

Part F: Tools for Prevention and Care

Chapter 11:

Prevention Interventions



Prevention Interventions

In Iowa, HIV prevention programs use an approach that addresses individuals' needs in the context of their own lives, with a focus on a broad set of issues. HIV providers have created service delivery systems that link those living with HIV and at risk for HIV with services such as substance abuse, mental health, STD and hepatitis screening and treatment. Providers use strategies and interventions that are responsive to the daily realities faced by people living with or at risk for HIV.

The Serostatus Approach to Fighting the HIV Epidemic (SAFE) recommended by Gayle (2000) serves as the overarching theme of the chapter. The chapter includes an overview of the CDC's Advancing HIV Prevention (AHP) initiative, crosscutting themes, descriptions of prevention interventions, and identification of interventions for target populations. Information is presented as a guide and a resource for prevention planning and program design.

Section 1 – Crosscutting Themes: SAFE, Recommendations, and Behavior Theory

Section 1 begins with a description of SAFE. Crosscutting themes and general recommendations for the planning, design, and implementation of programs are presented. A discussion of behavior theory and its application to HIV prevention is included.

Section 2 – Prevention: Interventions and Cost Effectiveness

Interventions for HIV prevention are presented in discrete categories. Prevention information, messages, and mode of delivery are dictated by the specific prevention needs of the target population. Providers are encouraged to combine theories, strategies, and interventions, or elements of each of these, in the development of their HIV prevention programs. Cost-effectiveness of implementing prevention programs is discussed.

Section 3 – Intervention Sets for Target Populations

This chapter concludes with the identification of interventions for target populations. Section 3 provides Fact Sheets on the programs and curriculums in the intervention sets.

Section 1 - Crosscutting Themes

Serostatus Approach For Fighting the Epidemic (SAFE)

General Guidelines

Program Components

Organizational Components

Minimum Standards of Service

Strategies for Prevention Interventions and Community Endeavors (SPICE) Principles

Behavior Theory

Health Belief Model

Social Cognitive Theory

Stages of Behavior Change Model

Theory of Reasoned Action

Diffusion of Innovation Theory

Empowerment Theory

Social Networks and Social Support

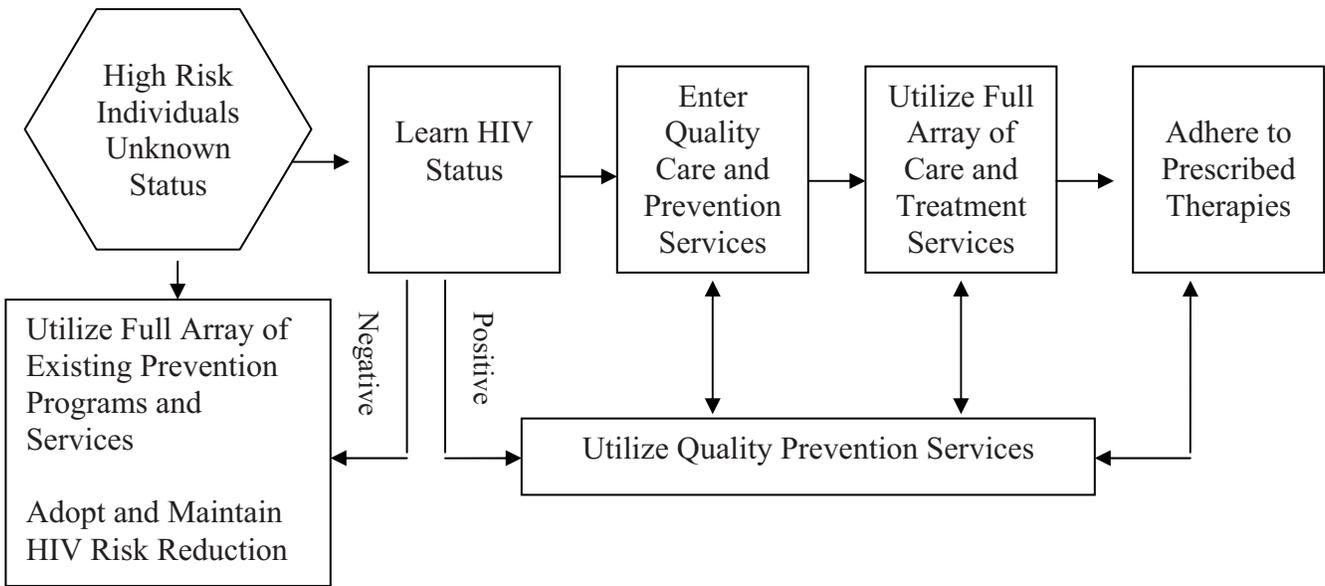
SEROSTATUS APPROACH TO FIGHTING THE HIV EPIDEMIC

The SAFE approach represents a continuum through which high-risk individuals, both positives and negatives, receive optimal prevention and treatment services (Gayle 2000).

SEROSTATUS APPROACH	
<i>HIV prevention activities directed towards HIV-positive individuals and high-risk individuals who are either HIV-negative or do not know their serostatus</i>	
Definition/Description	This strategy directs HIV prevention activities toward HIV-positive individuals and high-risk individuals who are either HIV-negative or do not know their serostatus. The goal is to direct people to appropriate interventions based on their serostatus.
Implementation Recommendations	<p><i>Agencies should:</i></p> <ul style="list-style-type: none"> ▪ Encourage clients to learn their serostatus, using safe, confidential, culturally sensitive referrals to counseling and testing. ▪ Develop linkages and partnerships with agencies that provide care services and prevention for positives. <p><i>For high-risk HIV-negative individuals, agencies should:</i></p> <ul style="list-style-type: none"> ▪ Refer clients to appropriate HIV prevention programs that focus on risk reduction. <p><i>For HIV-positive individuals, agencies should:</i></p> <ul style="list-style-type: none"> ▪ Refer clients to appropriate HIV/AIDS health services. ▪ Refer clients to HIV prevention programs for PLWH that focus on risk reduction. ▪ Refer seronegative partners to appropriate HIV prevention programs.
Strengths	<p><i>The serostatus approach can:</i></p> <ul style="list-style-type: none"> ▪ Reach individuals who do not know their serostatus. People who know they are HIV positive are more likely to take action to protect their partners. ▪ Help prevent opportunistic infections for HIV-positive individuals through referrals to treatment, and thus potentially decrease their ability to transmit HIV. ▪ Address the risks of clients' partners. ▪ Provide much-needed links between prevention and care services.
Limitations	<p><i>The serostatus approach may:</i></p> <ul style="list-style-type: none"> ▪ Not reach high-risk individuals who do not know their serostatus who are members of marginalized or hard-to-access populations. ▪ Be difficult to implement given the segmentation of prevention and care funding.

