planning

Previously, the *State HIV/AIDS Epidemiologist* along with consultants and external peer reviewers developed the Epidemiology Profile and provided Epidemiology support for prevention planning. Epidemiology input to prevention planning was largely limited to the following activities: a) the orientation of new members, which included a once-off analyses and presentation of an overview of the Epidemiology of HIV/AIDS in PA to the full Community Prevention Planning Group (CPG); b) development of the model for prioritization of target populations and analyses of relevant data, input and update of the prioritization model as new data become available to operationalize the model (an update of the prioritization of target populations has been included as an appendix to this application) ; and c) providing ongoing Epidemiology consultation to prevention planning meetings and planning processes. In 2002, the Community Prevention Planning Group was restructured and for the first time a formal Epidemiology Subcommittee including committee members was formed.

Main Objectives of the Epidemiology Subcommittee for 2003

- Review/revise subcommittee's goals and develop objectives and action steps
- Request resources (data, expertise, etc.) necessary to perform subcommittee's function
- Identify best epidemiology practices
- Use best epidemiological practices to identify existent and emerging risk groups
- Refine prioritization model based on epidemiological data
- Respond to Epidemiologic data requests from other subcommittees
- Plan for and prioritize allocation of epidemiology resources
- Prepare, review and approve specific components of Prevention Plan and application concerning Epidemiology

- Ensure linkages between Epidemiology and all other subcommittees, e.g. providing Epidemiology input to prioritization of target populations or providing technical support for the use of Epidemiology studies to evaluate outcomes of interventions.
- Ensure linkage between Epidemiology subcommittee, the larger planning process, the Prevention Plan and the annual application for funding with regard to epidemiology
- Facilitate the recruitment of new committee members with formal Epidemiology expertise
- Build CPG's capacity to understand epidemiology data and support the subcommittee's work

A timeline of specific Epidemiology inputs and support activities is being developed that will outline the planned activities of this subcommittees in 2003:

A series of Epidemiology inputs to the prevention planning process that need to be conducted by the Epidemiologist for Prevention Planning in order to enhance the capacity of the CPG membership to more fully utilize and interpret the wealth of Epidemiologic data available to the prevention planning process include the following:

a) Introduction to the utilization and interpretation of Epidemiology data for prevention planning (orientation);
b) Overview of the Epidemiology of HIV/AIDS in Pennsylvania (Full CPG);
c) A series of Epidemiology inputs during the planning year on the Epidemiology of HIV/AIDS in PA among specific target populations:
    i. Epidemiology of HIV/AIDS among MSM and MSM/IDU by various characteristics in PA;
    ii. Epidemiology of HIV/AIDS among IDU and MSM/IDU by various characteristics in PA;
    iii. Epidemiology of HIV/AIDS among Heterosexuals by various characteristics in PA;
    iv. The distribution of the HIV/AIDS epidemic by geographic area across PA;
    v. HIV/AIDS among special populations such as persons attending Counseling and Testing sites, incarcerated, homeless, transgender, and other at-risk populations by various characteristics in PA;
d) The Epidemiology Subcommittee members have also prioritized providing mentorship to new members on utilization and interpretation of Epidemiology data.

Year 2000, 2001 And 2002 Updates of the 1999 Edition of the Epidemiological Profile of HIV/AIDS in Pennsylvania:

The overall aims and objectives of 2000, 2001 and 2002 Updates were to assist the HIV/AIDS prevention and care planning processes gain more access to empirical data that can be used to plan and develop prevention and care services in Pennsylvania, this update extends the analyses conducted and presented in the 1999 Epidemiological Profile of HIV/AIDS in Pennsylvania. In addition to HIV/AIDS incidence data presented in 1999, the primary objectives of the year 2000, 2001 and 2002 updates are to determine and describe:

1) Changes over time in incidence and prevalence of AIDS in Pennsylvania and infer relevant changes in HIV trends.
2) The geographic distribution of recent changes in AIDS incidence and prevalence in Pennsylvania;
3) Changes over time in the likelihood of death among cases diagnosed with AIDS and to highlight the resulting changes in survival time after diagnosis with HIV/AIDS in Pennsylvania;
4) Changes over time in estimated prevalence of HIV in the general population and the geographic distribution of estimated HIV prevalence in Pennsylvania.

Background and Significance of the 2000, 2001 and 2002 Updates; Inference on HIV occurrence from AIDS Surveillance data in the HAART era and HIV reporting in Pennsylvania:
The Epidemiological Profile of HIV/AIDS in Pennsylvania that was redeveloped and issued in 1999 consisted mostly of data describing changes over time in the HIV/AIDS epidemic in Pennsylvania through 1997. This 1999 analyses was truncated in 1997 to reflect earlier trends in AIDS incidence which could be inferred to reflect HIV incidence trends (of a decade ago). Subsequent to 1997, when highly active antiretroviral therapy (HAART) became widely distributed in PA, AIDS incidence trends were increasingly less likely to be reflective of the direction of the HIV epidemic as new AIDS diagnoses and consequently AIDS incidence trends were pre-empted by HAART. More specifically, the data presented in 1999 focused on showing change over time using AIDS incidence data along with some surrogate data (mainly STD data) to describe attributes of the HIV/AIDS epidemic pertaining to: a) person, b) place and c) time. Thus, the data presented showed: a) which population-transmission groups are affected [*person*, i.e. which groups of persons are affected, by demographic distribution (age groups, race/ethnicity, geographic location and sex) and by probable modes of transmission]; b) which parts of the state are affected (*place*, i.e. as in geographic distribution); and c) changes over *time* in the epidemic's impact on the affected geographic parts of the state and the population-transmission groups.

Delays in the commencement of HIV reporting in Pennsylvania (HIV reporting has now been approved to start in October 2002) means that the state will not have usable HIV trend data for another 2-3 years. Due to these delays in HIV reporting and the lack of resources to update the current profile with AIDS surveillance and other relevant data, we have not been able to do a full update of the Epidemiologic Profile since 1999. As an interim measure, we have incrementally updated the Epidemiologic Profile of HIV/AIDS in Pennsylvania in the 2000, 2001 and 2002 planning years, to include more epidemiologic analyses of disease occurrence that are addressed by the four objectives indicated above.

In the absence of data that is reflective of HIV incidence, i.e. trends data that could be generated from complete reporting of newly diagnosed *recently infected HIV cases*, we are using these additional types of analyses to try and describe the epidemic more fully and to infer the likelihood of new HIV infections in various geographic areas and their affected population-transmission groups AND at the same time describe the likelihood of growth in the population that is living with HIV/AIDS in Pennsylvania. The inference that can be made from these data will enable HIV/AIDS prevention and care planners to better determine which population-transmission groups and geographic areas should be prioritized for resources for preventive and care services.

Plans for Development of a Full Update of the Epidemiologic Profile based on the New CDC/HRSA Guidelines and Provision of Epidemiology Support for Prevention Planning:
The CPG has voted on resolutions to support the allocation of prevention resources to support a position for "Epidemiologist for Prevention and Care Planning" in previous planning years and during this current planning year. However, the necessary resources have not been made available for this purpose. The lack of allocation of financial and human resources to more fully provide Epidemiology support has meant that the planning process could only get partial Epidemiology support, which was provided by the *State HIV/AIDS Epidemiologist* (his primary responsibilities are the development and management of the Department's HIV/AIDS surveillance and research projects). As a consequence, the last full development of the Epidemiological Profile was in 1999 using data through 1997. The next full update needs to be prepared in 2003 to support the next 3-5-year plan beginning with the next 5-year grant cycle in 2004. The commencement of HIV reporting in October 2002 and the envisaged expansion of HIV/AIDS surveillance and research projects further limit the already limited time that the State HIV/AIDS Epidemiologist is able to devote to Epidemiology Support for Prevention Planning. **Without allocation of resources for Epidemiology support for Prevention Planning, it will not be possible**

for the HIV/AIDS Epidemiology Section of the PA Department of Health to develop the next full update of the Epidemiology Profile of HIV/AIDS in PA – this update is supposed to be a more detailed Integrated HIV/AIDS Epidemiology Profile to serve both the Prevention and Care Planning processes, in accordance with the new CDC/HRSA guidelines for Epidemiology Profiles. **Technical support may be needed to facilitate and ensure the allocation of adequate resources for Epidemiology support for prevention (and care) planning.**

Unlike in the past when data was presented in separate profiles for care and prevention planning to meet the needs of the separate funding processes, the next full update of the Epidemiological Profile of HIV/AIDS in PA will need to be a more integrated profile designed to take cognizance of the integrated nature of the continuum of prevention and care services, in accordance with the new CDC/HRSA guidelines for development of Epidemiology Profiles. Due to the dual-purpose of the Integrated Epidemiological Profile, the contribution of resources for the re-development of the Epidemiological Profile in accordance with the new CDC/HRSA guidelines needs to be done jointly from both the prevention and care services funding streams.

Overall Responsibilities of the Envisaged Position of "Epidemiologist for Prevention and Care Planning":

The position of Epidemiologist for Prevention and Care Planning is envisaged as a position that will provide Epidemiology support to both the Prevention and Care Planning Processes (and will therefore need to be supported by resources from both the Prevention and Care Planning funding streams). Specific responsibilities will include:

a) **Providing Epidemiologic support for the development of annual updates of the Integrated Epidemiologic Profile of HIV/AIDS in PA and providing Epidemiology support for the annual federal grant applications for CDC HIV/AIDS prevention and HRSA care/treatment funding which collectively secure close to $30 million worth of federal funds for PA (This Epidemiologic profile forms the scientific basis of the state's plans for HIV prevention and care/treatment services plans and is a required part of the annual federal CDC prevention and HRSA treatment/care grant applications for federal funding of HIV/AIDS prevention and care services in PA);**

b) **Providing Epidemiology support for linkage of HIV reporting to early intervention prevention and care services: i.e. development and management of the envisaged provider-mediated referral systems between the HIV reporting system and partner counseling and referral, case management, and other prevention and care service systems;**

c) **Attendance of all the State prevention and care services planning meetings (and the Epidemiology and Data Needs subcommittees) and providing ongoing Epidemiology analyses and consultation to the planning proceedings at these meetings;**

d) **Providing HIV/AIDS data and epidemiology support for regional HIV/AIDS Coalition planning processes;**

e) **Providing Epidemiology support for HIV/AIDS prevention/care service program monitoring and data collection systems, epidemiologic research and evaluation including the following functions:**

Assisting the Epidemiology and Data Needs sub-committees of the Prevention and Care Planning Committees with identifying data needs and development of health service research plans to address data and research needs for program planning, implementation and evaluation which may also include providing Epidemiology support for:

i. **Planning of essential prevention/care services research including monitoring and outcome evaluation of prevention/care service delivery – this entails providing the programs with Epidemiologic consulting for health services and evaluation research study design; conduct and implementation of Epidemiologic, health services and outcome evaluation research;**

ii. **Data analysis for Epidemiologic, health service research and outcome evaluation; performing relevant interpretation of Epidemiologic data in support of HIV/AIDS service programs; and**

iii. **Development and regular review of Epidemiologic and health services research input to the prioritization and planning processes for HIV/AIDS prevention and care services;**

Needs Assessment

Needs Assessment

A needs assessment process initiated in 2000 was completed in 2002. This assessment entailed a qualitative assessment of subpopulations of the three largest risk populations: Injection drug users (IDUs), men who have sex with men (MSM), and heterosexuals at risk of HIV.

The goal of the needs assessment was to fill gaps of information that existed concerning the needs and barriers to HIV prevention among HIV risk populations. Thirteen such risk populations were identified in the Committee's 1999 *Pennsylvania Community HIV Prevention Plan*. These populations were named according to primary HIV risks and other characteristics such as age, sex, and race/ethnicity. Each of the 13 populations can be categorized under one of three larger risk populations identified above. These three larger categories were used to organize the needs assessment into three separate but similar processes.

An identical needs-assessment planning and implementation process was followed for each of the three populations. Each process began with the review of the literature and past needs assessment data to identify gaps of information required to be filled. Then, a series of planning steps were implemented as detailed in this report. This planning was inclusive of representatives from the respective risk populations, those with expertise in addressing HIV-specific needs and barriers per population both locally and nationally, service providers, researchers, Committee members, and DOH personnel.

Planning also included identification of subpopulations within each of the larger populations for and from whom information needed to be gathered. Once information gaps and subpopulations were identified, panels of individuals assisted PPP in determining the questions that needed to be asked and the best methods for acquiring this information from representative samples of these subpopulations. Then, data gathering took place through focus groups and interviews (determined to be the best methods for information needed in all three processes). Further details about the implementation and data analysis are provided in the attached Executive Summary of the final Needs assessment report.

This needs assessment was qualitative in nature; that is, it sought to capture perceptions and ideas of subpopulations of IDUs, MSM, and heterosexuals. Findings are not necessarily representative of all members of each of the subpopulations. Instead, they provide general direction for HIV-prevention planning statewide, and also provide the basis for one of the next steps in the assessment process—a quantitative, rapid needs assessment of larger numbers (representative samples) of members of risk populations is being considered by the Needs Assessment Subcommittee.

Findings from this assessment exclude risk populations in Philadelphia, which receives separate CDC funding. However, statewide and Philadelphia HIV-prevention planners share needs assessment information with one another through reporting and various meetings.

Methods similar to the needs assessment just completed are now underway to learn the HIV prevention needs and barriers of "emerging" and "special" populations at risk of HIV." These populations are defined as follows:

- "Emerging populations" of people at risk of HIV, i.e., populations for which we have insufficient data to infer HIV-infection trends, but for which some information on recent risks indicates that HIV transmission may be a growing issue.

- "Special populations" of people at risk of HIV, i.e., populations that are already a part of a larger risk population, but which have special circumstances, such as homelessness or persons who are transgender, for which particular information is needed.

The emerging and special populations under study include:

- People who are homeless.
- Asian/Pacific Islander MSM.
- Prisoners about to be released or recently released from county jails.
- People who are transgender.

Additionally, a consultant to the Department of Health and Planning Committee also head a research project looking at the HIV prevention needs of people with severe mental illness in Pennsylvania. He is compiling findings from this research for the Planning Committee.

Additionally, the needs assessment subcommittee of the Planning Committee is currently reviewing needs assessment findings conducted by the Ryan White Coalitions. These Coalitions, besides addressing HIV/AIDS care and services, also coordinate state legislature funding to their respective regions for conducting HIV prevention. Therefore, the Coalitions' needs assessments, in part, address HIV prevention needs and barriers. The needs assessment subcommittee is attempting to integrate these findings with the findings from the statewide needs assessment for better understanding of regional needs/barriers. (Full Epidemiological Profiles are in the Appendix to the Plan)

Young Adult Roundtables

Young Adult Roundtables began in 1995 with four groups (Allentown, Erie, Pittsburgh, and York). Subsequently the nationally recognized Young Adult Roundtable has been created in nine communities in 2002 (Camp Hill, Erie, Harrisburg, Lehigh Valley, Norristown, Pittsburgh, Reading, Williamsport, and York). This is the eighth year of facilitating the participation of at-risk young people in HIV prevention community planning. Incorporating recommendations from Roundtable members, from Committee members and from Department of Health staff, the Roundtables change from year to year to accommodate planning needs and project capacities. They continue to struggle finding recruiters and high risk young people (those who engage in high-risk behaviors) for young people living with HIV and young people living in rural settings.

Each group is composed of a select demographic group of young people (gay, African American or Latino, for example) who are at the greatest risk for HIV infection/re-infection. As such, these individuals can convey both a clearer understanding of risk behaviors and the HIV prevention needs of young people.

When asked, "Why do you participate in this group?":

"because I need to learn more about sex cause my mom don't talk to me about it."

"It's been an integral part of my individual campaign against AIDS/HIV."

"To learn more about HIV and what I can do to help. I have been at very high risk many times in my life (including recently). I have been diagnosed with HPV and PID. I feel I have important info to give."

Convenience-sampling methods are used to recruit new project members. Because Roundtable members are not randomly selected from the general population, the opinions and recommendations of Roundtable member are not representative of all high-risk young people. However, the input and ideas of Roundtable members certainly help us to understand more clearly the perceptions of young people at risk of HIV infection/re-infection.

Recruiting efforts were moderately successful in 2002 due largely to the leadership of Roundtable representatives, who, together with local gatekeepers worked hard to identify new members. The goal was to have an average of 15 young people in each group. This year, the Roundtables are composed of 110 young adults, an average of 14 members per group (The full update is attached to this Plan Update).

On the weekend of 14 and 15 March 1998 the Department of Health funded the roundtable Youth Summit in Harrisburg. The Summit was attended by 64 youth from seven Roundtables across the state. This two-day planning conference, coordinated by the Pennsylvania Prevention Project, consisted of plenary and small group didactic activities which facilitated the generation of data for the development of the 1998 Pennsylvania Young Adult Consensus Statement (the full document is attached to this Plan Update). The current Young Adult Roundtable Executive Staff is updating the 1998 document to be included within the five-year cycle commencing in 2004.

Since the beginning of the Roundtables, members expressed the urgent need for HV prevention education and interventions that target risk reduction needs of sexually active young people. This need was repeated by other young people in focus groups conducted around the state in 1996. At the Roundtable Summit in 1998, Roundtable members decided to document this and other HIV prevention needs. Finally in 2000 the project got under way. The original group of planners consisted of 18 young people and in October 2001 this group created a subcommittee to continue the work. They are working in collaboration with other young peer educators who understand HIV prevention and effective ways to communicate with adolescents and young adults. This intervention will be designed entirely by and for young people and should be ready for pilot testing in 2003.

This is our voice. We have been plagued by AIDS, an epidemic that seems incurable and is spreading rapidly in our lives and affecting our families, friends, partners and communities. It is our responsibility to educate ourselves, while promoting less risky behaviors.

We are a team that represents a cross-section of high-risk young adults. We have come together with different experiences; therefore, we are better equipped to convey the HIV/AIDS, STI and unintended pregnancy prevention needs of young adults. We recognize the need for peer-based, sex-positive HIV/AIDS, STI and unintended pregnancy prevention programs and interventions.

According to the Centers for Disease Control and Prevention (CDC ****), the majority (%) of young adults are sexually active and are being infected by HIV and other STIs at alarming rates. When we came together we knew that abstinence-only and abstinence-based programs are not meeting young adults' needs; therefore, we have designed this original intervention, based on harm reduction principles, to reach those who we represent.

We have provided an intervention that empowers sexually-active young adults to make healthier decisions that will reduce their risk of STI and HIV infection/re-infection, of AIDS and of unintended pregnancy.

Four individuals from the Young Adult Roundtable Executive Committee are elected by their peers to be voting members of the HIV Prevention Committee. This is an increase of one representative from previous years to match the four new subcommittees created in January 2002.