The following diagram illustrates a continuum through which high-risk HIV-negative individuals and those living with HIV receive optimal prevention and treatment services. In this continuum:

- Individuals determine their HIV status through voluntary HIV testing and counseling as early as possible after infection;
- If they are negative, they utilize the full array of existing prevention interventions and care services to adopt and maintain HIV risk reduction;
- If they are HIV positive, they utilize quality prevention services and work to adopt and sustain lifelong protective behaviors to avoid transmission of the virus to others;
- If they are HIV positive, they enter the care system as soon as possible to garner the benefits of primary care and treatment;
- Once in the care system, they benefit from comprehensive quality services, including mental health and substance abuse services, treatment for HIV infection, opportunistic infections, and other infections such as STDs and TB; and
- In conjunction with their providers and support networks, they work to develop strategies to optimize adherence to prescribed therapies.



GENERAL GUIDELINES

In developing guidelines for programs outlined in this chapter, several themes emerged that cut across all HIV services. For this reason, a set of general recommendations for program design, implementation, and evaluation was developed that applies to all HIV providers.

PROGRAM DESIGN

Defining the Target Population

The more well defined the population the more effective and cost-effective the program. High levels of knowledge and awareness about HIV/AIDS have resulted in interventions that target the general population being less relevant. Behavioral risk, gender, age, sexual orientation, ethnic or cultural identity, HIV serostatus, or a combination of these factors can define target populations. Defining the target population allows providers to better assess the particular prevention or care needs of the group and design more responsive programs.

Needs Assessment

Assessing the needs of the target population or community is the first step in designing a program that addresses the relevant HIV-related issues of that group. One purpose of looking into these needs is to identify the degree of risk for HIV faced by a particular community or target population.

- Do they lack knowledge?
- Do they need behavior modification skills?
- What are the barriers to HIV prevention for this population and how can they be overcome?
- What are the barriers to accessing HIV care services and how can they be overcome?

The knowledge gained from the needs assessment is used to define the program by allowing the provider to define its target group and state the problem in behavioral terms. A description of the current services (or gaps in services) targeting this group can also be included. The target population must be allowed an active role in this assessment.

A needs assessment is important to gauge commitment and timing requirements for its audience, and to measure the feasibility of a proposed intervention within political and contextual constraints. In addition, needs assessments should identify the most effective venues and media for prevention work, the conditions of client participation, the levels of need and interest in the community for different intervention types, and the kinds of cultural/linguistic competence and organizational capacity necessary for an intervention to take hold. Services should be provided in the appropriate language(s) and at the appropriate literacy and developmental levels of the target population. The hours that services are provided need to be flexible to accommodate the needs of the target population.

Needs Assessment Resources

CAPS Fact Sheets: <http://www.caps.ucsf.edu/>
Chapters 4 through 7: Community Services Assessments

Program Planning

Program planning begins with the needs assessment as described above, first to define the problem and then to define the program to address these needs. The actual plan for the program is outlined in its objectives. A program's objectives describe specific activities to be carried out by staff (process objectives) and expected changes that will result because of the intervention (outcome objectives). Objectives always consist of statements identifying who, what, when, where, and how much. Interventions are selected that are reflective of the needs assessment results and are feasible given the resources available. After the intervention is selected, implementation and evaluation plans are developed.

A strong program plan includes the following elements (CDC 1999)

- *A target population that is clearly defined (e.g. behavioral risk population, race, ethnicity, gender, age)*
- *Clearly defined goals and specific objectives*
- *Behavioral theory as its foundation*
- *A focus on reducing specific risk behaviors through practicing skills*
- *A realistic timeline for implementing activities and achieving objectives*

Program Planning and Design Resources

Program Planning: <http://hivinsite.ucsf.edu/InSite>

Diffusion of Effective Behavioral Interventions (DEBI): www.effectiveinterventions.org

Guidance: http://www.cdc.gov/nchstp/YMSMandTransPA/docs/Attachment_2_Procedural.Guidance.pdf

Program Evaluation

Program evaluation determines whether a program is being delivered as planned (process evaluation) and whether the program's objectives are being met (outcome evaluation). Evaluation tells providers whether and how their interventions and programs are working and may also include assessing client satisfaction with services.

The completion of evaluation tasks allows program directors to document successful programs and to identify areas that need to be modified to better serve the target population. Ongoing evaluation processes determine whether the program's objectives are being met and the expected outcomes of the intervention are being fulfilled. For this reason, organized evaluations are critical to the continuation and development of effective programs. Documentation of work, data collection, data analysis, and regular reports are among the tasks that must be built into program structure to demonstrate that a program is meeting its objectives, to assure quality services are being delivered, and to justify continuation. Appropriate staff time and expertise should be allocated to evaluation activities. The integration of evaluation tools into program structure may save a program that is failing to meet its expected outcomes through early diagnosis of problems. When appropriate, evaluations should incorporate client input.

Prevention Data Collection Requirements

In an effort to better document service delivery, all IDPH HIV/AIDS prevention funded agencies are required to collect and submit the data for each intervention used in their program.

Implementation Principles

Prevention messages should be concise, relevant, and appropriate to the target population. It is important that messages address the target audience member in a socio-cultural context with recognition of the whole person and the complex realm of interests, needs, and concerns.

Providers need to keep in mind the intent of prevention interventions: to effect changes in behaviors that put people at risk for HIV.

Prevention messages should raise awareness that HIV does not exist in a vacuum. Providers must use messages that speak to the whole person and her or his complex realm of interests, needs, and concerns, instead of focusing only on HIV. Some issues that can be productively linked when providing HIV prevention and care services are STDs, substance abuse, racism, sexism, homophobia, biphobia, immigration, poverty, homelessness, unemployment, youth issues, domestic violence, pregnancy and contraception, health care, mental health stressors, survival sex, rape, suicide, and access to social services. Designing prevention messages in collaboration with members of the target audience is an effective way to address these kinds of issues with appropriate language and sense of context.