Evaluation

The Five-Year Strategic Evaluation Plan has six components, each describing a distinct type of evaluation:

7. Evaluation of the community planning process and prevention plan development.
8. Establishment of Intervention Plans.
9. Evaluation of linkages between the Comprehensive HIV Prevention Plan and application for funds, and between the Comprehensive HIV Prevention Plan and resource allocation.
10. Process monitoring.
11. Outcome monitoring and process evaluation.
12. Outcome evaluation.

All but number 5, outcome monitoring and process evaluation, are required by the CDC.

The following describes progress in implementing the Evaluation Plan since the last report contained in the PA Department of Health's Application for Funding submitted in fall 2001. The right-hand columns provide a sample of lessons learned to date relative to each type of evaluation and technical assistance needs.

Type of Evaluation	Progress in Implementation since Fall 2001	Lessons Learned	Plans for January to December 2003	TA Needs
1. Evaluation of the community planning process and prevention plan development.	The annual evaluation of the community planning process was conducted at and around the regular Community Planning Committee meeting in November 2001. As in the past, this evaluation consisted of an anonymous member survey and a co-chair survey based on the CDC's guidance; and guided discussion groups that were moderated by outside, objective facilitators to assess the year's Committee and planning process. These data have been analyzed. Ongoing discussion about findings occurred throughout the regular planning year subsequent to the November meeting.	A significant discussion among the Committee was that the subcommittee might be reconfigured to more closely match the CDC's format for community planning. Based on this discussion, the Committee reconstituted its subcommittee structure during planning year 2002. This new structure consists of 4 subcommittees: Needs Assessment, Epidemiology, Interventions, and Evaluation. Further, a Steering Committee consisting of the chairs and co-chairs of the 4 subcommittees was formed.	The same evaluation of the community planning process and prevention plan development will be implemented in the November 2002 Committee meeting.	TA is needed for the PA Department of Health to effectively facilitate the process of developing the statewide HIV prevention plan. The planning process needs to be more goal and objective oriented, and structured around the tasks that need to be accomplished.

Type of Evaluation	Progress in Implementation since Fall 2001	Lessons Learned	Plans for January to December 2003	TA Needs
2. Intervention Plans.	Intervention Plans were completed by all agencies (i.e., local health departments and their subcontractors) receiving CDC 99004 funds in Fall 2001. Based on process evaluation of the implementation of Intervention Plans, Intervention Plans for FY 2003 will be based on Process Monitoring Data for July 1, 2001 to June 30, 2002. Two other categories of agencies **that do not receive** CDC 99004 funds to implement HIV prevention, but that receive other public (state) funding to conduct such prevention, have also adopted the use of Intervention Plans in their annual planning and contracting with the PA Department of Health. These agencies include 7 Ryan White Care Coalitions and their subcontractors and the state's Council of Spanish Speaking Organizations.	Completion of the Intervention Plans by local health departments revealed a number of lessons, including: • Evidence of the need for continuing training among constituents until a uniform data collection/reporting system is fully implemented through 2003. For instance, the problem of overuse of "heterosexual risk" and "general population" as default categories could be corrected through further training and quality control of Intervention Plans. • Evidence of the need to target HIV prevention interventions even more in the future. For instance, it is the belief of the PA Department of Health, that "General Population" should be targeted less and less among ILIs, GLIs, and Outreach Interventions, and increasingly among the other risk populations. Eventually, General Population should not be a category used in these three types of interventions. In brief, the Intervention Plans will need to replicate increasingly and closely the prioritization of HIV target populations in the future.	Intervention Plans will continue to be completed by both CDC 99004-funded and non-CDC funded agencies receiving public funding. The decision to require completely new Intervention Plan data for each subsequent planning year, or basing Intervention Plan data based on the past year's Process Monitoring Data for each agency will be decided through further assessment of Intervention Plans.	No TA needed at this time.

Type of Evaluation	Progress in Implementation since Fall 2001	Lessons Learned	Plans for January to December 2003	TA Needs
3. Evaluation of linkages between the Comprehensive HIV Prevention Plan and application for funds, and between the Comprehensive HIV Prevention Plan and resource allocation.	The framework for gap analysis is set for the next planning cycle.	Sufficient information for a gap analysis was not available to adequately complete the linkage tables as well as to prioritize interventions	The Evaluation Subcommittee will develop the comprehensive linkage tables as per the CDC evaluation guidance in the next five-year Plan development.	TA in evaluating linkages may be useful.
4. Process Monitoring.	All providers receiving resources from CDC 99004 funding have fully implemented Process Monitoring as of July 1, 2001, and non-CDC funded providers providing HIV prevention fully implemented Process Monitoring using the CDC-guided system as of July 1, 2002. As discussed above, these non-CDC-funded providers include 7 Ryan White Coalitions and their subcontractors that implement HIV-prevention activities, as well as the Spanish-Speaking Organizations in PA.	Lessons from the Process Monitoring process among nine local health departments and their subcontractors that provide HIV-prevention services are similar to those learned from assessment of Intervention Plan data. Briefly: • Continuing training of providers in uniform data collection and reporting needs to include guidance on seeming overuse of the categories "heterosexual" and "general public" as "default" risk populations when multiple risks or vague risks are present. • Better targeting of the highest risk populations needs to be encouraged, supported with training, and monitored. • A better system of estimating FTE staff per intervention type/risk population needs to be designed.	Process Monitoring will be continued by all CDC 99004-funded and non-CDC-funded agencies throughout 2003.	TA regarding ways of making better estimates of FTE staff may be needed.

Type of Evaluation	Progress in Implementation since Fall 2001	Lessons Learned	Plans for January to December 2003	TA Needs
5. Outcome monitoring and process evaluation (not required by CDC)	The outcome evaluation described below also contains components addressing outcome monitoring and process evaluation.	It is too soon for many lessons, but an early lesson learned to date through process evaluation and preparing for the outcome evaluation is that male and female clients differ greatly in the perceptions of the format of HIV prevention interventions to which they would respond. Female respondents prefer interventions delivered in small groups of female peers. Male respondents prefer one-on-one interventions delivered by prevention experts.	The evaluator will implement the assessment throughout 2003 and will report at least intermediate results in September 2003.	No TA needed at this time.
Type of Evaluation	**Progress in Implementation since Fall 2001**	**Lessons Learned**	**Plans for January to December 2003**	**TA Needs**
6. Outcome evaluation	An outcome evaluation has been initiated for a Perinatal/Young Adult (male and female) HIV-Prevention Demonstration Project. An outside evaluator has been identified and a contract has been established with this evaluator to work with the administering agency in completing design and implementing an outcome evaluation. As stated above, the larger evaluation design includes assistance to the provider agency in appropriately monitoring outcome and process evaluation. This process evaluation addresses reasons why clients may choose some levels and types of interventions over other types and levels within the multi-intervention project; it also assesses client satisfaction and project staff and, when appropriate, clients' families' impressions of the project. The outcome evaluation assesses risk behaviors at baseline and changes in intent to change	Too soon for lessons.	The evaluator will implement the assessment throughout 2003 and report at least intermediate results in September 2003.	TA is not needed at this time; yet, close contact with CDC PERT staff and Project Officer has been and will continue to be appreciated when specific evaluation questions arise. Lisa Manley and Charles Collins at the CDC have been contacted for consult on capacity building efforts in other states, and whether our methods can be viewed as a model that other states can follow.

Type of Evaluation	Progress in Implementation since Fall 2001	Lessons Learned	Plans for January to December 2003	TA Needs
	behavior and actual behavior change over time intervals. A time-series design is used so that changes among individual clients is assessed over time. Additionally, "natural" comparison groups may exist in the project; that is, outcomes of clients choosing to receive lower intensity of interventions may be compared to those choosing to receive higher intensity and multiple interventions over time. The new evaluation subcommittee is engaging in a capacity-building undertaking to build a statewide infrastructure for HIV prevention program evaluation, including outcome research. To initiate this process, the subcommittee is identifying and surveying the capacity of universities across the state to conduct HIV-prevention evaluation			

Priority Populations

This document is an update on the progress of the Prioritization Model for HIV/AIDS Prevention Planning in 2002. Although, the model is still under development, the interim stage that the project has reached illustrates how the model would work under ideal conditions when all/most of the necessary data components that are/will be identified are entered into the model. The model continues to undergo peer review and development and, as each recommendation emerges, it is submitted to the CPG for review. **The only update since last year's submission of the model with the 2002 HIV Prevention Plan involves line 11, Number of Factors in Transmission Category that are Barriers to Prevention. Based on needs assessment data on Socio-Behavioral Barriers to HIV Prevention, line 11 has been completed. Explanation of ways in which scores for Socio-Behavioral Barriers were derived for risk populations is described in the Final Report of the HIV Prevention needs assessment submitted to the Pennsylvania Department of Health and the Planning Committee by the Pennsylvania Prevention Project in summer 2002.**

OUR UNDERSTANDING OF CDC'S GUIDANCE ON PRIORITIZATION:

All jurisdictions receiving CDC funding must establish a prioritization process. To support establishment of this process, the CDC provides guidance for establishing priorities. It envisions prioritization occurring in two ways:

1. Prioritization of target populations at risk of HIV transmission.
2. Prioritization of HIV-prevention interventions for each target population.

The CDC recommends the following "key priority setting tasks":

1. Identify target populations.
2. Identify potential factors for prioritizing target populations (e.g., AIDS case rates, HIV transmission rates, barriers to prevention, etc.).
3. Gather existing data sets or identify new data you need for each factor for each population.
4. Weight target population factors (giving the most important or reliable greater weight, and the least important or reliable lesser weight).
5. Rank and score target populations using the above factors.
6. Use the above scores to prioritize the target populations.
7. Identify a list of interventions for each target population.
8. Identify factors for each intervention.
9. Gather data on each factor for each intervention.
10. Weight Intervention factors.
11. Rank and score interventions for each target population using factors.
12. Prioritize interventions for each target population.
13. Review and evaluate the overall priority-setting process.
14. Incorporate the above prioritization process in writing the prevention plan.
15. Review the Health Department application and determine concurrence.

METHODS: SUMMARY OF METHODS FOR APPLICATION OF PROPOSED PRIORITIZATION MODEL FOR HIV/AIDS PREVENTION PLANNING IN PENNSYLVANIA (EXCL. PHILADELPHIA).

1. Transmission categories and factors by which the transmission categories would be ranked were established.
2. Categories within each factor were ranked and each factor assigned a relative weight compared to other factors in the model;

3. Then the rank for each factor was multiplied by the weight associated with the factor, resulting in a product score for that factor corresponding with the appropriate transmission category;
4. The product for each factor by transmission category was then entered into the respective cell in the transmission category column;
5. The totals for each transmission category column were calculated; based on the sum of the column scores, the percentage for each transmission category were calculated and entered;
6. Each transmission category was stratified by race/ethnicity to establish population-transmission categories. Each transmission category sum of scores was thus stratified by race/ethnicity according to the relative percentage of incident AIDS cases (diagnosed in more recent years, 1995-1997) in each transmission category by race/ethnicity;
7. A combined composite was established from the population/transmission group cross-tabulation;
8. Each population/transmission group was ranked according to its percentage share of the total score for all population/transmission groups.

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

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

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

FACTOR	RANK OF CATEGORY WITHIN EACH FACTOR	Weight	A. MSM			B. MSM/IDU	C. IDU	D. HETEROSEXUAL				E. Peri-natal	F. Other
			A. Overall	(i) Gay-ID (overall =receptive & insertive)	(ii) Non Gay-ID (overall= receptive & insertive)	B. (iii)	C. (iv)	D. Overall	(v) Female sex partners of male IDU (receptive)	(vi) Male sex partners of female IDU (insertive)	(vii) Het. Sex partner of unknown HIV status (receptive & insertive)	E. (viii)	F. (ix)
HIGHER WEIGHT MORE OBJECTIVE EPI DATA (WEIGHT RANGE: 6 – 10)													
1. Predominant mode/risk behavior	10=Blood-to-blood; 8=Unprotected anal sex; 6=Unprotected vaginal sex; 2=Unprotected oral sex;	10	80	NA*	NA	100	100	60	NA	NA	NA	100	NA
2. Estimated live HIV cases in transmission category as proportion of total living with HIV in Pennsylvania (excl. Philadelphia).	10= Over 40%; 8= >30-35%; 9= >35-40%; 5= >20-25%; 6= >25-30%; 3= >10-15%; 4= >15-20%; 1=0-5%; 2= >5 –10%	8	72 (4,412) 35.7%	NA	NA	16 (784) 6.3%	80 (4,950) 40.0%	24 (1,477) 12.0%	NA	NA	NA	8 (201) 1.6%	NA NA

FACTOR	RANK OF CATEGORY WITHIN EACH FACTOR	Weight	A. MSM			B. MSM/IDU	C. IDU	D. HETEROSEXUAL				E. Peri-natal	F. Other
			A. Overall	(i) Gay-ID (overall =receptive & insertive)	(ii) Non Gay-ID (overall= receptive & insertive)	B. (iii)	C. (iv)	D. Overall	(v) Female sex partners of male IDU (receptive)	(vi) Male sex partners of female IDU (insertive)	(vii) Het. Sex partner of unknown HIV status (receptive & insertive)	E. (viii)	F. (ix)
3. Estimated unadjusted relative risk or likelihood of death; => relative survival time for transmission category; => relative likelihood of increase/decrease in prevalent pool of infected persons, (assuming no de-cline in other con-tributing factors	9 =Better survival =lower likelihood of death [RR < 0.5, 1=referent grp. (MSM)]; 7 =RR=(0.5-<1.0)	6	30	NA	NA	30	42	30	NA	NA	NA	NA	NA
	5= Survival comparable to referent grp. (MSM), [RR=1]		RR~=1			RR~=1	RR<1	RR~=1				NA	NA
	3=RR=(>1.0-2.0) 1 = Poor survival = higher likelihood of death [RR= >2]												
4. Prevalence of predominant risk behavior during most recent behavioral survey (% of transmission category practicing predominant behavior).	10=0ver 50%	7	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	7=25-30%												
	5=10-24%												

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

FACTOR	RANK OF CATEGORY WITHIN EACH FACTOR	Weight	A. MSM			B. MSM/IDU	C. IDU	D. HETEROSEXUAL				E. Peri-natal	F. Other
			A. Overall	(i) Gay-ID (overall =receptive & insertive)	(ii) Non Gay-ID (overall= receptive & insertive)	B. (iii)	C. (iv)	D. Overall	(v) Female sex partners of male IDU (receptive)	(vi) Male sex partners of female IDU (insertive)	(vii) Het. Sex partner of unknown HIV status (receptive & insertive)	E. (viii)	F. (ix)
LESS OBJECTIVE LOW WEIGHT NEEDS INDICATOR DATA (1-3)													

FACTOR	RANK OF CATEGORY WITHIN EACH FACTOR	Weight	A. MSM			B. MSM/IDU	C. IDU	D. HETEROSEXUAL				E. Peri-natal	F. Other
			A. Overall	(i) Gay-ID (overall =receptive & insertive)	(ii) Non Gay-ID (overall= receptive & insertive)	B. (iii)	C. (iv)	D. Overall	(v) Female sex partners of male IDU (receptive)	(vi) Male sex partners of female IDU (insertive)	(vii) Het. Sex partner of unknown HIV status (receptive & insertive)	E. (viii)	F. (ix)
10. Services Allocated to Transmission Category Relative to Transmission Category as Percentage of Total (sum of factors 1-6).	10=≥5 transmission-category total than services. 5=≥1.5 times and <5 times transmission-category total than services. 3=<1.5 to 1 times transmission-category total than services. 1=more services than transmission-category total.	Local health depart. data= .8 --- Couns. & Testing data= .1 --- Coali-Tion data= .1	3 (17.2% services/22.7% transmission total) **= 2.4** --- 5 7.6% C&T/ 22.7% transmission total **= .5** --- 5 (15% services/ 22.7% trans. total **= .5** **SUBTOTAL= 3.4**	NA --- NA --- NA	NA --- NA --- NA	10 (1.5% services/ 18.8% transmission total) **= 8** --- 10 .5 C&T/18.8% transmission total **= 1** --- 10 (1% services/ 18.8% trans. total **= 1** **SUBTOTAL= 10**	5 (14.8% ser-vices/28.3% transmission total) **= 4** --- 5 10.7% C&T/ 28.3% transmission total **=.5** --- 5 17% services/ 28.5% trans. total **= .5** **SUBTOTAL = 5**	1 (39.5% ser-vces/18.6% transmission total **= .8** --- 1 28.5% C&T/ 18.6% transmission total **= .1** --- 1 33% services/ 18.6% trans. total = **.1** **SUBTOTAL = 1**	NA --- NA --- NA	NA --- NA --- NA	NA --- NA --- NA	5 (4.7% services/ 11.6% transmission total) **= 4** --- 10 .06% C&T /11.6% transmission total **=1** --- 5 6% services/ 11.6% **= .5** **SUBTOT-AL = 5.5**	NA Gen. Pub. 22.3 % serv. --- NA All Oth-er 52.6 4% C& T --- NA Oth-er 28% serv.

FACTOR	RANK OF CATEGORY WITHIN EACH FACTOR	Weight	A. MSM					B. MSM/IDU			C. IDU			D. HETEROSEXUAL						E. Peri-natal			F. Other
			A. Overall			(i) Gay-ID (overall =receptive & insertive)	(ii) Non Gay-ID (overall= receptive & insertive)	B. (iii)			C. (iv)			D. Overall			(v) Female sex partners of male IDU (receptive)	(vi) Male sex partners of female IDU (insertive)	(vii) Het. Sex partner of unknown HIV status (receptive & insertive)	E. (viii)			F. (ix)
11. Number of Factors in Transmission Category that are Barriers to Prevention	0-12 score on socio-behavioral barriers scale (0=no barriers to 12=extreme barriers)	1	10.5			NA	NA	10.5			10.5			11			NA	NA	NA	NA			NA
	TOTAL OF EACH COLUMN	Rank x Weight Sum of Score	225.9			NA	NA	196.5			279.5			186			NA	NA	NA	113.5			NA
Race/Ethnicity as Proportion of AIDS incidence 1995-1997.	W=White B=Black H=Hispanic	Percent within Transm. Category	W 73	B 23	H 4			W 40.5	B 46.0	H 13.5	W 26	B 50	H 24	W 39	B 40	H 21				W 4	B 48	H 48	NA
	% x Column Total		165	52	9			80	90	27	73	140	67	73	74	39				5	54	54	NA
	Relative Row %		18.6	5.8	1.0			9.0	10.1	3.0	8.2	15.8	7.6	8.2	8.3	4.4				NA			NA
Rank of Population/ Transmission Category	**Rank of Population/Transmission Category**		**1**	**9**	**12**			**4**	**3**	**11**	**6 tie**	**2**	**8**	**6 tie**	**5**	**10**				**Proposed for set-aside funds, see Table 2**			

NA* = DATA NOT YET AVAILABLE TO ENTER INTO MODEL

TABLE 2:
SUMMARY RESULTS OF PROPOSED PRIORITIZATION MODEL FOR HIV/AIDS RANKED POPULATION/TRANSMISSION GROUPS: 2002 BY SEX/AGE/GROUP

Rank	Relative % (Overall Score)	Population/ Transmission Group	Sex M=Male/F=Female Distribution	Age Group/ Miscellaneous	Geographic Distribution
1	18.6% (165)	White - MSM	M	*20-39; 13-19, 40-49;	NA*
2	15.8% (140)	Black - IDU	M & F, Mostly Male	*20-39; 13-19	NA
3	10.1% (90)	Black - MSM/IDU	M	*20-39	NA
4	9.0% (80)	White - MSM/IDU	M	*20-39	NA
5	8.3% (74)	Black - Hetero	F & M, Mostly Female sex partners of IDU	-history of STD, 13-19; -partners of IDU, 13-39;	NA
6 (tie)	8.2% (73)	White - IDU	M & F, Mostly Male	*20-39	NA
6 (tie)	8.2% (73)	White - Hetero	F & M, Mostly Female sex partners of IDU	-history of STD, 13-19; -partners of IDU, 13-39; -(?white F<13?)	NA
8	7.6% (67)	Hispanic - IDU	M & F, Mostly Male	++13-19; *20-39	NA
9	5.8% (52)	Black - MSM	M	13-(*20-29)-39	NA
10	4.4% (39)	Hispanic - Hetero	F & M, Mostly Female sex partners of IDU	-history of STD, 13-19; -partners of IDU, 13-39;	NA
11	3.0% (27)	Hispanic – MSM/IDU	M	*20-29	NA
12	1.0% (9)	Hispanic MSM	M	*20-29	NA
TOTAL ADULTS	100% - ?5%?				
13	1 %	Perinatal Transmission	Blacks & Hispanics Comparable, Whites 2%; See Table 1.	Hetero Females who are IDU and/or partners of IDU	NA
	?4 %?	Emerging Risk Group Needs assessments	To be determined by CPG informants;		NA
TOTAL ALL GROUP	100%	ALL RISK GROUPS	ALL RISK GROUPS	ALL RISK GROUPS	ALL RISK AREAS

NA*=Variable not applied in model.

>>*^Please note that perinatal transmission has been removed from the final distribution model for adults ranked 1-12;

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

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

Priority Interventions

In the 2002 Plan Update the Committee did not believe it was prepared to submit a full plan to commence the prioritization of interventions as it had just completed the prioritization of populations. In addition, an accurate gap analysis needs to be completed. There are AIDS service organizations subcontracted with the seven Ryan White HIV/AIDS Regional Planning Coalitions, nine local county and municipal health departments, and the Spanish Speaking Organizations utilizing both state and federal HIV prevention funds for HIV prevention. The Department of Health and the Pennsylvania Prevention Project have instituted a uniform data collection system to gather consistent HIV prevention activities within the categories established by the Centers for Disease Control and Prevention.

The Centers for Disease Control and Prevention requires that a gap analysis be conducted across the state. A gap analysis allows the Committee to assess what HIV prevention intervention agencies are doing and what populations they are reaching with those interventions. The problem was that each agency was collecting data in their own unique way and it was difficult to compare what different agencies were doing. In July 2001, the five local county health departments—Allegheny, Bucks, Chester, Erie, Montgomery, and four municipal health departments—Allentown, Bethlehem, Wilkes-Barre, and York began to implement a uniform data collection system.

The uniform data collection system is one suggested by the Centers for Disease Control and Prevention (CDC). The CDC developed the forms and the Department of Health and local county and municipal health departments and the Pennsylvania Prevention Project modified the forms to fit agency needs. Every year, each agency sends to the Department of Health their intervention plans estimating the populations to be addressed the following year. Quarterly data is sent to the Department of Health where it is aggregated and included on Process Evaluation forms. Data regarding race/ethnicity, age and gender are collected as well as information on such things as number of contacts, materials distributed and so forth. Beginning in July 2002 the seven Ryan White HIV/AIDS Regional Planning Coalitions and in January 2003 the Spanish Speaking Coalitions will initiate uniform data collection.

At the March 2002 Committee meeting a Committee member initiated a survey of Committee members and the Ryan White HIV/AIDS Regional Planning Coalition staff to determine HIV prevention activities funded by other state or federal resources as well as local foundations or grants. This data is still being gathered, analyzed and will be utilized in the gap analysis for the five-year Plan developed in 2003.

The Committee requested in the 2002 Plan Update that the Health Department seek technical assistance in establishing priority interventions as well as assistance in gap analysis. The Co-Chairs and Pennsylvania Prevention Staff consulted via telephone conference calls with the Academy for Educational Development. The Academy provided one day of technical assistance in July 2002 on developing priority interventions with 81% of the Committee in attendance. Several samples of gap analyses were also provided to Committee members.

The Interventions Subcommittee is considering the North Carolina model. This model includes developing Intervention factors such as, accessible to the target population, targets to specific populations, evaluation, and so forth. Each factor was provided a definition, for example, accessible—the extent to which the intervention is available and approachable to the intended audience. Each factor was then provided a weight with the most important factors having the greatest weight. In this example all six-factor weights added to a total of 100. Each intervention factor was then operationalized on a three-point scale. For example the factor accessible to the target population was 3=very accessible to the target population, 2=moderalty accessible to the target population, and 1=barely (or not) accessible to the target population. Finally each Intervention type is scored and summed with the weight score for a total weighted sum score. The final document indicates each priority population such as teens and rank orders the related intervention. In this example, a peer/natural opinion leader program was scored at 264 and Needle exchange rated 134 at the bottom of thirteen teen interventions. The subcommittee will continue to work setting the groundwork for the development of priority interventions within the next five-year planning cycle in 2003.

HIV Prevention Field Staff

Nine HIV Prevention Program nurses (Community Health Nurse positions) and four HIV Prevention Program Representatives (Public Health Program Representative positions) are located in the Pennsylvania Department of Health's six Health Districts. Two of the nurses are Hispanic in origin and provide bilingual program services. One of the program representatives is bilingual (Spanish). All program staff are responsible for the following:

- Work with the Division of HIV/AIDS in establishing publicly funded HIV COUNSELING AND TESTING sites within their jurisdiction. Sites have been established in health centers, STD and TB clinics, drug treatment facilities, county prisons, AIDS Service Organizations (ASOs) and Community Based Organizations (CBOs), colleges and universities, and in other miscellaneous locations accessible to persons at-risk of HIV. More than 500 sites currently offer free, voluntary, some anonymous and all confidential, HIV Counseling and Testing services.
- Provide or arrange for training in HIV Prevention Counseling for site counselors.

- Provide counselors with information on Pennsylvania's Confidentiality of HIV-Related Information Act "Act 148" and other relevant laws and regulations affecting publicly funded HIV counseling and testing.
- Provide counselors with training in the collection of OraSure specimens.
- Provide training in completing the HIV consent form, the CDC HIV Counseling and Testing Report Form, laboratory submission forms, and other program related forms or paperwork.
- Provide consultation to HIV counselors regarding special client situations.
- Provide sites with CDC HIV counseling and testing report forms and mailing envelops.
- Develop HIV/AIDS referral manuals/resource directories for their specific health jurisdiction.
- Conduct or be a part of the results counseling of every HIV positive client identified at publicly funded sites within their jurisdiction.
- Explain and offer HIV positive clients the following services.
  *Options for Partner Counseling and Referral Services (PCRS)
  *TB testing
  *CD4+ T-Cell and Viral Load testing
  *Referral to medical and psychosocial services
  *Hepatitis B and influenza vaccines
  *Hepatitis C counseling and referral
  *Completion of Adult HIV/AIDS Confidential Case Report
- Conduct Partner Counseling and Referral Services for sex and needle sharing partners elicited during results counseling of HIV positive clients.
- Assist publicly supported sites (does not apply to anonymous testing) with locating high risk negative and HIV positive clients who do not return for results counseling.
- Provide HIV prevention education for priority populations identified by Pennsylvania's Community HIV Prevention Planning Committee.
- Offer HIV prevention education to inmates and staff of county and state correctional prisons and to staff and clients of drug treatment facilities.
- Provide HIV Counseling and Testing in county prisons and drug treatment facilities and/or establish these locations as publicly supported sites that offer HIV Counseling and Testing .
- Work with ASOs and CBOs within their jurisdiction to establish Participating Provider Agreements (PPA). As with those willing to provide HIV Counseling and Testing to their clients.
- Participate in HIV/AIDS community/provider coalitions to establish an ongoing interface between HIV prevention and care services.
- Work with HIV/AIDS coalitions in determining community needs.
- Provide ongoing CD4+ T-Cell and viral load testing to HIV positive persons from the public and private sector that have no other means to pay for these tests.
- Conduct audits of publicly supported HIV Counseling and Testing sites within their health jurisdiction to include:
  *Department of Health HIV, STD and TB sites
  *County prisons and drug treatment sites

*Sites in County and Municipal Health Departments
*Agencies with HIV Participating Provider Agreement's

- Document site audits on HIV Prevention Program audit tools.
- Complete and submit site audit reports to the Division of HIV/AIDS.
- Serve as a provider of anonymous HIV Counseling and Testing for persons who cannot or will not access anonymous Counseling and Testing services at state-designated anonymous test sites.
- Provide outreach Counseling and Testing to at-risk populations as determined by Pennsylvania's Community HIV Prevention Committee.
- Respond to HIV prevention and HIV Counseling and Testing questions and concerns from both public and private sector individuals, agencies and institutions.
- Work with Department STD staff in the integration of HIV and STD program services.

The Pennsylvania Prevention Project, University of Pittsburgh Graduate School of Public Health

- Facilitate and record the HIV Prevention Community Planning Committee meetings.
- Develop the annual CDC HIV prevention plan and grant application with the HIV Prevention Community Planning Committee (Committee) and Pennsylvania Department of Health (Department).
- Provide research, technical assistance, and support to the Committee, Steering Committee and subcommittees on prevention interventions, member recruitment, orientation, and mentoring. Administer and analyze the process evaluation of the Committee operation.
- Conduct statewide needs assessments of specific HIV risk populations to determine prevention service needs and barriers to HIV prevention. Present written needs assessment data summaries to the Department and Committee. Assist the Committee in incorporating the needs assessment data and epidemiological data into the process of prioritizing target populations and interventions.
- Conduct a Rapid Needs Assessment of a specific high-risk group identified by the Department.
- Facilitate and update the CDC mandated five-year evaluation plan and the outcome evaluation of the Perinatal/Women's Project.
- Direct the statewide implementation of the Uniform HIV Prevention Data Collection System.
- Plan, organize, convene and facilitate the Young Adult Roundtables and Young Adult Advisory Team to obtain needs assessment data from youth and young adults. Design and implement Roundtable process monitoring and evaluations. Design, implement, and evaluate HIV peer prevention interventions for sexually active youth.
- Identify the status of HIV/AIDS education provided to school age youth. Develop an HIV/AIDS intervention resource database. Promote the dissemination and implementation of effective HIV/AIDS educational materials and curricula.
- Contract with Serenity Hall in Erie, to carry out an outreach project to MSM.
- Contract with New Directions Treatment Services in Allentown/Bethlehem, to carry out a perinatal transmission/women's project.

- Maintain an HIV/AIDS intervention resource database and Community Resource Directory.
- Maintain the stophiv.com web site to improve access, navigation and site features.
- Enhancement of capacity building assistance for prevention programs delivering services for persons living with HIV.

Subcontractors with the University of Pittsburgh include:

Capacity Building Project – Men Who Have Sex with Men Serenity Hall, Erie

- Provide primary and secondary HIV prevention to African American and Latino Men who have Sex with Men (MSM).
- Continuation of a street outreach project established in 1999 targeting Injection Drug Users (IDU). The project has progressed from targeting IDUs to IDU/MSM and MSM.
- Utilize the indigenous leader outreach model.
- Foster community awareness and provides exposure and access to HIV/AIDS information.
- Distribute condoms, bleach kits, dental dams, and literature.
- Provide education and prevention and HIV prevention Counseling and testing using OraSure.
- Provide referrals to clinical and social support for health and mental health care, substance abuse treatment and other daily living needs.

Capacity Building & Evaluation Project – New Directions Treatment Services – The Living Project, Allentown/Bethlehem

- Provide primary and secondary HIV prevention to reduce perinatal HIV transmission targeting Latina and African American women, between the ages of 15 through 44.
- Continuation of a project established in 1999.
- Provide peer prevention and education groups through “home parties” and “baby showers”.
- Distribute condoms and literature.
- Provide HIV prevention counseling and testing.
- Provide case management and referral services.
- Ensure prompt drug and alcohol treatment for pregnant women.
- Refer for comprehensive health care.
- An outcome evaluation is being conducted of this project.

Capacity Building Project – Youth - Pittsburgh Play Back Theatre Project

- Continuation of a project implemented in 1999.
- Target gay and bisexual African American and Latino/a youth between the ages of 13 and 24, through a theatre-based, peer-based, outreach intervention.
- Adapted from a Nite-Star theatre program in New York City.

  Theatrical presentations and follow-up discussions include risk reduction topics and strategies aimed at behavior change through enhanced self-efficacy and self-management skills: HIV/AIDS/STD education, HIV testing, HIV self-risk

assessment, sexual negotiation skills development, and training in condom use and other modes of protection.

County and Municipal Health Department

The Division of HIV/AIDS has nine contracts with five County (Allegheny, Bucks, Chester, Erie, and Montgomery) and four Municipal (Allentown, Bethlehem, Wilkes-Barre, and York) Health Departments. The Health Departments and the HIV prevention staff funded by the contracts are responsible for the following in each of their jurisdictions.

- Establish publicly funded HIV Counseling and Testing sites within their jurisdiction to include health centers, STD and TB clinics, drug treatment facilities, county prisons, ASOs and CBOs, colleges and universities, and in other locations where persons at risk of HIV are accessible.
- Provide or arrange for training in HIV Prevention Counseling for site counselors.
- Provide counselors with information on Pennsylvania's Confidentiality of HIV-Related Information Act "Act 148" and other relevant laws and regulations affecting publicly supported HIV Counseling and Testing.
- Provide counselors with training in the collection of OraSure specimens.
- Provide training in completing the HIV consent form, the CDC HIV Counseling and Testing Report Form, laboratory submission forms, and other program related forms or paperwork.
- Provide consultation to counselors regarding special client situations.
- Provide sites with CDC HIV Counseling and Testing report forms and mailing envelops.
- Develop HIV/AIDS resource directories for their specific health jurisdiction.
- Conduct or be a part of the results counseling of every HIV positive client identified at publicly supported sites within their jurisdiction.
- Explain and offer HIV positive clients the following services.
  *Options for Partner Counseling and Referral Services.
  * TB testing
  * CD4+ T-Cell and Viral Load testing
  * Referral to medical and psychosocial services
  * Hepatitis B and influenza vaccines
  * Hepatitis C counseling and referral
  * Completion of Adult HIV/AIDS Confidential Case Report
- Conduct Partner Counseling and Referral Services for sex and needle sharing partners elicited during results counseling of HIV positive clients.
- Assist publicly supported sites with locating high risk negative and HIV positive clients who don't return for results counseling.
- Provide HIV prevention education for priority populations identified by Pennsylvania's Community HIV Prevention Planning Committee.
- Offer HIV prevention education to inmates and staff of county and state correctional prisons and to staff and clients of drug treatment facilities.
- Provide HIV Counseling and Testing in county prisons and drug treatment facilities and/or establish these locations as publicly supported sites that offer HIV Counseling

and testing Participate in HIV/AIDS community/provider coalitions to establish an ongoing interface between HIV prevention and care services.

- Work with HIV/AIDS coalitions in determining community needs.
- Provide ongoing CD4+ T-Cell and viral load testing to HIV positive persons identified as HIV positive in both the public and private sector that have no other means to pay for these tests.
- Provide Prevention Case Management (PCM) for high risk negative and HIV positive persons (Allegheny County and York City Health Departments).
- Insure HIV Counseling and Testing sites within their health jurisdiction abide by HIV prevention program policies, procedures, standards and guidelines.
- Serve as a provider of anonymous HIV counseling and testing for persons who cannot or will not access anonymous counseling and testing services at state-designated anonymous test sites.
- Provide outreach HIV counseling and testing to at-risk populations as determined by Pennsylvania's Community HIV Prevention Committee.
- Respond to HIV prevention and HIV counseling and testing questions and concerns from both public and private sector individuals, agencies and institutions.
- Work with STD staff in the integration of HIV and STD program services and response to epidemiologically related cases.
- Perinatal Outreach Project (York City Health Department).

Community Based Agencies

- 19 agencies contracted to offer HIV prevention Counseling and Testing to at-risk persons:
  AIDS Community Alliance—Lancaster/Cumberland/Lebanon
  AIDS Resource Alliance-Lycoming
  Beaver County AIDS Service Organization
  Carbon, Monroe, Pike Drug and Alcohol Commission
  ChesPenn Health Services—Delaware
  Southwest Behavioral Care Services—Westmoreland
  Delaware County AIDS Network
  Easton Hospital—Northampton
  Latinos for Healthy Communities—Lehigh/Northhampton
  Life and Liberty—Beaver
  Mon Yough Community Services—Allegheny/Westmoreland
  The AIDS Project—Centre
  Schuylkill Wellness Services (BAN)—Schuylkill
  United Neighborhood Centers—Lackawanna
  Urban League—Lancaster
  Wyoming Valley AIDS Council—Luzerne/Lackawanna/Wyoming
  Ujima—Lancaster
  SUN Family Planning—Snyder/Union
  Community Health Clinic—Westmoreland
- Agencies are reimbursed on a fee for service basis at $15 per 15 minutes of counseling that includes both prevention and results counseling.

- Counseling and testing made more accessible to at-risk persons through outreach and by scheduling of more convenient clinic hours.
- OraSure method of specimen collection utilized.
- Laboratory costs paid directly by the Division of HIV/AIDS.
- Counselors attend CDC HIV prevention counseling training.
- Documentation of services utilizing the CDC HIV Counseling and Testing Report Form.
- Results counseling of HIV positive persons conducted by Department HIV prevention program staff. PCRS and TB testing offered. Linkages to medical care, support and case management services made. CD4+ T-Cell and viral load testing made available.