Behavior Change Counseling

Providing information and education is an important step in both HIV prevention and care. All individuals who use HIV services should be offered the opportunity to participate in individualized behavior change counseling, either by a prevention or care provider or through referral. Building skills and creating social norms for adopting healthy behaviors are critical when focusing on behavior change. To effectively promote behavior change, providers need to be aware of and address the behaviors of their target populations. The community needs assessment can inform program planners about where to focus these efforts.

Individual Skills Building

The intent of prevention interventions is to effect changes in behaviors. Case managers work with clients to improve access to services, which may also include behavior change strategies. Providing information and education, building skills, and creating social norms for adopting behaviors are critical when focusing on behavior change. Approaches used should be interactive. For example, activities such as role-plays help individuals develop a sense of self-efficacy in adopting health-promoting behaviors.

Recruitment and Retention

Recruitment and retention of participants in HIV prevention programs and support groups can be challenging. Providing incentives such as food, food vouchers, transportation tokens, or condoms, bleach kits, health kits, and clean works can be useful for some target populations. Attention to recruitment and retention of staff and volunteers is critical for the continuity of programs. This in turn contributes to agency credibility and helps promote community trust.

Risk and Harm Reduction

HIV efforts should aim to reduce people's risk, not necessarily eliminate risk altogether. A harm reduction approach acknowledges that people engage in unhealthy behaviors and seeks to reduce the harm that results from the behavior. Prevention interventions and case management strategies should contain harm reduction options for clients.

HARM REDUCTION	
Definition/Description	This strategy accepts that harmful behavior exists, and the main goal is to reduce the negative effects of the behavior rather than ignore or pass judgment on the person or the behavior. The term "harm reduction" is used most often in the context of drug use, but the approach can be used with sexual risk behavior as well. A harm reduction approach encourages safer drug use or sexual practices among those engaging in high-risk behaviors and acknowledges the social and environmental factors such as poverty and racism that affect drug use and sexual practices.
Implementation Recommendations	<i>A harm reduction approach must:</i> <ul style="list-style-type: none"> ▪ Attempt to reach clients "where they are" to assist them in making choices toward better health. ▪ Be attentive to the health and well-being of the entire person in considering when to use harm reduction options.
Implementation Requirements	<ul style="list-style-type: none"> ▪ A harm reduction approach should be designed for a specific target audience, taking into consideration the population's norms and behaviors.
Strengths	<i>A harm reduction approach can:</i> <ul style="list-style-type: none"> ▪ Be used in an institutional (e.g., drug treatment facility) or community (e.g., outreach) setting. ▪ Encourage safe injection practices or condom use. ▪ Encourage positive risk reduction attitudes. ▪ Provide linkages to drug treatment.
Limitations	<i>A harm reduction approach:</i> <ul style="list-style-type: none"> ▪ Does not eliminate the potential harmful effects of a behavior. ▪ May not be as useful for individuals not ready to change harmful behaviors. ▪ May lead to increased harmful behavior if not implemented well (e.g., a harm reduction message that encourages withdrawal before ejaculation could inadvertently lead to decreased condom use or increased number of sex partners).

Community Involvement and Trust

All HIV programs should strive to stimulate community involvement through cultivation of community trust over time. Staff and volunteers must be nonjudgmental, open, compassionate, trustworthy, dedicated, sensitive, and responsive to community needs. Where appropriate, community members should be invited to participate in the development and implementation of programs.

Multiple Approaches

HIV programs are more likely to reach target populations if a variety of approaches are employed. Therefore, providers need to strive toward implementing a combination of several methods, or to work closely with other programs targeting similar communities, to assure that the multiple needs and issues of the target population are addressed. Providers should use multiple communication methods and design consistent messages that address the issue from more than one perspective.

Cultural Competence

Organizations must adhere to and demonstrate a philosophy of cultural competence and proficiency as characterized by acceptance of and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, and continuous expansion of cultural knowledge and resources. This philosophy should not be limited to communities of color. It is incumbent upon organizations providing HIV services to demonstrate

competency in addressing the diverse needs of the populations they serve in terms of age, gender, substance use, socioeconomic status, sexual orientation, linguistics, and geographic settings.

Linkages and Coordination

HIV prevention and care programs should share the larger goal of creating a coordinated system of referral to other social services. HIV prevention can be just one component of a set of services addressing multiple issues relevant to the community. Coordination of services enables clients to access information, especially about HIV prevention, that they might not otherwise receive. It can also be an excellent way for providers to provide outreach to clients at risk. Social services that can be coordinated with HIV services include substance abuse treatment; immigration services; legal services; general assistance; mental health and primary health care services; shelters for homeless; shelters for battered women and children; rape crisis counseling; child protective services; suicide prevention; job training and placement; youth and runaway services; family planning; STD care and prevention; services for people with physical, emotional, and/or learning disabilities; and hepatitis testing, care and prevention.

ORGANIZATIONAL COMPONENTS

Service Delivery Training

Training is an essential component of any HIV program and should be incorporated into proposals and contracts. Without adequate training, both clients and staff are at risk for misinformation. Training should be available for and provided to volunteers, peer educators, and paid staff. Scheduling constraints should be respected for volunteers and peer educators, who often have to balance their program work with other jobs or with school. Training may include:

- Cultural competency regarding the target population
- Current issues in HIV/AIDS
- Local HIV/AIDS and other health and social services resources
- Referrals
- Curriculums developed for specific interventions
- Capacity building for evaluation

Policies and Procedures

All HIV providers should develop and write a comprehensive policies and procedures manual. Critical policies include a confidentiality policy, a feedback and grievance procedure, and safety policies for staff and volunteers. It is important to encourage continuous input and feedback from clients and volunteers about their perceptions of the agency's sensitivity to its target populations. Formal grievance procedures outlining how complaints or disputes are resolved should also be developed. Other policies and procedures may include step-by-step instructions for how to deliver an intervention, protocols for reporting unusual incidents such as injuries, and workplace rules and regulations.

Volunteers

Volunteers need to be offered training and support opportunities similar to those available to regular staff. The expectations an agency has for its volunteers should be clearly delineated at the outset of the training. Volunteers should be made aware of the rules and regulations applying to all personnel. Volunteers should be well supervised for consistent quality control within the agency.

Issues to consider when taking on volunteers include:

- *Physical safety*
- *Possible health hazards*
- *Incentives in lieu of pay to improve recruitment and retention.*

The needs of volunteers should be considered and met with appropriate services. For example, volunteer safety in street outreach situations should be protected through the use of outreach pairs or teams, or through some other mechanism for supervision. The possible health hazards of the job should be seriously addressed for volunteers.