2003 Programmatic Goals and Objectives

In 1998 the Committee developed four overarching programmatic goals for the five years of the present planning cycle (1999-2003). These goals are to be used as beacons to guide the overall HIV prevention community planning process.

I Reduce the incidence of HIV transmission in the state of Pennsylvania.
II. Reduce the progression of HIV disease and prolong life in persons living with HIV in the state of Pennsylvania.
III. Reduce HIV-related stigma in the state of Pennsylvania.
IV. Increase the involvement of priority populations in developing and implementing effective HIV education and prevention in the state of Pennsylvania.

The Committee develops overall programmatic goals and objectives to assist the Division of HIV/AIDS addressing global concerns. The work of the former Counseling and Testing Subcommittee and the Health Education and Risk Reduction Subcommittees is now under the Interventions Subcommittee. The following are programmatic goals and objectives from the 2002 Plan Update that are scheduled to be completed in 2003:

Counseling &Testing (C&T) Goal I
Assure the availability of anonymous HIV testing, counseling, referral, and partner counseling and referral services within all 67 counties of Pennsylvania by December 31, 2003.

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

The following activities were added to Counseling and Testing Goal I, objective –1 for 2003:

Activity-1 In Cameron and Sullivan counties where no Department of Health office exists, provisions are made via the Department's HIV/AIDS Factline for clients in need of services. The field staff attends to testing needs upon request.

Activity-2 In the fall of 2002 a media campaign will advertise anonymous testing in all 67 counties, which will help to improve the access and reduce fear of new state reporting regulations. The Factline promotes the availability of testing for all who call. When testing occurs at Department of Health offices, it happens in concert with other services offered to further protect anonymity.

C&T Goal II
Increase HIV Prevention Services for incarcerated populations and increase their access to HIV prevention Counseling and Testing by December 31, 2003.

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

C&T Goal III
Increase the number of HIV counseling, testing, referral and partner counseling sites working with priority and emerging populations at risk by December 31, 2003.

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

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

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

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

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

C&T Goal VI
all publicly funded Counseling and Testing sites will be competent in issues related to mandatory HIV reporting by December 31, 2003.

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

In addition, to address the concerns of cultural competency in the provision of HIV prevention counseling and testing, the Interventions Subcommittee noted the following:

-grantees are addressing cultural diversity and competency in all programs with translators as needed.
-translators are available at most sites including those needed for American Sign Language and marginalized minority populations.
-the Department of Education provides cultural competency workshops to educators within the schools.
-all Department of Corrections staff are mandated to complete cultural competency training upon hiring and annually thereafter.

In addition the Interventions subcommittee created the following new Health Education Risk Reduction (HERR) goal:

HERR Goal IV
Technical Assistance will be offered on rural HIV needs and intervention development.

Objective-1 Conduct a literature search to determine what has been successful in rural areas.

Objective-2 Request CDC technical assistance on what has worked in rural areas.

Objective-3 Request the Pitt Men's Study at the University of Pittsburgh pool data on MSM outside of urban Allegheny County and present to the Committee.

Objective-4 Pool the rural focus data for review.

Objective-5 Request information about what the Health Department is doing on rural epidemiology via trip codes in rural areas.

Objective 6 Invite experts on HIV in rural areas to present to the Committee.

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

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

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

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

Objective-4 Reduce fear arising from the new HIV reporting plan, maintain the current volume of testing and increase people getting tested each year.

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

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

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

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

Objective-9 Continue demonstration projects using the Association for Drug Abuse Prevention and Treatment (Adapt) format to showcase successful interventions for interested organizations.

HERR Goal II

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

Objective-1 In the next two years continue counseling HIV positive persons about risk-reduction and harm-reduction in order to help them to prevent transmission and maintain health as long as possible.

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

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

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

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

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

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

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

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

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

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

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

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

Linkages Goal I
Referral with follow-up of HIV positive persons identified at publicly funded Counseling and Testing to case management, medical care, and support services.

Objective-1 Update and maintain regional resource directories.

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

Objective-1 Assess current primary care clinics to determine their capacity to accept assistance and implement HIV prevention programs for their patients.

Objective –2 Identify HIV primary prevention curriculum models, and other resources relevant to HIV+ persons and primary counseling staff.

Technical Assistance and & Quality Assurance (TAQA) Goal I
Increase the ability of pertinent stakeholders in the community planning process to conduct and utilize gap analysis in statewide HIV prevention planning.

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

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

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

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

Linkage tables are developed by examining HIV prevention that is supported with CDC resources and what the gap analysis reveals that is being supported through other efforts. Ideally linkage tables provide a clear picture of priority interventions targeted to the priority populations from multiple funding sources. This effort is a process of development. In the next five-year funding cycle the gap analysis and priority interventions will be completed. The following linkage tables are based upon what information is currently available.

Linkage Tables

	Interventions in the CDC Application	
Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target Population 1: White MSM		
	Twelve federally and one state funded Department HIV Prevention Staff provide anonymous/confidential CTR services to high-risk persons who cannot or will not access publicly funded CTR sites. Staff provides PCRS at 443 locations throughout the state. Staff also provides PCM. Note: The attached report on HIV CTR services provides a breakout of the target populations served.	
		The Department purchases and distributes male and female condoms to 443 publicly funded HIV CTR sites throughout the state.
	University of Pittsburgh School of Public Health conducted a needs assessment of this target population	
		University of Pittsburgh School of Public Health maintains the stophiv.com website (HC/PI).
	University of Pittsburgh School of Public Health has a subcontract with Serenity Hall, in Erie, to provide outreach, ILI, GLI and CTR services targeting MSM.	
		The Department contracts with the Centers for Disease Detection and the State Bureau of Laboratories for blood and oral fluid HIV antibody testing laboratory services for all publicly funded HIV CTR sites.
		Department provides funding for HIV CTR services at 97 STD clinics.
	The Department contracts with 5 county (Allegheny, Bucks, Chester, Erie, Montgomery) and 4 municipal health departments (Allentown, Bethlehem, Wilkes	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target Population 1 (Continued): White MSM		
	-Barre and York) to provide HIV CTR, PCRS and HIV prevention interventions (ILI, GLI, Outreach, PCM, HC/PI, CLI) to priority populations. In addition, the following subcontractors of the county/municipal health departments provide CTR services to this population: • Pittsburgh AIDS Task Force - Allegheny • Gay peer educators – Erie • Crossroads Hall, SHOUT Outreach – Erie • York Health Corporation Note: The attached "Process Monitoring Data" charts provide a breakout of target populations and interventions that were provided by the county/municipal health departments and their subcontractors.	
		The Department implemented a radio media campaign (HC/PI) designed to "reduce the stigma" of HIV/AIDS and encourage individuals to call the AIDS Factline for further prevention and testing information.
		The Department is in the process of implementing a radio media campaign to publicize the availability of anonymous testing.
	The Department funds the Allegheny County and York City Health Departments to subcontract for HIV PCM. Subcontractors: • York Health Corporation • New Life Urban Ministries	
	The Department contracts with over 20 community based agencies to provide CTR services. The following contractors target this specific population: • AIDS Community Alliance – Dauphin and Lancaster	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target Population 1 (Continued): White MSM		
	• AIDS Resource Alliance – Lycoming • Delaware County AIDS Network • The AIDS Project - Centre • Schuylkill Wellness Services - Schuylkill • Wyoming Valley AIDS Council – Luzerne, Wyoming, Lackawana • Berks AIDS Network • Butler Armstrong AIDS Alliance	
Target population 2: Black IDUs		
	Twelve Department HIV Prevention Field Staff provide anonymous/confidential CTR services to high-risk persons who cannot or will not access publicly funded CTR sites. Staff provides PCRS at 443 locations throughout the state. Staff also provides PCM. Note: The attached report on HIV CTR services provides a breakout of the target populations served.	
	The Department purchases and distributes male and female condoms to 226 substance abuse treatment facilities that provide HIV CTR services.	
	University of Pittsburgh School of Public Health conducted a needs assessment of this target population	
		University of Pittsburgh School of Public Health maintains the stophiv.com web site (HC/PI).
	University of Pittsburgh School of Public Health has a subcontract with Serenity Hall, in Erie, to provide outreach, ILI, GLI and CTR services to minority MSM/IDUs.	
	The Department contracts with the Centers for Disease Detection and the State Bureau of Laboratories for blood and oral	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 2 (Continued): Black IDUs		
	fluid HIV antibody testing laboratory services for over 200 substance abuse treatment facilities that provide HIV CTR services.	
		The Department provides funding for HIV CTR services at 97 STD clinics.
	The Department contracts with 5 county (Allegheny, Bucks, Chester, Erie, Montgomery) and 4 municipal health departments (Allentown, Bethlehem, Wilkes-Barre and York) to provide HIV CTR, PCRS and HIV prevention interventions (ILI, GLI, Outreach PCM, HC/PI, CLI) to priority populations. In addition, the following subcontractors of the county/municipal health departments provide CTR services to this population: • Kingsley Association – Allegheny • Pittsburgh AIDS Task Force - Allegheny • City of Pittsburgh Housing Authority - Allegheny • Mon-Yough Community Services - Allegheny • Minority Health Education Delivery Systems – Erie • Crossroads Hall, SHOUT Outreach - Erie • York Health Corporation - York Note: The attached "Process Monitoring Data" charts provide a breakout of target populations and interventions that were provided by the county/municipal health departments and subcontractors.	
		The Department implemented a Health Communication/Public

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 2 (Continued): Black IDUs		
		Information media campaign (radio) designed to "reduce the stigma" of HIV/AIDS and encourage individuals to call the AIDS Factline for further prevention and testing information.
		The Department I s in the process of implementing a radio media campaign to publicize the availability of anonymous testing.
	The Department funds the Allegheny County and York City Health Departments to subcontract for HIV PCM. Subcontractors: • York Health Corporation • New Life Urban Ministries - Allegheny	
	• The Department contracts with over 20 community based agencies to provide CTR services. The following contractors target this specific population: • Beaver County AIDS Service Organization - Beaver • ChesPenn Health Services - Delaware • Easton Hospital – Bethlehem • Life and Liberty - Beaver • Mon-Yough Community Services - Allegheny • United Neighborhood Center - Lackawana • Urban League - Lancaster • Community Check-Up Center - Dauphin • Hamilton Health Center - Harrisburg • Visiting Nurse Association of Central Pennsylvania - Dauphin	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 3: Black MSM/ IDUs		
	Twelve Department Prevention Field Staff provide anonymous/confidential CTR services to high-risk persons who cannot or will not access publicly funded CTR sites. Staff provides PCRS at 443 locations throughout the state. Staff also provides PCM. Note: The attached report on HIV CTR services provides a breakout of the target populations served.	
	The Department purchases and distributes male and female condoms to 226 substance abuse treatment facilities that provide HIV CTR services.	
	University of Pittsburgh School of Public Health conducted a needs assessment of this target population	
		University of Pittsburgh School of Public Health maintains the stophiv.com website (HC/PI).
	University of Pittsburgh School of Public Health has a subcontract with Serenity Hall, in Erie, to provide outreach, ILI, GLI and CTR services to MSM/IDU.	
	The Department contracts with the Centers for Disease Detection and the State Bureau of Laboratories for blood and oral fluid HIV antibody testing laboratory services for 226 drug and alcohol treatment facilities that provide HIV CTR services.	
		The Department provides funding for HIV CTR services at 97 STD clinics.
	The Department contracts with 5 county (Allegheny, Bucks, Chester, Erie, Montgomery) and 4 municipal health departments (Allentown, Bethlehem, Wilkes-Barre and York) to provide HIV CTR, PCRS and HIV prevention interventions (ILI, GLI, Outreach,	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 3 (Continued): Black MSM/ IDUs		
	PCM, HC/PI, CLI) to priority populations. In addition, the following subcontractors of the county/municipal health departments provide CTR services to this target population: • Kingsley Association – Allegheny • Pittsburgh AIDS Task Force - Allegheny • City of Pittsburgh Housing Authority - Allegheny • Mon-Yough Community Services - Allegheny • Peer Educators – Erie • Minority Health Education Delivery Systems - Erie • Hispanic American Council - Erie • Crossroads Hall, SHOUT Outreach – Erie • York Health Corporation - York Note: The attached "Process Monitoring Data" charts provide a breakout of target populations and interventions that were provided.	
		The Department implemented a HC/PI media campaign (radio) designed to "reduce the stigma" of HIV/AIDS and encourage individuals to call the AIDS Factline for further prevention and testing information.
		The Department is in the process of implementing a radio media campaign to publicize the availability of anonymous testing.
	The Department funds the Allegheny County and York City Health Departments to subcontract for HIV PCM. Subcontractors: • York Health Corporation • New Life Urban	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 3 (Continued): Black MSM/ IDUs		
	Ministries - Allegheny	
	The Department contracts with over 20 community based agencies to provide CTR services. The following contractors target this specific population: • Beaver County AIDS Service Organization • Life and Liberty - Beaver • United Neighborhood Centers - Lackawana	
Target population 4: White MSM/ IDUs		
	Twelve Department HIV Prevention Field Staff provide anonymous/confidential CTR services to high-risk persons who cannot or will not access publicly funded CTR sites. Staff provides PCRS at 443 locations throughout the state. Staff also provides PCM. Note: The attached report on HIV CTR services provides a breakout of the target populations served.	
	The Department purchases and distributes male and female condoms to 226 substance abuse treatment facilities that provide HIV CTR services.	
	University of Pittsburgh School of Public Health conducted a needs assessment of this target population	
		University of Pittsburgh School of Public Health maintains the stophiv.com website (HC/PI).
	University of Pittsburgh School of Public Health has a subcontract with Serenity Hall, in Erie, to provide outreach, ILI, GLI and CTR services to MSM.	
	The Department contracts with the Centers for Disease detection and the State Bureau of Laboratories for blood and oral fluid HIV antibody testing laboratory services for 226	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 4 (Continued): White MSM/ IDUs		
	substance abuse treatment facilities conducting HIV CTR services.	
		The Department provides funding for HIV CTR services at 97 STD clinics.
	The Department contracts with 5 county (Allegheny, Bucks, Chester, Erie, Montgomery) and 4 municipal health departments (Allentown, Bethlehem, Wilkes-Barre and York) to provide HIV CTR, PCRS and HIV prevention interventions (ILI, GLI, Outreach, PCM, HC/PI, CLI) to priority populations. In addition, the following subcontractors of the county/municipal health departments provide CTR services to this population: • Pittsburgh AIDS Task Force - Allegheny • Mon-Yough Community Services – Allegheny • Peer educators – Erie • Crossroads Hall, SHOUT Outreach – Erie • York Health Corporation - York Note: The attached "Process Monitoring Data" charts provide a breakout of target populations and interventions that were provided.	
		The Department implemented a radio media campaign (HC/PI) designed to "reduce the stigma" of HIV/AIDS and encourage individuals to call the AIDS Factline for further prevention and testing information.
		The Department is in the process of implementing a radio media campaign to publicize the availability of anonymous testing.

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 4 (Continued): White MSM/ IDUs		
	The Department funds the Allegheny and York Health Departments to subcontract for HIV PCM. Subcontractors: • York Health Corporation • New Life Urban Ministries - Allegheny	
	The Department contracts with over 20 community based agencies to provide CTR services. The following contractors target this specific population: • AIDS Community Alliance – Dauphin, Cumberland, Lancaster • AIDS Resource Alliance - Lycoming • Delaware County AIDS Network • The AIDS Project - Centre • Schuylkill Wellness Services - Schuylkill • Wyoming Valley AIDS Council – Lackawana, Luzerne, Wyoming • Berks AIDS Network - Berks • Butler/Armstrong AIDS Alliance	
Target population 5: Black Heterosexuals		
	Twelve Department HIV Prevention Field Staff provide anonymous/confidential CTR services to high-risk persons who cannot or will not access publicly funded CTR sites. Staff provides PCRS at 443 locations throughout the state. Staff also provides PCM. Note: The attached report on HIV CTR services provides a breakout of the target populations served.	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 5 (Continued): Black Heterosexuals		
		The Department purchases and distributes male and female condoms to 443 publicly funded HIV CTR sites throughout the state.
	University of Pittsburgh School of Public Health conducted a needs assessment of this target population	
		University of Pittsburgh School of Public Health maintains the stophiv.com website (HC/PI).
		The Department contracts with the Centers for Disease Detection and the State Bureau of Laboratories for blood and oral fluid HIV antibody testing laboratory services for all publicly funded HIV CTR sites.
		Department provides funding for HIV CTR services at 97 STD clinics.
	The Department contracts with 5 county (Allegheny, Bucks, Chester, Erie, Montgomery) and 4 municipal health departments (Allentown, Bethlehem, Wilkes-Barre and York) to provide HIV CTR, PCRS and HIV prevention interventions (ILI, GLI, Outreach, PCM, HC/PI, CLI) to priority populations. In addition, the following subcontractors of the county/municipal health departments provide CTR services to this population: • Kingsley Association – Allegheny • Pittsburgh AIDS Task Force - Allegheny • City of Pittsburgh Housing Authority - Allegheny • Mon-Yough Community Services – Allegheny • Seasonal Farm Workers – Erie	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 5 (Continued): Black Heterosexuals		
	• Minority Health Education Delivery Systems - Erie • York Health Corporation - York • Planned Parenthood - York Note: The attached "Process Monitoring Data" charts provide a breakout of target populations and interventions that were provided.	
		The Department implemented a radio media campaign (HC/PI) designed to "reduce the stigma" of HIV/AIDS and encourage individuals to call the AIDS Factline for further prevention and testing information.
		The Department is in the process of implementing a radio media campaign to publicize the availability of anonymous testing.
	The Department funds the Allegheny and York Health Departments to subcontract for HIV PCM. Subcontractors: • York health Corporation • New Life Urban Ministries – Allegheny	
	The Department contracts with over 20 community based agencies to provide CTR services. The following contractors target this specific population: • Beaver County AIDS Service Organization • ChesPenn Health Services - Delaware • Easton Hospital - Northampton • Life and Liberty - Beaver • Mon-Yough Community Services - Allegheny • United Neighborhood Centers - Lackawana	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 5 (Continued): Black Heterosexuals		
	• Urban League Lancaster • Community Check-Up Center - Dauphin • Hamilton Health Center - Dauphin • Kline Plaza Medical - Dauphin • Visiting Nurse Association of Central PA - Dauphin • PinacleHealth - Dauphin	
Target population 6 (tie): White IDUs		
	Twelve Department HIV Prevention Field Staff provide anonymous/confidential CTR services to high-risk persons who cannot or will not access publicly funded CTR sites. Staff provides PCRS at 443 locations throughout the state. Staff also provides PCM. Note: The attached report on HIV CTR services provides a breakout of the target populations served.	
	Department purchases and distributes male and female condoms to 226 substance abuse treatment facilities that provide HIV CTR services.	
	University of Pittsburgh School of Public Health conducted a needs assessment of this target population	
		University of Pittsburgh School of Public Health maintains the stophiv.com website (HC/PI).
	University of Pittsburgh School of Public Health has a subcontract with Serenity Hall, in Erie, to provide outreach, ILI, GLI and CTR services to MSM.	
	The Department contracts with the Centers for Disease Detection and the State Bureau of Laboratories for blood and oral fluid HIV antibody testing laboratory services for 226 substance abuse treatment facilities that provide HIV CTR	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 6 (tie): White IDUs		
	services.	
		The Department provides funding for HIV CTR services at 97 STD clinics.
	The Department contracts with 5 county (Allegheny, Bucks, Chester, Erie, Montgomery) and 4 municipal health departments (Allentown, Bethlehem, Wilkes-Barre and York) to provide HIV CTR, PCRS and HIV prevention interventions (ILI, GLI, Outreach, PCM, HC/PI, CLI) to priority populations. In addition, the following subcontractors of the county/municipal health departments provide CTR services to this population: • Pittsburgh AIDS Task Force - Allegheny • City of Pittsburgh Housing Authority - Allegheny • Mon-Yough Community Services – Allegheny • Peer educators – Erie • Crossroads Hall, SHOUT Outreach – Erie • York Health Corporation - York Note: The attached "Process Monitoring Data" charts provide a breakout of target populations and interventions that were provided.	
		The Department implemented a radio media campaign (HC/PI) designed to "reduce the stigma" of HIV/AIDS and encourage individuals to call the AIDS Factline for further prevention and testing information.
		The Department is in the process of implementing a radio media campaign to publicize the availability of anonymous testing.

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 6 (tie) (Continued): White IDUs		
	The Department funds the Allegheny and York Health Departments to subcontract for HIV PCM. Subcontractors: • York Health Corporation • New Life Urban Ministries - Allegheny	
	The Department contracts with over 20 community based agencies to provide CTR services. The following contractors target this specific population: • AIDS Community Alliance – Dauphin and Lancaster • AIDS Resource Alliance - Lycoming • Carbon/Monroe/Pike Drug and Alcohol Program • Southwest Behavioral Care - Westmoreland • Schuylkill Wellness Services • Discovery House - Butler • New Directions Treatment Services – Berks • Visiting Nurse Association of Central PA - Dauphin	
Target population 6 (tie): White Heterosexuals		
	Twelve Department HIV Prevention Field Staff provide anonymous/confidential CTR services to high-risk persons who cannot or will not access publicly funded CTR sites. Staff provides PCRS at 443 locations throughout the state. Staff also provides PCM. Note: The attached report on HIV CTR services provides a breakout of the target populations served.	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 6 (tie) (Continued): White Heterosexuals		
		The Department purchases and distributes male and female condoms to 443 publicly funded HIV CTR sites throughout the state.
	University of Pittsburgh School of Public Health conducted a needs assessment of this target population	
		University of Pittsburgh School of Public Health maintains the stophiv.com website (HC/PI).
		The Department contracts with the Centers for Disease detection and the State Bureau of Laboratories for blood and oral fluid HIV antibody testing laboratory services for all publicly funded HIV CTR sites.
		The Department provides funding for HIV CTR services at 97 STD clinics.
	The Department contracts with 5 county and 4 municipal health departments (Allegheny, Allentown, Bethlehem, Bucks, Chester, Erie, Montgomery, Wilkes-Barre and York) to provide HIV CTR, PCRS and HIV prevention interventions (ILI, GLI, Outreach, PCM, HC/PI, CLI) to priority populations. In addition, the following subcontractors of the county/municipal health departments provide CTR services to this population: • Pittsburgh AIDS Task Force - Allegheny • York Health Corporation Note: The attached "Process Monitoring Data" charts provide a breakout of target populations and interventions that were provided.	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 6 (tie) (Continued): White Heterosexuals		
		The Department implemented a radio media campaign (HC/PI) designed to "reduce the stigma" of HIV/AIDS and encourage individuals to call the AIDS Factline for further prevention and testing information.
		The Department is in the process of implementing a radio media campaign to publicize the availability of anonymous testing.
	The Department funds the Allegheny and York Health Departments to subcontract for HIV PCM. Subcontractors: • New Life Urban Ministries - Allegheny • York Health Corporation	
	The Department contracts with over 20 community based agencies to provide CTR services. The following contractors target this specific population: • AIDS Community Alliance – Dauphin and Lancaster • AIDS Resource Alliance - Lycoming • Delaware County AIDS Network • The AIDS Project - Centre • Schuylkill Wellness Services • Wyoming Valley AIDS Council – Luzerne, Wyoming, Lackawana • Berks AIDS Network • Butler/Armstrong AIDS Alliance • Kline Plaza Medical - Dauphin • PinacleHealth - Dauphin • Visiting Nurse Association of Central PA - Dauphin • Planned Parenthood of Harrisburg - Dauphin	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 8: Hispanic IDUs		
	Twelve Department HIV Prevention Field Staff provide anonymous/confidential CTR services to high-risk persons who cannot or will not access publicly funded CTR sites. Staff provides PCRS at 443 locations throughout the state. Staff also provides PCM. Note: The attached report on HIV CTR services provides a breakout of the target populations served.	
	The Department purchases and distributes male and female condoms to 226 substance abuse treatment facilities that provide HIV CTR services.	
	University of Pittsburgh School of Public Health conducted a needs assessment of this target population	
		University of Pittsburgh School of Public Health maintains the stophiv.com website (HC/PI).
	University of Pittsburgh School of Public Health has a subcontract with Serenity Hall, Erie, to provide outreach, ILI, GLI and CTR services to MSM/IDU.	
	The Department contracts with the Centers for Disease detection and the State Bureau of Laboratories for blood and oral fluid HIV antibody testing laboratory services for 226 substance abuse treatment facilities that provide HIC CTR services.	
		The Department provides funding for HIV CTR services at 97 STD clinics.
	The Department contracts with 5 county (Allegheny, Bucks, Chester, Erie, Montgomery) and 4 municipal health departments (Allentown, Bethlehem, Wilkes-Barre and York) to provide HIV CTR, PCRS and HIV prevention interventions (ILI, GLI, Outreach,	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 8 (Continued): Hispanic IDUs		
	PCM, HC/PI, CLI) to priority populations. In addition, the following subcontractors of the county/municipal health departments provide CTR services to this population: 1. Outreach Workers – Chester • Interpreter – Chester • Seasonal Farm Workers – Erie • Minority Health Education Delivery Systems – Erie • Hispanic American Council – Erie Note: The attached "Process Monitoring Data" charts provide a breakout of target populations and interventions that were provided.	
		The Department implemented a radio media campaign (HC/PI) designed to "reduce the stigma" of HIV/AIDS and encourage individuals to call the AIDS Factline for further prevention and testing information.
		The Department is in the process of implementing a radio media campaign to publicize the availability of anonymous testing.
	The Department funds the Allegheny and York Health Departments to subcontract for HIV PCM. Subcontractors: • York Health Corporation • New Life Urban Ministries - Allegheny	
	The Department contracts with over 20 community based agencies to provide CTR services. The following contractors target this specific population: • Latinos for Healthy Communities - Lehigh • Mt. Pleasant Hispanic American Association -	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 8 (Continued): Hispanic IDUs		
	Dauphin • New Directions Treatment Services – Berks • Spanish Speaking Council of Reading - Berks	
Target population 9: Black MSM		
	Twelve Department HIV Prevention Field Staff provide anonymous/confidential CTR services to high-risk persons who cannot or will not access publicly funded CTR sites. Staff provides PCRS at 443 locations throughout the state. Staff also provides PCM. Note: The attached report on HIV CTR services provides a breakout of the target populations served.	
		The Department purchases and distributes male and female condoms to 443 publicly funded HIV CTR sites throughout the state.
	University of Pittsburgh School of Public Health conducted a needs assessment of this target population	
		University of Pittsburgh School of Public Health maintains the stophiv.com website (HC/PI).
	University of Pittsburgh School of Public Health has a subcontract with Serenity Hall, Erie, to provide outreach, ILI, GLI and CTR services to MSM.	
		The Department contracts with the Centers for Disease detection and the State Bureau of Laboratories for blood and oral fluid HIV antibody testing laboratory services for all publicly funded HIV CTR sites.
		Department provides funding for HIV CTR services at 97 STD clinics.

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 9 (Continued): Black MSM		
	The Department contracts with 5 county (Allegheny, Bucks, Chester, Erie, Montgomery) and 4 municipal health departments (Allentown, Bethlehem, Wilkes-Barre and York) to provide HIV CTR, PCRS and HIV prevention interventions (ILI, GLI, Outreach, PCM, HC/PI, CLI) to priority populations. In addition, the following subcontractors of the county/municipal health departments provide CTR services to this population: • Kingsley Association – Allegheny • Pittsburgh AIDS Task Force - Allegheny • Peer Educators – Erie • Minority Health Education Delivery Systems – Erie • Crossroads Hall, SHOUT Outreach – Erie • York Health Corporation Note: The attached "Process Monitoring Data" charts provide a breakout of target populations and interventions that were provided.	
		The Department Implemented a radio media campaign (HC/PI) designed to "reduce the stigma" of HIV/AIDS and encourage individuals to call the AIDS Factline for further prevention and testing information.
		The Department is in the process of implementing a radio media campaign to publicize the availability of anonymous testing.
	The Department funds the Allegheny and York Health Departments to subcontract for HIV PCM. Subcontractors: • York Health Corporation	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 9 (Continued): Black MSM		
	• New Life Urban Ministries - Allegheny	
	The Department contracts with over 20 community based agencies to provide CTR services through outreach. • Beaver County AIDS Service Organization • Delaware County AIDS Network • Life and Liberty - Beaver	
Target population 10: Hispanic Heterosexuals		
	Twelve Department HIV Prevention Field Staff provide anonymous/confidential CTR services to high-risk persons who cannot or will not access publicly funded CTR sites. Staff provides PCRS at 443 locations throughout the state. Staff also provides PCM. Note: The attached report on HIV CTR services provides a breakout of the target populations served.	
		The Department purchases and distributes male and female condoms to 443 publicly funded HIV CTR sites throughout the state.
	University of Pittsburgh School of Public Health conducted a needs assessment of this target population	
		University of Pittsburgh School of Public Health maintains the stophiv.com website (HC/PI).
	University of Pittsburgh School of Public Health subcontracts for the Pittsburgh Play Back Threatre Project. This project provides outreach, GLI interventions targeting gay and bisexual African American and Latino youth between the ages of 13 and 24.	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 10 (Continued): Hispanic Heterosexuals		
		The Department contracts with the Centers for Disease detection and the State Bureau of Laboratories for blood and oral fluid HIV antibody testing laboratory services for all publicly funded HIV CTR sites.
		The Department provides funding for HIV CTR services at 97 STD clinics.
	The Department contracts with 5 county (Allegheny, Bucks, Chester, Erie, Montgomery) and 4 municipal health departments (Allentown, Bethlehem, Wilkes-Barre and York) to provide HIV CTR, PCRS and HIV prevention interventions (ILI, GLI, Outreach, PCM, HC/PI, CLI) to priority populations. In addition, the following subcontractors of the county/municipal health departments provide CTR services to this population: • Interpreters – Chester • Peer educators – Erie • Seasonal Farm Workers – Erie • Minority Health Education Delivery Systems – Erie • Hispanic American Council – Erie Note: The attached "Process Monitoring Data" charts provide a breakout of target populations and interventions that were provided.	
		The Department implemented a radio media campaign (HC/PI) designed to "reduce the stigma" of HIV/AIDS and encourage individuals to call the AIDS Factline for further prevention and testing information.

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 10 (Continued): Hispanic Heterosexuals		
		The Department is in the process of implementing a radio media campaign to publicize the availability of anonymous testing.
	The Department funds the Allegheny and York Health Departments to subcontract for HIV PCM. Subcontractors: • York Health Corporation • New Life Urban Ministries - Allegheny	
	The Department contracts with over 20 community based agencies to provide CTR services. The following contractors target this specific population: • Latinos for Healthy Communities - Lehigh • Mt. Pleasant Hispanic American Association - Dauphin • Spanish Speaking Council of Reading - Berks	
Target population 11: Hispanic MSM/IDU		
	Twelve Department HIV Prevention Field Staff provide anonymous/confidential CTR services to high-risk persons who cannot or will not access publicly funded CTR sites. Staff provides PCRS at 443 locations throughout the state. Staff also provides PCM. Note: The attached report on HIV CTR services provides a breakout of the target populations served.	
	The Department purchases and distributes male and female condoms to 226 substance abuse treatment facilities that provide HIV CTR services.	
	University of Pittsburgh School of Public Health conducted a needs assessment of this target population	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 11 (Continued): Hispanic MSM/IDU		
		University of Pittsburgh School of Public Health maintains the stophiv.com website (HC/PI).
	University of Pittsburgh School of Public Health has a subcontract with Serenity Hall, in Erie, to provide outreach, ILI, GLI and CTR services to MSM/IDU.	
	The Department contracts with the Centers for Disease Detection and the State Bureau of Laboratories for blood and oral fluid HIV antibody testing laboratory services for 226 substance abuse treatment facilities that provide HIV CTR.	
	The Department contracts with 5 county (Allegheny, Bucks, Chester, Erie, Montgomery) and 4 municipal health departments (Allentown, Bethlehem, Wilkes-Barre and York) to provide HIV CTR, PCRS and HIV prevention interventions (ILI, GLI, Outreach, PCM, HC/PI, CLI) to priority populations. In addition, the following subcontractors of the county/municipal health departments provide CTR services to this population: • Seasonal Farm Workers – Erie • Minority Health Education Delivery Systems - Erie • Hispanic American Council – Erie • Crossroads Hall, SHOUT Outreach – Erie • Outreach workers – Chester • Interpreters – Chester Note: The attached “Process Monitoring Data” charts provide a breakout of target populations and interventions that were provided.	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 11 (Continued): Hispanic MSM/IDU		
		The Department provides funding for HIV CTR services at 97 STD clinics.
		The Department implemented a radio media campaign (HC/PI) designed to "reduce the stigma" of HIV/AIDS and encourage individuals to call the AIDS Factline for further prevention and testing information.
		The Department is in the process of implementing a radio media campaign to publicize the availability of anonymous testing.
	The Department funds the Allegheny and York Health Departments to subcontract for HIV PCM. Subcontractors: • York Health Corporation • New Life Urban Ministries - Allegheny	
	The Department contracts with over 20 community based agencies to provide CTR services. The following contractors target this specific population: • Latinos for Healthy Communities - Lehigh • Mt. Pleasant Hispanic American Association - Dauphin • Spanish Speaking Council - Berks	
Target population 12: Hispanic MSM		
	Twelve Department HIV Prevention Field Staff provide anonymous/confidential CTR services to high-risk persons who cannot or will not access publicly funded CTR sites. Staff provides PCRS at 443 locations throughout the state. Staff also provides PCM. Note: The attached report on HIV CTR services provides a breakout of the target populations served.	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 12 (Continued): Hispanic MSM		
		The Department purchases and distributes male and female condoms to 443 publicly funded HIV CTR sites throughout the state.
	University of Pittsburgh School of Public Health conducted a needs assessment of this target population	
	The Department contracts with 5 county (Allegheny, Bucks, Chester, Erie, Montgomery) and 4 municipal health departments (Allentown, Bethlehem, Wilkes-Barre and York) to provide HIV CTR, PCRS and HIV prevention interventions (ILI, GLI, Outreach, PCM, HC/PI, CLI) to priority populations. In addition, the following subcontractors of the county/municipal health departments provide CTR services to this population: • Outreach workers – Chester • Interpreters – Chester • Peer educators – Erie • Seasonal Farm Workers – Erie • Minority Health Education Delivery Systems – Erie • Crossroads Hall, SHOUT Outreach – Erie • York Health Corporation Note: The attached "Process Monitoring Data" charts provide a breakout of target populations and interventions that were provided.	
		University of Pittsburgh School of Public Health maintains the stophiv.com website (HC/PI).
		The Department contracts with the Centers for Disease Detection and the State Bureau of Laboratories for blood and oral fluid HIV antibody testing

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 12 (Continued): Hispanic MSM		
		laboratory services for all publicly funded HIV CTR sites.
		The Department provides funding for HIV CTR services at 97 STD clinics.
		The Department implemented a radio media campaign (HC/PI) designed to "reduce the stigma" of HIV/AIDS and encourage individuals to call the AIDS Factline for further prevention and testing information.
		The Department is in the process of implementing a radio media campaign to publicize the availability of anonymous testing.
	The Department funds the Allegheny and York Health Departments to subcontract for HIV PCM. Subcontractors: • York health Corporation • New Life Urban Ministries - Allegheny	
	The Department contracts with over 20 community based agencies to provide CTR services. The following contractors target this specific population: • Latinos for Healthy Communities - Lehigh • Mt. Pleasant Hispanic American Association - Dauphin • Spanish Speaking Council - Reading	
Target population 13: Perinatal transmission		
		The epartment purchases and distributes male and female condoms to 443 publicly funded HIV CTR sites throughout the state.
	Twelve Department HIV Prevention Field Staff provide anonymous/confidential CTR services to high-risk persons who cannot or will not access publicly funded CTR sites. Staff provides PCRS at 443 locations throughout	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 13 (Continued): Perinatal transmission		
	the state. Staff also provides PCM. Note: The attached report on HIV CTR services provides a breakout of the target populations served.	
	University of Pittsburgh School of Public Health conducted a needs assessment of this target population	
		University of Pittsburgh School of Public Health maintains the stophiv.com website (HC/PI).
	University of Pittsburgh School of Public Health has a subcontract with New Directions Treatment Services, The Living Project. This project targets Latinas and African American women between the ages of 15 and 44 and provides outreach, ILI, GLI and CTR services.	
		The epartment contracts with the Centers for Disease Detection and the State Bureau of Laboratories for blood and oral fluid HIV antibody testing laboratory services for all publicly funded HIV CTR sites.
		The Department provides funding for HIV CTR services at 97 STD clinics.
		The Department implemented a HC/PI media campaign (radio) designed to "reduce the stigma" of HIV/AIDS and encourage individuals to call the AIDS Factline for further prevention and testing information.
		The Department is in the process of implementing a radio media campaign to publicize the availability of anonymous testing.
	The Department provides funding to the York City Bureau of Health to implement a project to reduce perinatal HIV transmission in York County.	