Incentives should be considered as a possibility for recruitment and retention of volunteers. Prevention events and care services provided to the community at risk can be considered as possible opportunities for volunteer recruitment.

Confidentiality

HIV-related confidential information that is acquired while rendering HIV services must be safeguarded against disclosure. This includes verbal or written disclosure, maintenance of records, or recording of an activity without appropriate releases of consent. Statute and regulations explicitly govern circumstances under which HIV-related information may be disclosed (Iowa Administrative Code, Chapter 141A). Professional ethics or personal commitment to the preservation of trust may impose even stricter confidentiality guidelines than those reflected in the law.

HIV providers should develop and implement methods by which client confidentiality protections and rights are communicated and consent for services is obtained. Such methods should be appropriate to the intervention provided. Different types of interventions present different requirements for how confidentiality should be handled. For instance, during group sessions participants and facilitators can set ground rules that address issues for disclosure of personal information. In all cases, legal requirements must be followed.

Any and all personal information that is disclosed one-on-one to an outreach worker, peer educator, case manager, or other personnel in the context of an intervention or an intake should be kept strictly confidential by the program representative. The general issues that come up in the course of a counseling session or outreach interaction can be documented and discussed with supervisors or other members of an intervention team. They should not be detailed in a way that allows recognition of the particular client by sight or name without prior approval by the client. Peer educators must be trained and prepared for the transition from the usual social interactions with their peers to the bounded relationship required for successful and ethical prevention work.

MINIMUM STANDARDS OF SERVICE

The following standards must be considered when creating a comprehensive HIV/AIDS prevention program.

Minimum Standards of Service

Services are:

- Offered in as safe of an environment as possible.

Interventions:

- Follow the Strategies for Prevention Interventions and Community Endeavors (SPICE) principles as outlined on the following page.

Agencies have:

- A policy and procedure manual. This manual must contain all intervention protocols, policies, and procedures of the services being delivered.
- Current collaborative linkages within the community and should be aware of Iowa's HIV Community Planning Group.
- Staff that are familiar with available community resources.
- Staff that are trained in the implementation of the program interventions. All trainings must be documented in staff folders or personnel files. The agency should promote and encourage continuing educational trainings.
- Grievance procedures in place and a method for informing clients of this process. Proof of client receipt should be documented in client charts.
- Policies on staff safety, both on-site and off-site.
- A relationship with the local authorities, such that the program is well known in the community.
- Regular assessments of client feedback through client surveys.
- Regular management/supervisors meetings with program staff to discuss project and status progress towards stated outcomes.

(SPICE) Principles

In addition to the general recommendations presented, the CPG has identified central principles to be used for all prevention interventions, care services, evaluation, and planning efforts. The SPICE Principles of Successful Prevention and Care Efforts, which summarize these principles and general recommendations, precedes the discussion of behavior theory models.

STRATEGIES FOR PREVENTION INTERVENTIONS, AND COMMUNITY ENDEAVORS (SPICE): PRINCIPLES OF SUCCESSFUL PREVENTION EFFORTS

The Iowa HIV Community Planning Group has identified principles that are central to the successful design and implementation of HIV prevention interventions, care services, evaluation, and planning efforts. These are referred to as the Strategies for Prevention Intervention and Community Endeavors (SPICE). Grantees and applicants for HIV prevention funds must demonstrate how they will address these principles in implementing HIV prevention programs.

The successful project is designed to reach the target population

- ⇒ targets a clearly defined population at risk for or infected with HIV (as defined by the CPG);
- ⇒ addresses a demonstrated need of the target population;
- ⇒ is specific to the target population(s) with regard to gender, age, race and ethnicity, culture, language, sexual orientation and identity, socioeconomic status, and geographic location, and recognizes the diversity within the population;
- ⇒ involves members of the target population(s) in the creation, development, implementation, and evaluation of the project;
- ⇒ is delivered at a site and setting which is acceptable and accessible to the population(s) it intends to reach; and
- ⇒ uses materials that are relevant and appropriate to the target population(s).

The successful project makes sense as an intervention approach

- ⇒ has clearly defined measurable understandable goals and objectives (process evaluation);
- ⇒ utilizes interventions that are clearly understandable;
- ⇒ utilizes interventions that have been shown to be effective and make sense in terms of behavioral or social science theory;
- ⇒ utilizes intervention strategies at appropriate levels -- such as individual, group, community, and capacity-building;
- ⇒ supports the initiation and maintenance of behavior change;
- ⇒ focuses on long-term, incremental changes in behavior and community norms; and
- ⇒ is cost-effective.

The successful project enhances and is integrated with the larger HIV prevention and human service delivery system

- ⇒ is designed to be continuing and sustainable, not solely dependent upon continuation funding;
- ⇒ contains flexibility and capacity for change and employs a variety of approaches;
- ⇒ supports ongoing development of staff and volunteers;
- ⇒ includes collaboration to ensure access to the target population and expertise in delivering HIV prevention services;
- ⇒ develops linkages with services reaching the same target populations to enhance the quality of services and avoid duplication;
- ⇒ enhances the capacity of organizations to integrate HIV services throughout their array of services; and
- ⇒ includes an evaluation component to measure success over time in changing or maintaining behaviors or accessing services (outcome evaluation).

BEHAVIOR THEORY AND HIV PREVENTION

HIV interventions that are based on sound theoretical models are the most effective at affecting behavior change (Fisher & Fisher, 1992; Valdiserri, West, Moore, Darrow & Hinman, 1992). Formal behavior theories help service providers understand the components of behavior and the steps that commonly lead to behavior change. Behavior theory can be used to disentangle the complexities behind the behaviors targeted in HIV prevention programs and can facilitate determining the design and goals of an HIV intervention. Furthermore, using theories can improve the overall quality of interventions and conserve limited resources.

Things to consider when selecting a model or theory:

- Who is my target population?
- What are my objectives for my target population?
- What resources are available? Personnel? Buildings?
- What theory or model best suits the target population? WHY?
- How will the theory or model apply to the intervention? Apply to behavior change?