Recommendation in the Plan	**… that match recommendation in the Plan**	**…that do not match recommendation in the Plan**
Target population 13 (Continued): Perinatal transmission		
	The Department contracts with 5 county (Allegheny, Bucks, Chester, Erie, Montgomery) and 4 municipal health departments (Allentown, Bethlehem, Wilkes-Barre and York) to provide HIV CTR, PCRS and HIV prevention interventions (ILI, GLI, Outreach, PCM, HC/PI, CLI) to priority populations. In addition, the following subcontractors of the county/municipal health departments provide CTR services to this population: • Planned Parenthood – York Note: The attached "Process Monitoring Data" charts provide a breakout of target populations and interventions that were provided.	
	The Department funds the Allegheny and York Health Departments to subcontract for HIV PCM. Subcontractors: • York health Corporation • New Life Urban Ministries - Allegheny	
	The Department contracts with over 20 community based agencies to provide CTR services. The following contractors target this specific population: • Easton Hospital – Northampton • Community Check-Up Center – Dauphin • Hamilton Health Center – Dauphin • Kline Plaza Medical - Dauphin • PinnacleHealth - Dauphin	

The Pennsylvania Community HIV Prevention Planning Committee has prioritized populations and is currently developing a process to prioritize interventions. Therefore, only the priority populations and current interventions are listed. Items listed under the column "that do not match recommendation in the Plan" are interventions targeted for the general population or for all targeted populations. They are not specific to any one priority population.

State Funded HIV Prevention

The Division of HIV/AIDS, utilizing state resources, funds a variety of HIV prevention related services.

The Council of Spanish Speaking Organizations of the Lehigh Valley, Inc. (CSSOLV)

The Council is the lead organization of similar Latino organizations in and around the Lehigh Valley area. Their primary purpose is to provide HIV/AIDS education and referral services through outreach workers in four cities in Pennsylvania. Their subgrants are as follows: Christian Churches United through its La Casa de Amistad program (Harrisburg), Spanish Speaking Council of Reading and Berks (Reading) and the Spanish American Civic Association (Lancaster). The Grantee provides these services in Bethlehem. They also provide services to the at risk Latino population via referral through the appropriate channels to ensure that such persons with HIV infection and AIDS receive quality services, including supportive services for their friends, families and significant others.

Drug and Alcohol Services

The Pennsylvania Department of Health, Bureau of Drug and Alcohol Programs allocates in excess of three million dollars, annually, for HIV Early Intervention (HIV EI) services to substance abusers in treatment, including injection drug users, in areas of the state that have the greatest need (as determined by AIDS epidemiology). A Drug and Alcohol Program Analyst in the Division of HIV/AIDS administers and manages the HIV EI program for the Bureau of Drug and Alcohol Programs. The Drug and Alcohol Program Analyst provides technical assistance in program development and implementation, as well as, guidelines and monitoring.

HIV funds were allocated for HIV Early Intervention services through contracts at the Spanish American Civic Association/Nuestra Clinica, in Lancaster city, and the following drug and alcohol Single County Authorities (SCA): Allegheny, Berks, Bucks, Chester, Dauphin, Delaware, Lehigh, Montgomery, Northampton, Philadelphia, and Schuylkill.

In calendar year 2001, 16,153 substance abusers in treatment received HIV prevention counseling; 10,855 were tested for HIV antibodies; and, 167 HIV positive substance abusers were identified and linked with health and social services. HIV EI services included the following: one-on-one, client centered, HIV prevention counseling; oral fluid and blood specimen HIV antibody testing (ELISA and Western Blot); results

counseling; partner notification; CD4 and viral load testing; other diagnostic, evaluation and therapeutic services; and linkage with health and social services.

There is a strong collaborative relationship between the Bureau of Communicable Diseases, Division of HIV/AIDS, and the Bureau of Drug and Alcohol Programs, Department of Public Welfare, county and municipal health departments, HIV Prevention Program field staff, and Ryan White-funded providers. Training on HIV, tuberculosis, sexually transmitted diseases and other health-related topics is provided for drug and alcohol treatment staff through an on-site training system that is a collaboration between the Division of HIV/AIDS and the Bureau of Drug and Alcohol Programs. The Division of HIV/AIDS funded the laboratory contracts for blood and oral fluid HIV antibody testing, and CD4 and viral load testing. Hepatitis B vaccines are made available to substance abuse treatment programs through a cooperative effort of the Bureau of Communicable Diseases, Division of Immunizations and the Bureau of Drug and Alcohol Programs.

Anonymous Test Sites

In preparation for carrying out the recently approved HIV reporting regulations that require the confidential reporting of HIV infected people by name to the Department, 130 sites have been designated to continue offering free anonymous HIV counseling and testing. Anonymous HIV Counseling and Testing will be accessible in each of Pennsylvania's 67 counties. An identification number will be given to people tested and used to identify the person's HIV specimen. The person will be required to present the identification number in order to access their test results. The only information reported to the Department on individuals identified as HIV positive at anonymous sites will include the person's identification number and their county of residence. The list of anonymous HIV Counseling and Testing sites can be accessed online at www.state.pa.us. Click on State Agencies, etc then click on Health and look for HIV Anonymous Counseling and Testing Sites.

CD4 T-Cell and Viral Load Testing

CD4 Testing is supported with state funding and Viral Load Testing is supported with Ryan White funds. Because CD4 cells are the targets for HIV and these cells play a primary role in fighting off opportunistic infections, knowing their absolute number is critical for appropriate clinical management of people with HIV. The lower the CD4 cell count, the more at risk an individual is for developing life threatening illnesses. HIV infection coupled with a CD4 cell count of 200 or less meets the CDC case definition of AIDS. The viral load test measures the level of HIV viral RNA in an individual's blood. This test is used to determine whether an individual is responding to therapy and can also predict progression to full blown AIDS.

Free, confidential CD4 and viral load tests are offered to HIV positive individuals under the care of a physician who have no other means to pay for the tests or who participate in the Department of Public Welfare's Special Pharmaceutical Benefits Program. HIV positive individuals are referred to the Department of Health for testing from publicly supported HIV Counseling and Testing sites, physicians, and agencies that provide them

other HIV/AIDS services. For more information on CD4 and viral load testing call the AIDS Factline at 1-800-662-6080.

Annual number of CD-4+ T-Cell tests and Viral Load tests performed on persons with HIV or AIDS in Pennsylvania: 1995 – 2001.

	1995	1996	1997	1998	1999	2000	2001
CD4 Tests	392	729	592	874	864	743	873
Viral Load Tests	0	0	734	1343	1224	1132	1261

State Funded HIV Participating Provider Agreements

The Department provides funding for HIV prevention Counseling and Testing to 13 community-based AIDS service organizations that provide services in the counties where no state health office exists:

AIDS Community Alliance—Dauphin
Berks AIDS Network
Butler-Armstrong AIDS Alliance
Community Check-Up Center—Dauphin
Discovery House—Butler
Hamilton Health Center—Dauphin
Kline Plaza Medical Center—Dauphin
Mt. Pleasant American Hispanic Center—Dauphin
New Directions—Berks
PinacleHealth System—Dauphin
Planned Parenthood Harrisburg—Dauphin
Spanish Speaking Council—Berks
VNA of Central PA—Dauphin

Philadelphia Department of Public Health

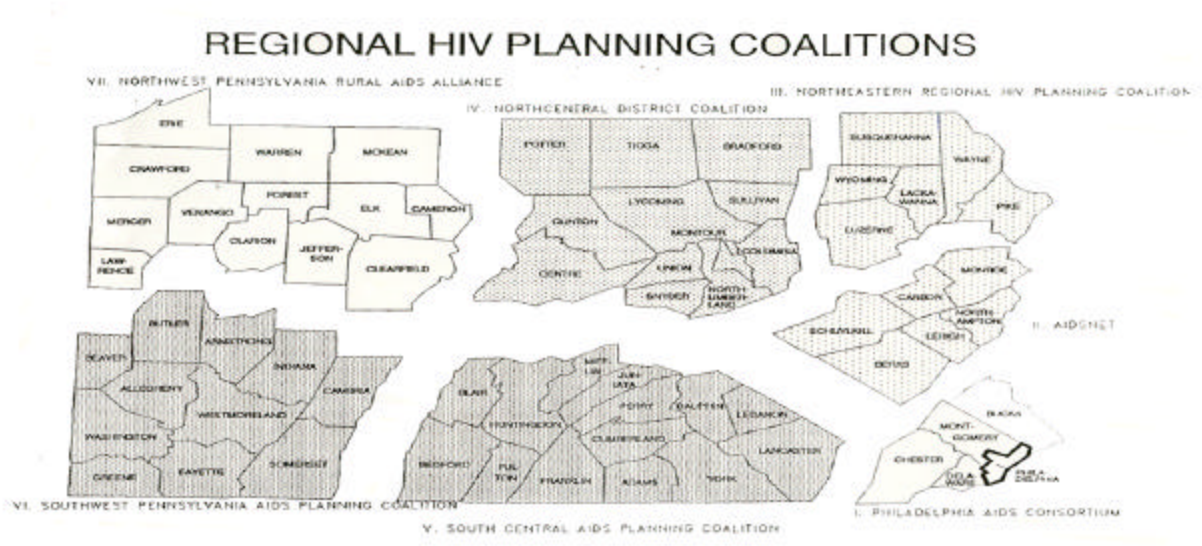
The Department provides an annual Grant of $1,041,090 in state funding, to the Philadelphia Department of Public Health to provide a wide variety of HIV prevention interventions to the residents of the city of Philadelphia. The statewide AIDS hotline is also funded through this grant.

The Philadelphia Department of Public Health uses these state funds to contract with the following agencies for the HIV prevention interventions listed:

- American Red Cross — Health Communication/Public Information (HC/PI)
- CHOICE — HC/PI
- Congresso de Latinos Unidos — Group Level Intervention (GLI)
- Intercultural Family Services — GLI
- Maternity Care Coalition — GLI, Out Reach (OR)
- Philadelphia FIGHT — GLI, OR, Individual Level Intervention (ILI)
- Philadelphia Health Management Corporation — HC/PI, OR
- Vision for Equality — GLI
- Greater Philadelphia Urban Affairs Coalition — GLI, Prevention Case Management
- Philadelphia Community Health Alternatives — HC/PI, OR

Ryan White HIV/AIDS Regional Planning Coalitions

The Department also provides state HIV prevention resources to the seven Ryan White HIV/AIDS Regional Planning Coalitions.



Limited HIV prevention information has been extracted from the Coalition Regional Services and Strategic Plans (CRSSP) reports.

Northwest PA Rural AIDS Coalition

Erie, Crawford, Mercer, Lawrence, Venango, Clarion, Forest, Warren, McKean, Elk, Jefferson, Clearfield and Cameron Counties

During this past fiscal year, the Alliance has had a complete turnover in its prevention/education staff. Coupled with the fact that, as noted in the 1998 and 1999 plans, prevention/education had not been fully staffed during the last few years and much of the time of the one experienced educator has been consumed by training of new educators. This has resulted in the education/prevention team operating in a reactive, rather than proactive mode for several years deploying significant resources in primary prevention activities. Despite these staffing issues, the Alliance reached its targeted number of people for prevention/education services through dedicated staff work.

Women are a particular target for prevention/education in the region. To enhance the information they had to direct prevention activities for women; the Coalition developed and distributed a simple survey, working with family planning clinics, WIC programs, and sexual and domestic violence programs. Results of this survey, detailed in the appendices, showed that these women feel a need for more education and that many of them are not using safer sex practices even though they have had multiple sex partners within the last year. This information will be used in planning future outreach to women.

In addition, the Coalition convened a Prevention Education Committee to develop outcomes for the region's Prevention/Education efforts. While this material is not finalized and data collection approaches to support this have not yet been fully integrated

into the region's activities, this effort will continue until it is fully integrated into the work being done.

There is a continued emphasis at the state and federal level on outcomes and outcome measurements. Simultaneously, there is difficulty in linking primary prevention efforts to reduction of risky behaviors. The targeting, as well as the evaluation of the outcomes of the Northwest Region's efforts, through the Alliance and the subcontractors, represents an area that will receive significant attention during the year ahead.

AIDSNET
Schuylkill, Berks, Lehigh, Northampton, Carbon and Monroe Counties

AIDSNET distributed a survey to prevention agencies in the AIDSNET Coalition. Those persons who completed this survey are representative of two areas with the highest estimated HIV infection rates within our region. The purposes of the survey were to determine HIV knowledge, perceived risk and actual risk behaviors. This was done in an attempt to evaluate gaps between:

- Accurate HIV knowledge
- Accurate risk perception compared to actual risk behaviors
- Desire for risk reduction information and/or intervention

Prevention Services that are Available within AIDSNET region:

- Incarcerated/prison education programs
- Drug and Alcohol HIV/AIDS Education programs – Adults and Youths
- HIV/AIDS peer education training programs
- Street outreach programs
- Minority Education programs
- Perinatal Education programs
- MSM Targeted Education Programs
- PWA Speakers Bureau Program
- Medical Professionals Infection Control Programs
- Condom Distribution/Education Programs (Adult and Youth)
- Prevention/Education Programs (Low Income Women)
- Prevention Programs for Battered Women
- HIV Prevention Education for Juvenile/Detention Centers
- Migrant Workers Prevention Education Programs

Secondary prevention and risk reduction objectives are to evaluate, identify need and promote risk reduction theory and practice to clients with HIV disease to decrease or prevent re-infection with different strains of HIV, or co-infection with HBV/HCV, and STI. As a result, we may able to prevent and/or reduce primary infection of sexual and/or drug partners.

In an effort to provide consistent evaluation and assessment of need for secondary prevention strategies, a category is being developed for inclusion in the Consumer

Holistic Inventory Scale (CHIS), which is utilized by all case managers in the AIDSNET region to assess secondary needs and develop a plan of care. This category will be developed and implemented by July 2001.

The Northeastern Regional HIV Planning Coalition
Susquehanna, Wyoming, Luzerne, Lackawanna, Wayne and Pike Counties

Prevention Survey
The region's Prevention Survey tool was developed jointly by grantee and prevention subgrantee staff. While similar to surveys conducted in the past, we did make some minor changes this year to new information for planning purposes.

Important Observations:
- 56% of the females surveyed were tested for HIV.
- Among all respondents, the most common place for HIV testing was at the Physician's office, where 29% reported being tested. The second highest response was the hospital at 23%.
- Of those who had been tested for HIV, 83% had the traditional blood draw, while 13% had OraSure test.
- 63% of the IDUs in treatment have shared needles or did not bleach their needles every time.
- 60% of the MSMs who did not identify as "gay" said they were heterosexual males, however all participants were located at areas where they engaged in homosexual sex.

The Southwestern Pennsylvania AIDS Planning Coalition (SWPAPC)
Beaver, Washington, Greene, Fayette, Butler, Allegheny, Armstrong, Westmoreland, Indiana, Cambria and Somerset Counties

Six agencies receive funds to provide HIV/AIDS prevention and HIV/AIDS education services in the region. There are a few other agencies providing these services that are not funded by the Coalition. The priority strategy for HIV/AIDS prevention is outreach not funded by the Coalition. The priority strategy for HIV/AIDS prevention is outreach (street/peer), and this is the predominant activity. There is confidential HIV testing available and there is one anonymous HIV testing site. Condom distribution, safer sex parties, distribution of literature and brochures additionally occurs. Trainings, instructions and presentations are the usual HIV/AIDS education activities.

The programs target the following populations:
- Intravenous drug users
- Inmates of the Allegheny County jail
- MSM (White and African American)
- Women
- Adolescent females and minorities
- In-treatment clients of drug and alcohol service providers
- Homosexual and bi-sexual youth
- Residents of low income housing facilities

The outreach (small group) efforts of these prevention service providers involved 6,194 participants, who were mostly male (67.9%) and mostly Black (60.7%). Twenty-one individuals of Hispanic ethnicity were among the outreach population. Nearly 6,000 pamphlets were distributed and 2,339 condoms were given out. Street/peer outreach contacted 19,630 individuals, 57.6% were males and 77.8% were Black. Over twenty-five thousand contacts were made. Nearly 15,000 pamphlets and 32,281 condoms were distributed.

HIV/AIDS prevention and education activities are conducted at various geographic locations in the region including: public sex areas/bi-sexual bars and events, Mon-Valley communities, Pittsburgh East End communities, Allegheny County jail, the Program for Female Offenders, drug and alcohol treatment facilities in Allegheny County, colleges, schools, low income housing communities and senior citizen high rises.

North Central District AIDS Coalition

Potter, Clinton, Centre, Tioga, Lycoming, Union, Snyder, Northumberland, Montour, Columbia, Sullivan and Bradford Counties

Prevention/Education Priorities
Percentages of Funds:

- 40% Individual Outreach
- 15% Small Group Outreach
- 16% Instruction
- 9% Training
- 9% Consultation
- 6% Media Efforts
- 5% Presentations

Which equal:

- 63% Interventions and Outreach
- 37% Health Communication/Public Information and Other Activities

Target Groups for Prevention:

- **High Priority:**
  - MSMs
  - Women 18-35
  - African American men and women who are IDU's or sexual partners of IDU's
  - Sexually active African American females
- **Medium Priority:**
  - Substance Abusers including IDU's
  - At risk Youth
- **Low Priority**
  - Prison Populations

AIDS Planning Coalition of South Central Pennsylvania

Bedford, Blair, Huntingdon, Fulton, Franklin, Mifflin, Juniata, Perry, Cumberland, Adams, York, Dauphin, Lebanon and Lancaster Counties

Prevention Service Need that are Being Met:

Bedford and Blair

- Drug and Alcohol treatment facilities
- AIDS Intervention Project
- Schools that have the State set the curriculum

Huntingdon

- Drug and Alcohol
- Task Force
- Home Nursing – limited
- AIDS Intervention Project
- Schools that have the State set the curriculum

Franklin

- Drug and Alcohol
- Keystone Health Center – Adolescent/Drug and Alcohol/Women
- Schools that have the State set the curriculum

Fulton—Keystone Health

- Drug and Alcohol
- Schools that have state set the curriculum

Adams—AIDS Community Resource Program

- No representation

Lancaster—Urban League of Lancaster County and Nuestra Clinica

- Sexual Abuse Center
- Gay and Lesbian Health Initiative
- Testing and Education
- Presentations in Schools
- Peer educator in and out of schools
- Street Outreach
- Presentations in schools
- Coffee chats
- Education in prisons and drug and alcohol rehabilitation centers
- Radio programs
- Target Hispanic population
- Health fairs
- Work place prevention programs

Lebanon—AIDS Community Alliance

- Education among Hispanics and African Americans in churches, community centers

York—York Health Corporation, Family Services of York County, Open, Atkins House, and Planned Parenthood of York County

- Church Presentations
- Peer educators

- Media efforts
- Home visits- women, youth
- Workshops at conferences
- Education in drug and alcohol rehabilitation centers
- Consults with school districts
- Presentations in jails
- Education in schools – teens
- Distribution of condoms and bleach kits
- Testing
- Training of professionals
- Health Education Centers

Dauphin, Cumberland, Perry, Juniata, Mifflin—Pinnacle, Mt. Pleasant Hispanic Center, AIDS Community Alliance, and Juniata Tri-County Drug and Alcohol Commission

- Outreach through WIC
- Spanish youth
- Women's Health Clinic
- Incarcerated Hispanic population
- Targeting injecting drug users – African American
- Hospital workers blood borne pathogen training
- PinacleHealth Systems' REACCH Program – medical and education for women and kids
- Evening testing and counseling
- Media Campaign – newspaper, radio ads, talk shows
- Nontraditional sources – Nation of Islam

Appendix

2002 Needs Assessment Summary

SUMMARY OF NEEDS ASSESSMENTS CONDUCTED BY PENNSYLVANIA HIV PLANNING COALITIONS

I. Background:

The needs assessment sub-committee of the PA HIV Prevention Community Planning Committee asked PA Prevention Project (PPP) staff to summarize findings from needs assessments performed by HIV Planning Coalitions in Pennsylvania. This summary is presented below. PPP staff were able to obtain reports from the following the AIDSNET, South Central, Northcentral, and Philadelphia regions. A summary of methods is presented, followed by findings, recommendations for prevention, and conclusions.