***Behavior Theory** is a model or framework, developed through multiple observations over time that depicts and predicts how people behave and that shows how the different factors that influence behavior are linked together.*

The health education behavior theories discussed in this chapter include:

- Health Belief Model (Janz and Becker 1984)
- Social Cognitive Theory (Bandura 1977; Bandura 1994)
- Stages of Behavior Change (Prochaska and DiClemente 1983)
- Theory of Reasoned Action (Ajzen and Fishbein 1980)
- Diffusion of Innovations (Rogers 1983)
- Empowerment (Rappaport 1984; De La Cancela, Chin et al. 1998)
- Social Networks and Social Support (Israel 1982)

Resources for intervention planning, designing, implementing and evaluation:

McKenzie, James F. *Planning, Implementing and Evaluating Health Promotion Programs*. Pearson Education: CA. 2005.

www.cdc.gov

http://ctb.ku.edu/tools/en/tools_toc.htm

<http://www.idph.state.ia.us/>

<http://www.tcw.utwente.nl/theorieenoverzicht/Theory%20clusters/>

http://hsc.usf.edu/~kmbrown/TRA_TPB.htm

<http://www.cdc.gov/programs/hiv10.htm>

Health Belief Model

(Petosa and Jackson 1991) suggest that safer sex intentions are influenced by "personal beliefs regarding susceptibility to AIDS, the health consequences of AIDS, and the effectiveness of safer sex practices in reducing susceptibility." According to the Health Belief Model, people have to believe in the benefits of and have the ability to engage in safer behavior. The Health Belief Model calls for providers to increase people's perceptions of their risk, knowledge of the effects of HIV infection, and willingness to protect themselves. Providers should also seek to reduce the barriers to self-protecting behaviors (Becker and Joseph 1988).

The Health Belief Model has four constructs: perceived *susceptibility*, perceived *severity*, perceived *benefits*, and perceived *barriers*. These constructs account for an individual's "readiness to act." Additional concepts are *cues to action*, which stimulates overt behavior, and *self-efficacy*, which is one's confidence in the ability to successfully perform an action.

<i>Components</i>	<i>Hypothetical HIV Example</i>
Perceived Susceptibility: People are motivated to change behavior when they believe that they are susceptible to the disease.	A woman has a low perceived susceptibility because no one in her social circle talks about HIV or to her knowledge has HIV.
Perceived Severity: People are motivated to change behavior when they believe that the disease generally has serious consequences.	She has a high-perceived severity of HIV disease because she reads about HIV-related deaths in the newspaper.
Perceived Benefits: People are motivated to change behavior when they believe that changing the behavior will reduce their risk.	She believes that using condoms will reduce her risk of acquiring HIV.
Perceived Barriers: People are motivated to change behavior when they believe that there are few or no negative consequences (e.g., expensive, dangerous, unpleasant, inconvenient) for changing the behavior.	She is afraid her partner, who has a history of abuse, may accuse her of cheating on him if she asks him to use condoms. Therefore, the benefit of condom use is outweighed by the risk that she may anger her partner.
Cue to Action: A specific stimulus, such as a prevention intervention, is often required to trigger behavior change.	On her way to work every day, she hears an ad on the radio with an HIV prevention message. She also just heard that her uncle died of HIV 10 years ago, when everyone thought he had died of cancer.
Hypothetical Intervention: Engage the woman in individual counseling in which the counselor strives to increase the woman's perception of her own risk and susceptibility. The counselor will refer her to domestic violence services and help her learn and practice condom negotiation skills to help her deal with the perceived barriers.	

Social Cognitive Theory

Bandura's Social Cognitive Theory - also known as Social Learning Theory - emphasizes a reciprocal interaction of behavioral, social, and physical factors. Social Cognitive Theory maintains that a change in any one of these three factors influences the others. The two primary forces that affect change in these three factors are what Bandura calls “expectancies” and “incentives.” To support behavior change a prevention provider would emphasize change among one or more of the factors. This theory is implemented to emphasize the role of reinforcement in shaping behavior.

<i>Components</i>	<i>Hypothetical HIV Example</i>
Environment: Factors external to the person may influence behavior.	Two homophobic brothers kicked a gay man out of his house when they learned that he was gay. He moves into a single room occupancy hotel in Coralville. He has no health insurance.
Situation: A person's perception of their environment influences behavior.	He feels that he has no control over his situation – it is the result of how his family has treated him. He sees his peers engaging in commercial sex work for survival and thinks this is his only option.
Behavioral Capability: A person's knowledge and skills to perform a behavior influence whether a person engages in a behavior.	He knows how to use condoms but is not very skilled at talking to his partners/clients about using them.
Outcome Expectations/Expectancies: A person expects certain results from engaging in a particular behavior and places a certain value on the results, and these factors affect their behavior.	He expects that using condoms will prevent him from getting HIV, and this is a highly desirable outcome for him.
Self-efficacy: A person's confidence in performing the behavior affects whether they will engage in the behavior.	He is not very confident that he can get a partner/client to use a condom.
Observational Learning: A person acquires new behaviors from watching the actions of others and observing the results.	Because sex is usually a private act, he does not get to observe how other people negotiate condom use.
Reciprocal Determinism: The interaction of the person, the behavior, and the environment in which the behavior is performed affects a person's behavior.	All the above factors combined affect the man's ability to reduce his risk for HIV. If one of the factors changes, it may result in changes in the other factors.
Hypothetical Intervention: Start a multiple session workshop at a community center in Coralville and enroll the man. The group works on changing their perceptions of the environment and increasing self-efficacy to use condoms in survival sex situations. They will also spend a lot of time on role-playing how to negotiate condom use in different situations. The group leader or someone at the agency will also refer the man to prevention case management for a referral to housing services.	

Stages of Behavior Change Model (Transtheoretical Model)

Stages of Behavior Change Model considers the dynamic aspects of human behavior and suggests that different people may be at different stages with respect to changing any particular behavior (Prochaska and DiClemente 1983). This differentiation is the primary value of the model because service providers and researchers can assess where an individual or group is in relation to making a behavior change and then target an intervention accordingly to move people from one stage to the next. This model proposes that behavior changes occur according to a process of successive stages.