These needs assessments focused on service provision for persons with HIV with the exception of the RARE methodology in Philadelphia, a small number of prevention-related questions in South Central, and one of several components of the AIDSNET project. As a result, the majority of the findings presented below may be more relevant to secondary, as opposed to primary prevention. Finally, with very few exceptions (e.g., African-Americans in South Central PA, high school students in North Central PA), these needs assessments did not target sub-populations of at-risk individuals, but instead more generally described the views of consumers, providers, and community leaders.

In the following, we summarize the **methods** used by the Coalitions to conduct their needs assessments. Then we give a bullet summary of **key findings**, followed by **recommendations** for interventions. We end with a few broad **conclusions** regarding HIV prevention needs assessment that may be helpful for the subcommittee and Committee.

II. Methods:

With the exception of Philadelphia, the methods employed by various Coalitions were somewhat similar to one another. For example, the AIDS Planning Coalition of South Central PA utilized key-informant-interviews with community leaders, surveys with consumers, providers, and physicians, and, focus groups with consumers, caregivers, human service providers, and high school students. AIDSNET implemented focus groups with providers, and surveys with consumers and providers. In addition, this coalition hosted a prevention summit involving ten local, HIV-prevention experts. The North Central AIDS Coalition implemented a survey of consumers and health care providers, focus groups and interviews with providers, case managers, and mothers of children who have AIDS in addition to secondary data analysis of governmental statistics. The Philadelphia group used the Rapid Assessment, Response, and Evaluation (RARE) methodology. This assessment focused on crack smoking women in two zip code areas. However, the RARE method allowed for an assessment of other risk populations as they interacted with these women. Four qualitative methods were used: street interviews with community experts and crack-smoking women; individual interviews with community experts, leaders, and service providers; focus groups with clients in a drug-treatment program, individuals receiving prevention, and community experts in target areas; and regular observation visits to target areas.

III. Key Findings:

- Major barriers with regard to the provision of HIV-related services include: 1) lack of money or insurance on the part of people with HIV/AIDS, 2) lack of transportation, and, 3) a perception that the confidentiality of the individual may be broken.

- Individuals' fears regarding confidentiality are particularly strong in rural areas.

- Many individuals with medical insurance were not always to get the medical care they needed as their insurance was limited.

- There is widespread difficulty in accessing appropriate mental health services for people with HIV/AIDS. This was attributed to too few mental health therapists in various parts of the state, lack of HIV-related skills among many existing practitioners, and lack of funding to pay for mental health care.

- Persons with HIV/AIDS in rural areas have much more difficulty accessing services than do individuals in urban areas.

- Persons with HIV/AIDS living outside of Pittsburgh and Philadelphia often have particular difficulty accessing care provided by medical specialists.

- Persons with HIV/AIDS often have trouble accessing legal, prevention/education, dental, housing, and drug & alcohol services. Such services with an HIV focus are not present in many parts of the state. Even when such services do exist, many people with HIV are not aware of them or do not know how to access them.

- Individuals with HIV/AIDS are sometimes not able to secure the medications they need.

- Some people with HIV/AIDS do not utilize the services provided by AIDS service organizations. Some of these individuals are not aware that these organizations exist, others do not feel comfortable with particular organizations because of their principal client populations (e.g., gay men, IDUs), while others are not comfortable accepting subsidized care.

- Health care providers often lack skills and sensitivity with regard to HIV (consistent with PPP findings

- Inadequate resources (e.g., money, person hours) stand in the way of providing adequate services.

- There are widespread negative attitudes about IDUs. Such attitudes stand in the way of developing and implementing services targeting this population.

- High levels of stigma related to HIV was found in rural areas and in smaller towns throughout PA. Most communities pass moral judgements on people with HIV, especially when the person is homosexual or an IDU. In general, there is widespread homophobia, and widespread denial of the existence of IDUs and of teenage populations engaging in unprotected sex.

- In NC, case management services for persons living with HIV/AIDS do not necessary include a discussion of HIV prevention. While the majority of agencies polled in AIDSNET provided prevention services for their HIV infected clients, a significant minority did not.

- Among youth in SC, health classes and the media were two major sources of HIV information, while the internet was another source though it was less prominent. These youth feel that schools do not do an adequate job of educating their students about HIV.

- A significant amount of HIV prevention services is present in the AIDSNET region. These services are reaching substance abusers, their sexual partners, racial and ethnic minorities, MSM, women, and youth. These populations were reached through interventions on the street, in prisons, schools, migrant camps, shelters, and juvenile detention centers.

The findings of the RARE project primarily relate to HIV prevention and include risk pockets, mixing, street science, and condom use as described below.

- **Risk pockets:** In each zip code, there were small pockets of drug sales, drug use, and sex exchange. These areas had high numbers of abandoned properties and neglected open spaces interspersed with occupied housing and residents. Many people avoided these environments, creating a space in which high-risk behaviors thrived. Respondents in these areas were unaware of HIV prevention services. The needs assessment team recommended that these types of risk pockets be the focus of "low-threshold, saturated" prevention intervention in the future.
- **Mixing:** There is frequency of contact between individuals of different socio-economic and ethnic backgrounds, sexual orientations, geographic areas, health status, and risk behaviors. This mixing provides opportunities for viral transmission in this and outside areas. Mixing is fueled by easy access to inexpensive sex and availability of crack cocaine.
- **Street science:** HIV risk and prevention issues are clearly misunderstood by many community experts. "Street science" combines facts with more popular myths, fold wisdom, and mistrust in government to provide good prevention intervention. There is a great need for accurate, culturally sensitive information that is accessible and trusted by those at risk of HIV. The needs assessment team recommended the implementation of a comprehensive street-level information campaign.
- **Condom use:** Primary HIV risks in these pockets were unprotected anal, oral, and vaginal sex. No community expert participated in consistent condom use. Many had partners with whom they did not use condoms. Respondents equated partner familiarity with risk reduction. Both the low-threshold, saturated intervention and street-level education campaign would be designed to address this risk by making condoms more accessible and acceptable.

IV. Recommendations:

- Address issues of confidentiality.

- Work with non-traditional providers to provide certain needed services.

- Implement mass media educational campaigns to increase the public's understanding of what services are available.

- Develop strategies to improve transportation systems with regard to persons with HIV/AIDS and existing services.

- Provide sensitivity and skill-building training for a wide variety of service providers to increase the quality of HIV-related services for persons with HIV/AIDS.

- There was a consensus that community-based education is needed. Implement seminars, lectures, and public forums on about HIV.

- Increase the provision of HIV education in schools and begin this during earlier grade levels. This was a major theme.

- Involve people living with HIV/AIDS in the implementation of HIV/AIDS education and prevention efforts.

- Youth in NC suggested that education of their peers should include basics on transmission.

- Women in SC suggested that HIV testing should become a routine part of a woman's annual genecological examination for women of child-bearing ages as well as a routine part of their prenatal care. Women need a "one-stop shop" for services.

- African-Americans who were part of a needs assessment in south central felt suggested that: 1) prevention needs to target African-Amercians, 2) African-American churches need to become more involved in providing HIV information, 3) many more African-American providers are needed, 4) more outreach is needed in African-American social settings, 5) testing sites need to be better advertised in African-American communities, 6) better transportation systems are needed for African-Americans, 7) and the cultural sensitivity and skills of providers needs to be strengthened.

- Recommendations of the prevention summit in AIDSNET included: increasing access to testing, multi-dimensional approaches to prevention, needle exchange, networked/corrdinated/collaborative/training of trainers, diversity training, changing norms, harm reduction, and social marketing with condom distribution/media campaigns. Populations to be targeted were classified as high priority (i.e., substance users, sexual partners of substance users, racial/ethnic minorities), medium priority (i.e., MSM, women, youth, offender/victim), and low priority (i.e., general population, other drug and alcohol users, other high risk groups).

Recommended approaches from RARE project:

- Street-level education and low-threshold interventions are recommended prevention approaches. The street-level intervention could follow the street-marketing model of hiphop record distributors, inundating each pocket with flyers, posters and giveaways. The message would counteract the street science myths, described above. This approach could be reinforced by public service announcements recorded by cultural experts and local celebrities. Murals could reinforce messages. Street fairs could be held in each intervention zone.

- The low-threshold intervention would be the responsibility of a team of community leaders. Support from neighbors in the community would be essential. The LTS teams in each pocket would become advocates for prevention needs of the local risk population. They would advocate for easy access to HIV/STD counseling and testing; drug treatment; housing; syringe exchange; job training; GED preparation and testing; legal services; mental health services; child care; and counseling. These teams would work non-traditional hours and be responsible for establishing and coordinating a collaborative effort with the local community leaders and service providers. These teams would become links to existing services. A primary goal would be to assist all sex workers in each pocket to have periodic testing for HIV and other STDs.

As a further recommendation, the investigators believed the RARE methodology could be used to plan and evaluate HIV prevention programs in addition to assessing future needs.

V. Conclusions:

1. The findings above are generally consistent with and support the findings of needs assessments implemented by PPP (e.g., lack of transportation, perceived problems related to confidentiality, need for more HIV education provided at early ages in schools).

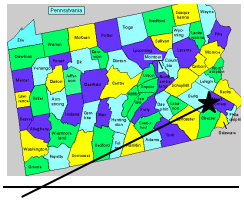
2. It is suggested that a saturation point has been reached with regard to the accumulation of data *in terms of the methodologies employed above.* While there are clearly special populations for whom little is known and for whom focus groups, individual interviews, and surveying could produce helpful information, it is probable that sufficient data has been collected about the major (as prioritized by the PA HIV Prevention Community Planning Committee) at-risk groups.

3. The RARE methodology may be a logical next step in terms of appropriate needs assessment strategies in that this approach may provide a more comprehensive understanding of overlapping risk groups and risk factors for HIV than other approaches (see major findings and recommendations of Philadelphia's RARE study above). In addition, community based, HIV prevention workers are trained as researchers (i.e., to collect data) as part of the RARE methodology thus increasing the likelihood that findings will be used to improve HIV prevention efforts. Finally, this approach may produce more comprehensive recommendations that other needs assessment strategies.

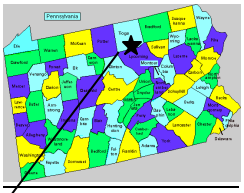
Appendix

Pennsylvania HIV Prevention Community Planning Committee Biographies

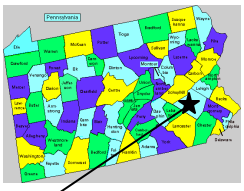
Pennsylvania Department of Health
Pennsylvania HIV Prevention
Community Planning Committee
2002



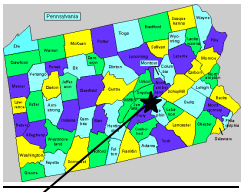
Shaista Ajaz – has been a member of the PA Young Adult Roundtables since January of 1996, is also a member of the Roundtable executive committee and of the Youth Advisory team in Pittsburgh which is a group of young people currently working to create their own HIV prevention intervention. She has an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



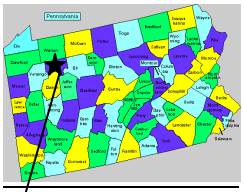
Gloria P. Banks – Originally from Newark, NJ where she did her first HIV/AIDS outreach training in 1988. She attended Newark schools and spent the greater part of her adult life being "Mom" to 3 children, all of whom are now in their adult years. She is currently working as an HIV/AIDS outreach worker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



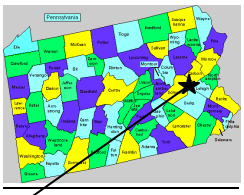
Ruth Banks Bell **–a clinical nurse practitioner.**



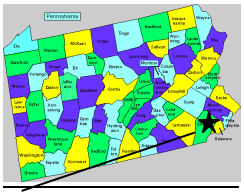
Shirley Black - has worked in the field of education since 1974 as a Health and Physical Education teacher/coach, Health and Physical Education Advisor for the Pennsylvania Department of Education and Pennsylvania HIV Project Director for CDC/DASH. Shirley has been involved with implementing HIV prevention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



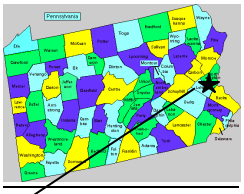
Richard Buzard – Has worked in the drug and alcohol field for 25 years and has been dealing with HIV issues since 1986. Currently works for Northwest Human Development, Inc. providing direct services and supervising the alcohol and other drug program. Enjoys raising and training German Shorthaired Pointers, upland bird hunting, and fly-fishing.



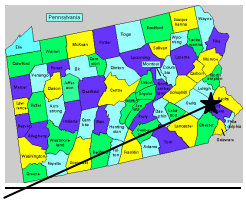
Rafael J, Canizares – is an immigrant Latino gay man who recently became the Executive Director of Latinos for Health Communities, a community-based agency that promotes healthy living in the Latino community, primarily through HIV/AIDS education and outreach. They promote collaboration and have formed partnerships with other local agencies. He is also a Youth Advocate with Youth Advocates Program, Inc. and has other experience working with youth at risk. His volunteer work includes working with incarcerated men at a federal prison and with men living with AIDS.



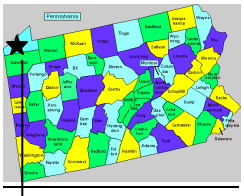
Sheila Church – has worked in the field of HIV/AIDS for the past ten years. Currently, she holds the title of Outreach Program Director at ChesPenn Health Services in Chester, Delaware County. She has experience in both street outreach and HIV/AIDS case management. She is also a Certified Addictions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



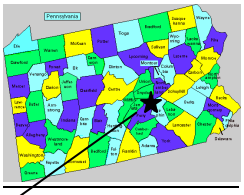
Anna M. Claudio – Experienced in social services, HIV/AIDS Case Management, and drug and alcohol counseling. Employed at New Directions Treatment Services in Allentown, PA. Is a leader in the Latino(a) Community and serves as a board member in various human services organizations. She is interested in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



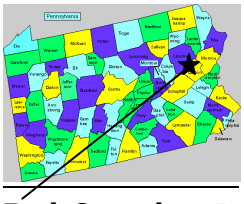
Ronnie Colcher – Is the Director of Drug, Alcohol and AIDS at Valley Forge Medical Center and Hospital, Montgomery County. Likes cooking, basket weaving and giving parties.



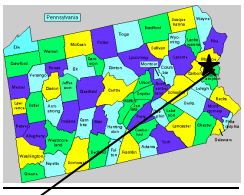
Sonny Concepcion – Working in the field of HIV/AIDS mainly with youth and incarcerated adults. Is originally from Puerto Rico and was an IV drug user. Lives in Erie, PA and is the father of three children. Hobbies include computer, food, and music.



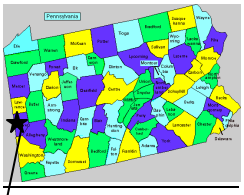
Janeen M. Davis – Employed as an HIV Education Coordinator with the Pennsylvania Department of Corrections at Elizabethtown, PA. Her duties are developing, coordinating and ensuring that HIV/AIDS education is provided appropriately and accurately to all Department employees and inmate population.



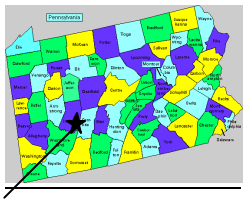
Rod Gereda – Provides corporate and personal coaching services in Transformational Leadership – Conflict Resolution Skills and Service Leadership Initiatives. Holds a Bachelor of Architecture from the University of Houston degree and practices along side his wife Kathy. His proudest achievement: three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



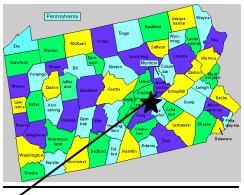
Steve Godin – Since 1998, I have been involved in the planning of HIV prevention at the state and local levels. Since joining the public health faculty at East Stroudsburg University, I have directed a number of community-based HIV prevention efforts, as well as provided technical assistance in the program evaluation and outcome assessment of numerous state and local-level prevention efforts. In the early 1990's, HIV prevention efforts were planned using the latest cutting-edge behavioral change and prevention theories. However, I sense the last five years has had little innovation and creativity in HIV prevention strategies. The data I have been collecting clearly indicates that young people today know less about HIV and AIDS than their counterparts did in the early 1990s. Approaches to education the public have become stale, and do not seem to grab the attention of youth, as well as seniors in the Commonwealth. In addition to traditional methods, I would like to see more use of multi-media approaches using social marketing theory and a "socail norms" approach. Web-based HIV risk screening, with effective prevention messages could be a cost-effective, novel approach to reaching a variety of populations (i.e., rural, urban, youth, seniors, etc.) including under-served populations.



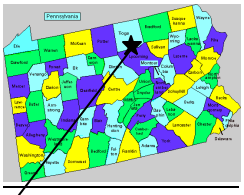
Henry P. Green – Worked for the Beaver County AIDS Service Organization for 3 years as Supervisor/Coordinator for Project Hope. Graduated from Aliquippa High School. Attended Bidwell Cultural and Training Center. Enjoys collecting ashtrays (the older the better). Also enjoys eating and tasting all sorts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



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

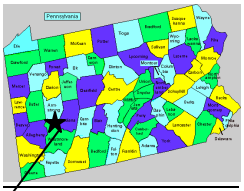


Reneé Hartford - is Prevention Project Coordinator with AIDS Community Alliance of Harrisburg. Reneé received a certificate in Substance Abuse Counseling at the University of California State Northridge in 1976. Over the years she has continued to up-date her education in the fields of drug and alcohol,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

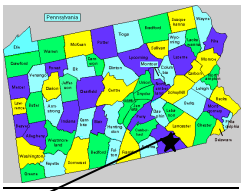


Larry D. Haverstadt-Cole – has been a minister in the United Methodist Church for the last 21 years., having served churches in Nebraska, and Pennsylvania. He is currently serving a church in Williamsport, Lycoming County and is Ministry Director of Sojourner Truth Ministries, a ministry provided for the homeless of body, mind, and spirit and for those felt separated or disenfranchised from the church for any reason. He also serves as Director of the pre-and post-release spiritual program for men incarcerated at the Lycoming County Jail. He has also

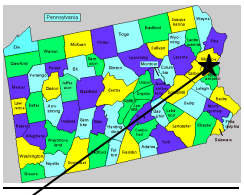
had experience working at the Department of Public Institutions and Department of Corrections in Nebraska. He has extensive experience in counseling and teaching, both in the public sector and in the church. He has a Bachelor of Science degree in Special Education (7^{th}-12^{th} grade) and a Master of Divinity degree from Saint Paul School of Theology, Kansas City, Missouri. His fee time, when he has any, is spent playing with his collectable cars and his two antique farm tractors. He also likes to sing but doesn't do weddings anymore.



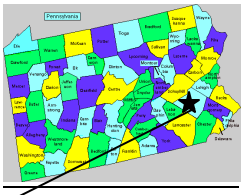
Rebekah Heilman – a resident of Wilkensburg is a representative of the Young Adult Roundtable to the Committee.



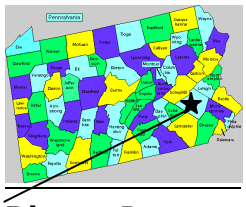
Jennifer L. Kunkel - is Research Coordinator for the South Central AIDS Planning Coalition. She has 12+ years in the substance abuse field as clinician and supervisor for multiple treatment modalities. In addition, Jen has 2+ years as an Adolescent substance abuse consultant for the inpatient adolescent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



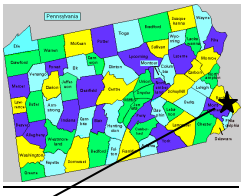
Robert Lee – is the Prevention Specialist with Carbon-Monroe-Pike Drug & Alcohol Commission, Lehighton, since September 1999. In addition, he is a substitute middle school teacher one-day per week at the Panther Valley School District. He retired in August 1999 from the Social Security Administration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



Orlando Lozada – is a resident of Reading, PA.

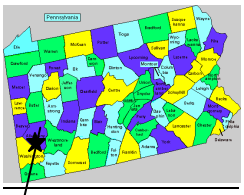


Dianna Pagan - has worked in the HIV field since 1989, is currently the Executive Director of Reading Risk Reduction, a harm reduction agency based in Reading, PA. Dianna's area of expertise is injection drug use and how it relates to HIV infection in Pennsylvania. In addition, Dianna is an avid football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

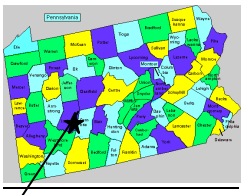


Elaine Pasqua - is an ex-dental hygienist whose passion is AIDS prevention education. After losing her mother and stepfather to AIDS she decided to speak out to teach others that AIDS is everyone's disease. Since 1995 she has worked with thousands of students. As president of Project Prevent, a not for profit

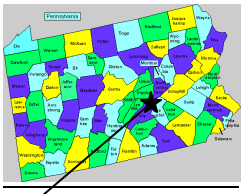
organization, she presents programs to elementary through high school students, as well as parent groups. Teacher training programs are also available. Since 1997, Elaine has presented a program called "Living and Loving In a World With AIDS" at over 60 colleges and universities across the country. She loves working with students of all ages! As a faculty member of the New Jersey AIDS Education and Training Center, she also presents programs to social workers, and health professionals. She loves to sing, hike, travel, garden, photography, and to play tennis. Elaine lives in Doylestown, with her husband Jeff, and her 11 and 9-year-old sons.



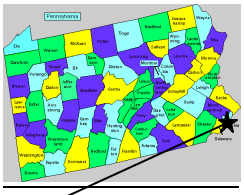
Floyd Patterson – is Community Relations Coordinator with the Pittsburgh AIDS Task Force since June 2000. "Prior to that, I was employed as the Social Services Coordinator for the Myasthenia Gravis Association of Western PA since 1992. Previously, I had volunteered for the Task Force in a variety of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



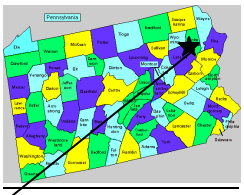
Angi Peacetree – I began working with HIV/AIDS in 1994 as a student at State University of New York Potsdam. As a Native American, I could fully sympathize with the marginalization and stigma that was associated with being HIV-positive. Many young people at the college and at our reservation tried to "pass" as healthy people and being sick with something else such as mono, cancer, and so forth. My background as a Native American Indian growing up and living with risk-takers had made me very sensitive to the needs of individuals who have special needs in our community. I think that caring for my cousin who died with most of the family not knowing that he had AIDS, taught me that even strong ties were not enough to cope, to help, or to heal. I would like to be a part of the process that promotes helping and healing from persons living with AIDS and those that love them.



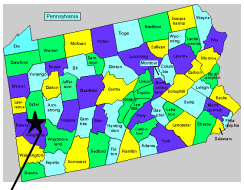
Joe Pease - Worked with the HIV/AIDS program in the Dept. of Health since 1987 currently as Director of the Division of HIV/AIDS. Graduated from the U. of Pittsburgh Graduate School of Public Health with a M.P.H. in Health Services Administration. Also received a Masters in Clinical Psychology "when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



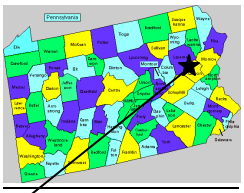
Judith Peters – is the Community Co-Chair Community Planning Group for HIV prevention in Philadelphia.



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

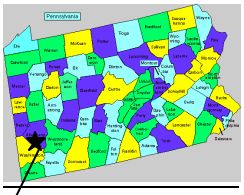


Deborah Rock – is the current Director for Mon Yough Community Services, Inc. Drug & Alcohol Support Services component. She attended Waynesburg college for Business Administration. She has successfully secured funding for 19 grants over a four-year period. She very much enjoys her daughter and dog BB.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

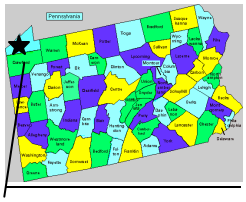


Ann Stuart Thacker - has worked in the field of HIV since 1985, notifying blood donors of their seropositive status, and working for the next ten years at Columbia University, School of Public Health in psycho-social research projects aimed toward helping people cope with HIV while looking at ways to change risk behaviors. Currently she is the program manager of the AIDSNET coalition and her focus remains reducing primary and secondary HIV infection. A bit of a control freak at heart, God has given her the task of raising her granddaughter who currently is 15,

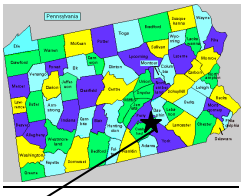
which not only gives her gray hair, but teaches her daily, depending on what the day brings, lessons in humility, frustration, wonder and homicidal ideation.



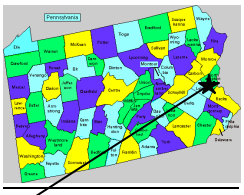
Shaquail Small – was born and raised in Fort Worth, Texas 28 years ago. She came to the University of Pittsburgh with a two-year degree in social work. She also received a degree in radiology from the ICM School of Business and Medical Careers in Pittsburgh. She has volunteered for two-half years with various AIDS service organizations. In addition, she has worked four years as the Program Assistant as well as the Transportation Coordinator for the Shepherd Wellness Community. She has been a transsexual for 16 years and is scheduled for reassignment surgery in 2003.



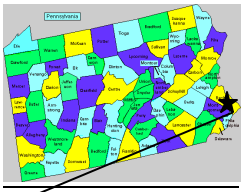
Tracey Thomas – wife and mother of three teenage children. She entered the field of substance abuse in 1981 specializing in work with "Adult Children of Alcoholics" like herself. She has continued in working with the full spectrum of treatment to include prevention, treatment, and dual diagnosis. She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



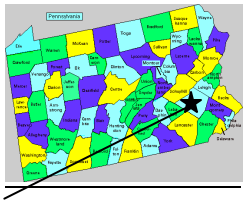
Travis Varner – is a member of the Roundtable executive committee and of the Youth Advisory team in Pittsburgh, which is a group of young people currently, working to create their own HIV prevention intervention.



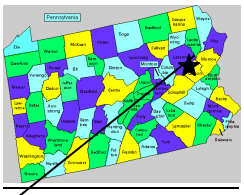
Elsa Vazquez – works as a Social Worker for HIV positive patients at Saint Luke's Hospital in Bethlehem for the past ten years. Previously, provided drug and alcohol treatment to Latino(a) clientele. She's an advocate for better human services for the Latino(a) population. A single mother of three who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



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



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



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

Appendix

1999 Young Adult Roundtable Consensus Statement

1995-2002 Pennsylvania Young Adult Roundtable Trends in Member Demographics

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

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:

_____	_____
Emily Clark	Lou Shar Robinson

York:

_____	_____
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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PENNSYLVANIA YOUNG ADULT ROUNDTABLES: TRENDS IN MEMBER DEMOGRAPHICS* 1995-2002

*The following demographic data were collected through anonymous questionnaires that were completed by Roundtable members at the initial group meetings (typically January and March) of each year. The total number of Roundtable members in a given year (n) reflects the number of individuals who completed anonymous questionnaires.

The Pennsylvania Young Adult Roundtables began in 1995 with four groups (Allentown, Erie, Pittsburgh and York) with the mission of providing high-risk young people in our state (excluding Philadelphia) an ongoing voice in the HIV prevention community planning process. The number of Roundtable groups (#) has increased over the past eight years, resulting in greater numbers of young people each year (n) in a greater variety of locations throughout the state, participating in the planning process. Average group size (m) has fluctuated, but hovers around the goal of fifteen. Certain groups (typically those comprised of GLBT young people and young people in recovery from IDU), by virtue of their composition, are difficult to recruit. Recruitment, for example, has been the problem in our attempts over the years to initiate a Roundtable comprised of young people living with HIV/AIDS.

ROUNDTABLES 1995-2002: GROUP SIZE & DISTRIBUTION OF MEMBERS

	#	n	m	AL	AB	CH	ER	ES	HB	LV	NE	NR	PT	RD	TV	WB	WP	YK
1995	**4**	**66**	**17**	16			25						17					8
1996	**6**	**90**	**15**	16			15					16	16		13			14
1997	**8**	**117**	**15**	15			15	13				15	19			11	17	12
1998	**7**	**119**	**17**	17			19					17	15			17	21	13
1999	**8**	**129**	**16**				21		19			8	15	17		13	23	13
2000	**8**	**126**	**16**				29		11			12	12	16		12	23	11
2001	**10**	**131**	**13**			2	22		15	5		14	13	17		5	24	16
2002	**8**	**110**	**14**		16		27		9	4		15	7				23	9

***AL**: Allentown; **AB**: Allentown/Bethlehem; **CH**: Camp Hill; **ER**: Erie; **ES**: East Stroudsburg; **HB**: Harrisburg; **LV**: Lehigh Valley; **NE**: Northeast; **NR**: Norristown; **PT**: Pittsburgh; **RD**: Reading; **TV**: Tannersville; **WB**: Wilkes-Barre; **WP**: Williamsport; **YK**: York.*

Each year new Roundtable members are recruited to existing groups in order to compensate for group attrition, which is typically between 35-50%. New members are recruited by demographic or behavioral criteria that match the existing group composition (e.g., African American, Latino, recovering IDU, young mothers, GLBT). In addition, age is a factor for new recruits, who, ideally, are between the ages of 13-18; however, with certain populations (again GLBT and IDUs) the age range is extended (usually to 24) in order to accommodate the special environmental and personal factors that effect these young people. (Another example is the anticipated group of young people living with HIV in Camp Hill; we expect that group to be older as a function of various factors around diagnosis: age, acceptance and willingness to share that information with others in your community.) As a result, over the past eight years, average age (m) of Roundtable members has steadily increased from 17 to 19. Another factor that may account for this, is that Roundtable members recruit new members in their communities for their groups; it is likely that existing members who, each year are aging, will recruit their peers who, each year are older. The age criterion for recruitment remains an important factor, however, in maintaining a younger cohort of Roundtable members.

ROUNDTABLE MEMBERS: 1995-2002 BY AGE (MEAN/RANGE)

		m	*range*
1995	**(n=66)**	17	13-26
1996	**(n=90)**	17	13-24
1997	**(n=117)**	17	13-29
1998	**(n=119)**	17	12-29
1999	**(n=129)**	18	13-30
2000	**(n=126)**	18	13-31
2001	**(n=131)**	19	13-27
2002	**(n=110)**	19	13-26

ROUNDTABLE MEMBERS: 1995-2002 BY SEX

		female	*male*
1995	**(n=66)**	53% (35)	47% (31)
1996	**(n=90)**	56% (50)	44% (40)
1997	**(n=117)**	46% (54)	54% (63)
1998	**(n=119)**	50% (60)	50% (59)
1999	**(n=129)**	50% (65)	50% (64)
2000	**(n=126)**	49% (61)	50% (65)
2001	**(n=131)**	65% (85)	34% (45)
2002	**(n=110)**	64% (70)	36% (40)

During the initial six years of the project (1995-2000), the composition of members by sex was fairly evenly divided. During the past two years, however, recruitment has resulted in an increase in participation by females. Two important factors that contribute to the decline in male representation in the project are the decrease in the number of GLBT groups (from 4 to 3), and the decline in (male) members within the remaining GLBT groups. Recruitment efforts for next year, as they did this year, will focus on increasing male participation, particularly within GLBT groups.

Diversity among participants is essential for effective and meaningful community planning. Therefore, diverse groups of high-risk young people (as determined, for example, by age, sex, race/ethnicity, geographic location and sexual orientation) comprise the statewide project. To maintain geographic diversity, the Roundtables attempts to convene at least one group in each of the seven Ryan White Regional Planning Coalitions. (The anticipated Northeast Roundtable, for example, though comprised of a different demographic – young people who live in rural communities, – will replace the Wilkes-Barre Roundtable in that region.) The opinions of Roundtable members, however, are NOT representational of all young people who reside in that particular region. Initiation and maintenance of a Roundtable is dependent upon, among other factors, the support and leadership of community members (including Roundtable and Planning Committee members, ASOs and other organizations), their capacity to identify and to recruit high-risk young people, and their belief that the principles of community planning are applicable to high-risk young people.

ROUNDTABLES: 1995-2002 BY REGION								
		AIDSNET	***NWPRAC***	***SWPAPC***	***NCDAC***	***APCSCP***	***NERPC***	***TPAC***
Allentown	1995-1998	✓						
Allentown/Bethlehem	2002	✓						
Camp Hill	2001					✓		
Erie	1995-2002		✓					
East Stroudsburg	1997	✓						
Harrisburg	1999-2002					✓		
Lehigh Valley	2001-2002	✓						
Northeast	2002						✓	
Norristown	1996-2002							✓
Pittsburgh	1995-2002			✓				
Reading	1999-2001	✓						
Tannersville	1996	✓						
Wilkes-Barre	1997-2001						✓	
Williamsport	1997-2002				✓			
York	1995-2002					✓		
	n=	**6**	**1**	**1**	**1**	**3**	**2**	**1**

When analyzing demographic percentages, please consider: (1) the total number (n) of Roundtable members in a given year; (2) the actual number (in parenthesis) of young people in a category in a particular year; (3) the number (#) of Roundtable groups being represented; (4) comparisons between that category and others WITHIN the same year (to understand proportion of that category with respect to others); and (5) comparisons between years within that same category (to understand proportional changes over the years).

ROUNDTABLE MEMBERS: 1995-2002
BY RACE/ETHNICITY (*AS REPORTED BY MEMBERS)

	n	#	*Black/African American*	*White/European American**	*Latino/Hispanic/ Puerto Rican**	*Asian American/ Pacific Islander*	*Multi-Racial**
1995	**66**	**4**	43% (28)	30% (20)	27% (18)	0%	0%
1996	**90**	**6**	26% (24)	50% (45)	24% (21)	0%	0%
1997	**117**	**8**	34% (39)	49% (57)	10% (12)	1% (1)	6% (8)
1998	**119**	**7**	27% (32)	40% (47)	19% (22)	3% (3)	12% (14)
1999	**129**	**8**	31% (40)	39% (51)	18% (23)	0%	11% (14)
2000	**126**	**8**	36% (45)	34% (43)	18% (22)	0%	13% (16)
2001	**131**	**10**	40% (52)	31% (40)	15% (19)	1% (1)	15% (19)
2002	**110**	**8**	42% (46)	25% (27)	25% (26)	0%	10% (11)

ROUNDTABLE MEMBERS: 1995-2002
BY SEXUAL ORIENTATION

	n	#	*straight*	*gay*	*bisexual*	*lesbian*	*not sure*
1995*	**66**	**4**					
1996	**90**	**6**	63% (57)	12% (11)	17% (15)	4% (4)	3% (3)
1997	**117**	**8**	59% (69)	18% (21)	13% (15)	5% (6)	5% (6)
1998	**119**	**7**	55% (65)	19% (23)	15% (18)	7% (8)	3% (3)
1999	**129**	**8**	49% (63)	25% (32)	15% (19)	4% (5)	3% (4)
2000	**126**	**8**	60% (76)	19% (24)	14% (18)	5% (6)	1% (1)
2001	**131**	**10**	55% (72)	16% (21)	18% (24)	6% (8)	3% (4)
2002	**110**	**8**	66% (73)	7% (8)	16% (17)	5% (5)	6% (7)

**This information was not collected the first year of the project.*

Though incomplete, the composition of the Roundtables attempts to reflect the AIDS epidemic among young people in our state, as we best understand it from current, available data (primary and surrogate). Therefore, with each passing year and with feedback from Roundtable members, Planning Committee members, DOH staff and needs assessment data, Roundtable composition changes.

While it is important to consider needs assessment information from the widest variety of high-risk young people, particular groups – runaways, for example, – are not compatible with the structured organization of the Roundtables, which requires ongoing contact by Pitt staff with members and their regular attendance at meetings. Needs assessment information from such groups is better obtained through focus groups or key informant interviews.

If you have any questions, comments or recommendations, please contact John Faber at 800.445.9573 or at faber@pitt.edu.

Thanks you for your continued support of the Roundtables.