<i>Components</i>	<i>Hypothetical HIV Example</i>
Precontemplation: A person has no intention of changing a behavior within the near future.	An injection drug user shares needles with her friends and has no plans to stop sharing.
Contemplation: A person intends to change a behavior within the near future.	A few months later, she has thought about not sharing needles with her friends because she just heard about someone who got HIV that way.
Preparation: A person has begun to take a few steps toward changing a behavior.	A few months later, she starts to ask around about how to access clean needles in her community.
Action: A person has made changes in a behavior.	She starts going to her local pharmacy to purchase needles regularly and stops sharing needles with friends.
Maintenance: A person is able to continue the new behavior for an extended period of time.	She hasn't shared needles for 8 months.
Pros and Cons: For people to move from one stage to the next, either the pros of changing the behavior must increase and/or the cons of changing the behavior must decrease.	Her case manager helped to move her along the stages of change by talking with her regularly about the pros and cons of sharing needles.
Hypothetical Intervention: A prevention case manager assesses the woman on intake and finds that she is in the contemplation stage and is thinking about not sharing needles anymore. The case manager works with her to move her toward preparation, action, and finally maintenance by emphasizing the pros of changing the behavior. For example, HIV is highly transmissible via shared needles, so eliminating sharing will reduce her risk greatly. The case manager also works on reducing the cons (e.g., her perception is that it is impossible to find clean needles). The case manager points out that the pharmacy right around the corner is participating in a needle access program. She also teaches her how to clean needles properly and watches her practice this skill. During the maintenance phase, the case manager uses relapse prevention techniques.	

Theory of Reasoned Action

Theory of Reasoned Action focuses on the translation of beliefs about a behavior and perceptions regarding threat to self into behavior change (Ajzen and Fishbein 1980; Abraham 1994). While other behavior theories target the individual, components of the Theory of Reasoned Action incorporate the social and interactional aspects of human behavior. This is particularly useful for intervening with sexual behavior that is inherently social in nature (de Wit, Teunis et al. 1994).

The Theory of Reasoned Action emphasizes attitudes, subjective norms, and intentions. Attitudes are individually determined and reflect beliefs about consequences associated with performing a behavior and evaluations of these consequences. Subjective norms are socially influenced, typically by peers' and role models' perceptions of what one should do with regard to a specific behavior (Jemmott and Jemmott 1991). Intentions to change a particular behavior are influenced by one's personal attitude and the subjective norm toward that behavior. Behavior, according to the Theory of Reasoned Action, is ultimately a result of intentions.

<i>Components</i>	<i>Hypothetical HIV Example</i>
Behavioral Intention: Whether a person intends to perform a behavior is the most important predictor of actual behavior.	Many adolescents in Sioux City do not intend to use condoms with their partners.
Attitude: A person's beliefs and values about the behavior determine his or her attitude about the behavior, and attitude affects behavioral intention.	They don't believe that using condoms will completely prevent them from acquiring or transmitting HIV or other STD's, but they place a high value on this result.
Subjective Norm: A person's perception of whether important individuals (e.g., peers) approve or disapprove of the behavior and whether he or she is motivated to act according to those people's opinions determine his or her subjective norm, and this norm affects behavioral intention.	They think that other people their age don't generally view condom use in a positive light, and so they are hesitant to discuss condoms with their partners.
Hypothetical Intervention: In a group outreach theater intervention, the youth actors play out a scene in which they talk about the effectiveness of condoms (to change attitudes) and emphasize that condoms can be a fun part of sex (to change subjective norms). They hand out colored condoms at the end of the skit.	

Diffusion of Innovation Theory

Diffusion theory has been applied to effect widespread change for myriad social problems. Diffusion refers to the process through which any new idea - an innovation - is communicated to the members of a group or population (Rogers 1983). The four primary components of Diffusion of Innovation Theory are: 1) the innovation: an idea, practice, or commodity which the target group perceives as new; 2) communication channels for dispersing the innovation message; 3) the time or process required for the innovation to reach group members; and 4) the presence of a social network or system that links the members of the target group (Dearing, Meyer et al. 1994; Dearing, Rogers et al. 1996).

<i>Components</i>	<i>Hypothetical HIV Example</i>
Diffusion: The process by which an innovation is communicated through certain channels over time among the members of a social system.	Gay community leaders in Cedar Rapids introduce an idea or a practice that is then spread throughout the gay community.
Innovation: An idea, practice, or object that is perceived as new by an individual or other unit of adoption.	An agency wants to promote a practice among gay men of 100% condom use among HIV-negative receptive partners and HIV-positive insertive partners to reduce HIV transmission via anal sex.
Innovators, early adopters, early majority adopters, late majority adopters, and laggards: The five categories of "adopters" according to how long it takes them to accept a new idea or implement a new behavior.	Some HIV-negative bottoms and HIV-positive tops already do this (the innovators) but most use condoms only some of the time (the early adopters, early and late majority adopters, and laggards).
Factors that influence the speed and extent of diffusion: Whether the innovation is better than the behavior or condition it will replace; whether it fits with the target audience's existing values, experiences, and needs; and how much commitment it takes to adopt the innovation.	This practice may not be accepted easily because many men may prefer not to use condoms with some partners, especially if they believe they have the same serostatus as their partner; therefore, the practice is not an improvement on what they are already doing. On the other hand, it may be adopted more quickly, for example, among HIV-positive gay men for whom protecting their partner is highly valued.
Hypothetical Intervention: Using natural opinion leaders, an agency designs a program targeted to the early and late majority adopters, focusing on their motivations for changing behavior (e.g., staying HIV-negative or preventing HIV transmission to another). Opinion leaders talk to gay men (both HIV-negative and HIV-positive) in bars and community settings to promote the practice of 100% condom use and discuss its effectiveness in preventing HIV transmission. The agency maintains this program for two to three years, because changing community norms takes a long time. The agency also uses other strategies to get the message out (e.g., media campaign, street theater).	

Empowerment Education Theory

Empowering Theory is based on Paulo Freire’s ideas of Popular Education. According to Freire, bringing groups of people together to discuss problems and jointly propose solutions can engender a sense of empowerment on the individual, community, and population levels (Wallerstein and Bernstein 1988). Given that research has documented the link between a person’s lack of sense of control over their own circumstances and illness, Empowerment Theory seeks to promote health by enhancing people’s feelings of power and sense of control (Wallerstein and Bernstein 1988; Bernstein, Wallerstein et al. 1994; Wallerstein and Bernstein 1994).

<i>Components</i>	<i>Hypothetical HIV Example</i>
Popular Education: Interventions based on this theory use a “problem-posing” and participatory methodology of education with a group of individuals from the target community.	A recent needs assessment in Des Moines revealed the presence of high-risk sexual behaviors, such as low rates of condom use with non-primary partners, in the Latino community.
Dialogue: In the dialogue process, everyone participates as “co-learners.” People discuss and share their experiences in a group.	An agency familiar with the community facilitates a group discussion about HIV/AIDS and HIV prevention, taking into account what they already know about the community’s issues and norms. Individuals in the group discuss the specific HIV-related issues they face and learn from each other’s experiences.
Critical Consciousness: Dialogue eventually leads to a process of critical reflection in which people begin to see and understand the social context for their personal problems.	The agency plans regular meetings of the group to continue dialogue about the specific factors that affect the risk behavior in the community. As they talk about events and issues in their personal lives, the facilitator helps them see common themes that contribute to HIV risk in their community, such as poverty and lack of access to health and social services.
Praxis: The ultimate goal is praxis, which is the continual interplay of discussion, critical thinking, problem solving, and action to promote individual and community change.	Over time, both the individuals and the group begin to develop a sense of power and control over their own lives. Based on group discussions, the agency develops a community outreach intervention. Some of the group members decide to train to become outreach workers. Other members of the group, as a result of the personal sense of empowerment they feel begin to be involved in their community in new ways, with the goal of promoting social change.
Hypothetical Intervention: A long-standing agency that knows the norms and values of this community decides to develop a program to decrease risk behaviors and address the behaviors in their social context. The agency convenes a group to outline the problems to discuss and address the issues in a participatory process.	

Social Networks And Social Support

Social networks and social support theories are based on the concept that social ties improve health and well being (Minkler 1982; Minkler, Satariano et al. 1983; Minkler 1984; Minkler 1985; Minkler, Blackwell et al. 2003). Social networks and social support meet basic human needs for companionship, intimacy, a sense of belonging, and reassurance of worth as a person. Social ties have been linked to better health and decreased involvement in HIV risk behaviors (Muhlenkamp and Nelson 1981; Brown, Muhlenkamp et al. 1983; Hubbard, Muhlenkamp et al. 1984; Muhlenkamp, Brown et al. 1985; Muhlenkamp and Joyner 1986; Muhlenkamp and Sayles 1986; Muhlenkamp and Broerman 1988; Yarcheski and Mahon 1989). These functions include providing a sense of belonging, opportunities for nurturance, reassurance of worth, assistance with acquiring needed goods or services, guidance and advice in uncertain or adverse circumstances, and access to new and diverse information.

<i>Components</i>	<i>Hypothetical HIV Example</i>
Social Networks: “Social networks” refers to the density, complexity, size, and other characteristics of a social group, and they are related to health and well being.	In Des Moines, an adult female alcoholic’s social and family networks are unsupportive of her abstinence from drinking, which has been associated with unsafe sexual behavior in her past. She lives with her husband and her sisters, all of whom drink regularly. Her social life revolves around going to bars with her friends. She does not receive strong social support from her family and peers. Her husband is emotionally abusive, and her friends do not support her in her attempts to quit drinking.
Social Support: “Social support” refers to the positive emotional and practical products that people derive from their social networks, and it is related to health and well-being.	
Peer Support: “Peer support” refers to the social support received from peers (people with whom a person identifies because of similar age, race/ethnicity, culture, or other aspects of identity), and it is related to health and well being.	
Hypothetical Intervention: A caseworker conducts an assessment with her client and they agree that her social networks and overall social environment are unhealthy. The caseworker refers her to a multiple session group workshop for female substance users focusing on HIV risk reduction. After going to the workshop, the client decides to participate in Alcoholics Anonymous (AA) to develop, promote, and increase her social networks that are supportive for healthy behavior. AA and the workshop provide her with a sense of belonging, opportunities for nurturance, reassurance of worth, guidance and advice in uncertain and adverse circumstances, and access to new and diverse information. In addition to emotional support and encouragement, the caseworker helps her get access to health care and other practical needs.	

Section 2 - Interventions, Cost Effectiveness, Barriers

Advancing HIV Prevention

Spectrum of Disease

Counseling Testing Referral & Partner Counseling and Referral Services

Counseling, Testing, Referral

Partner Counseling & Referral

Sexually Transmitted Disease (STD)

Hepatitis

Health Education and Risk Reduction

Individual Level Intervention

Prevention Case Management

Group Level Intervention

Outreach

Health Communication/Public Information

Media

Hotlines/Clearinghouses

Presentations/Lectures

Community Level Interventions

Community Organizing

Social Marketing

Public Events

Cost Effectiveness

Barriers to Prevention

ADVANCING HIV PREVENTION

The initiative, Advancing HIV Prevention: New Strategies for a Changing Epidemic, is aimed at reducing barriers to early diagnosis of HIV infection and increasing access to quality medical care, treatment, and ongoing prevention services. It emphasizes the use of proven public health approaches to reducing the incidence and spread of disease. Public health principles commonly applied to prevent disease and its spread are used, including appropriate routine screening, identification of new cases, partner notification, and increased availability of sustained treatment and prevention services for those infected.

The initiative consists of four key strategies:

Make HIV testing a routine part of medical care to ensure that all health-care providers include HIV testing, when indicated, as part of routine medical care on the same voluntary basis as other diagnostic and screening tests. This includes offering HIV testing to all patients in all high HIV-prevalence clinical settings and to those with risks for HIV in low HIV-prevalence clinical settings. Because prevention counseling, although recommended for all persons at risk for HIV, should not be a barrier to testing, CDC promotes adoption of simplified HIV-testing procedures in medical settings that do not require prevention counseling before testing.

Implement new models for diagnosing HIV infections outside medical settings. This includes using OraQuick[®] to increase access to early diagnosis and referral for treatment and prevention services in high-HIV prevalence settings, including correctional facilities and an increased emphasis on Partner Counseling and Referral Services (PCRS).

Prevent new infections by working with persons diagnosed with HIV and their partners. Although many persons with HIV modify their behavior to reduce their risk for transmitting HIV after learning they are infected, some persons might require ongoing prevention services to change their risk behavior or to maintain the change. CDC has disseminated guidelines to primary care providers and infectious disease specialists to assess their integration into medical practice. This also includes reaching persons in whom HIV infection has been diagnosed but who are not in ongoing medical or preventive care, emphasizing partner notification, offering rapid HIV testing to partners, and using peers to conduct partner prevention counseling and referral.

Further decrease perinatal HIV transmission through routine HIV testing of all pregnant women, and routine screening of any infant whose mother was not screened. This includes using rapid tests during labor and delivery, or post partum if the mother was not screened prenatally.

Additional Information:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5215a1.htm>

SPECTRUM OF INTERVENTION TYPES

An intervention is an organized activity designed to influence knowledge, attitudes, beliefs or behavior related to the prevention of HIV/AIDS. Interventions can vary widely in scope from a single educational material, such as a national mailing on AIDS information, to multifaceted comprehensive programs, such as client-centered counseling and testing activities. Spectrum of Prevention, developed by Cohen in 1993, provides a model for implementing HIV programs (Cohen and Taylor, 1991; Cohen and Swift, 1999).

Spectrum of Prevention

Level of Spectrum	Definition of Level	Example – HIV Testing
1 The Individual	Strengthening individual knowledge, skills, and ability to initiate and maintain behavior change	<i>Provide HIV counseling, testing and referral using standard or rapid testing</i>
2 The Community	Promoting community education, skills building, and behavior change through reaching groups of people with HIV prevention messages and resources to promote health and wellness	<i>Conduct a social marketing campaign to promote HIV counseling, testing, and referral among high-risk groups</i>
3 Provider Training	Educating providers to transmit skills and knowledge at Levels 1 & 2	<i>Providing training for HIV test counselors</i>
4 The Community of HIV Prevention Providers	Bringing together HIV prevention providers and their partners to reach broader goals and have a greater impact	<i>Establish a standard protocol for HIV prevention programs to link their clients to HIV counseling, testing, and referral services</i>
5 Structural Barriers	Changing organizational and systems-level practices to meet the multiple needs of people living with HIV or at risk for HIV (e.g. substance abuse, mental health)	<i>Develop strategies to increase available mental health and substance use treatment resources to which people can be linked after receiving an HIV test</i>
6 Policy and Legislation	Developing strategies to change laws and policies to influence outcomes of HIV prevention efforts	<i>Develop strategies to ensure that state and federal policies require that counseling and referral always accompany HIV testing</i>

INTERVENTION CATEGORIES

The following descriptions of intervention categories assist in making meaningful distinctions and choices among possible interventions.

Counseling, Testing, Referral

Partner Counseling and Referral Services (CTR/PCRS)

Counseling, testing, referral and partner counseling and referral systems assume that individuals will be encouraged to determine their serostatus through voluntary client-centered counseling and HIV testing.

HIV Counseling and Testing is a client-centered process whereby an individual is provided basic information about HIV/AIDS. Counseling is tailored to the behavior, circumstances, and special needs of a person. The client is given information about testing procedures and how to prevent the transmission and acquisition of HIV infection, and how to adapt this information to their life. The focus is on personal risk assessment, development of a personalized action plan and the decision to test.

Referral is the process by which individuals with high risk behaviors and those infected with HIV are guided toward prevention, psychosocial, and medical resources needed to meet their primary and secondary HIV prevention needs. Referral subcategories differentiate between various approaches to referral: (1) sites for referral systems, (2) referral systems linked to outreach programs, and (3) referrals for three important HIV prevention services - early intervention, drug treatment, and perinatal treatment.

Partner Counseling and Referral Services are a systematic approach for notifying sex and needle-sharing partners of HIV infected persons of their possible exposure to HIV.

The taxonomy describes not only physical settings where testing occurs, but also differentiates between enhanced/repeated post-test counseling and enhanced efforts to reduce post-test returning to high risk behaviors. These two categories emphasize the difficulties many programs have encountered with drop-out. Subcategories under Partner Counseling and Referral differentiate between the source of the referral (provider and patient) and the type of strategy to provide partners with information about their potential risk of infection.

Sexually Transmitted Disease Diagnosis and treatment refers to any intervention in which an individual receives testing or treatment for STDs, including chlamydia, gonorrhea, syphilis, hepatitis, and herpes.

Hepatitis infections and HIV are getting attention as research is conducted on hepatitis and its impact on HIV. Depending on the hepatitis virus, the organisms can be transmitted in similar fashions and many of the same risk populations are involved.

Health Education/Risk Reduction (HE/RR)

HE/RR is a broad category used to describe organized efforts to reach persons at increased risk of becoming HIV infected or, if already infected, of transmitting the virus to others. This category focuses on activities ranging from individual case management to broad community-based interventions.

Individual-Level Intervention is health education and risk-reduction counseling provided to one individual at a time. Counselors assist clients in making plans for individual behavior change and ongoing appraisals of their behavior.

Comprehensive Risk Counseling and Services is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems, and risk-reduction needs.

Group-Level Intervention shifts the delivery of service from the individual to groups of varying sizes. Group-level counseling uses peer and non-peer models involving a wide range of skills, information, and support.

Institution-based programs are defined by their locus of intervention (school, workplace, etc.). They can be further distinguished by their leadership model (peer vs. non-peer) or by their content. They may be a comprehensive health education program or a separate HIV education program. They may or may not include condom distribution.

Outreach Programs are defined by their locus of activity and by the content of their offerings. Both have important sub-categories of peer and non-peer models.

Health Communication and Public Information

Health Communications and Public Information is the delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services.

Electronic Media uses radio and television to communicate with large groups of people. It includes public service announcements, news broadcasts, and infomercials, which reach a large-scale audience.

Print Media refers to the use of print as well as magazines, newspapers, pamphlets, posters, and environmental media such as billboards and transportation signage. Reaches a large-scale or nationwide audience.

Hotlines/Clearinghouses are interactive electronic outreach systems using telephone, mail, and the internet to provide a responsive information service to the general public as well as high-risk populations.

Internet and computer-based HIV prevention strategies include listserves, chat rooms, electronic bulletin boards, informational web sites with links to resources, and computerized surveys and assessments.

Presentations and Lectures are one-time information only activities conducted in group settings. They are often called “one-shot” education interventions.

Speakers Bureaus bring together individuals who have been impacted by the HIV epidemic to speak to groups of people, communities, or organizations.

Community-Level Interventions

Community-level interventions are a distinct class of programs characterized by their scope and objectives. To be classified community level, it has to be clear that the program is designed to reach a defined community (may be geographic or an identified subgroup) with the intention of

altering social norms in that community as a way to influence high risk behavior. A community-level intervention may include aspects of other categories (e.g., peers, media, or counseling) but the combination must be aimed explicitly at community norms to be classified as a community-level intervention. Examples of CLI include community mobilizations, social marketing campaigns, community-wide events, policy interventions, and structural interventions.

Community Organizing is a strategy that involves grassroots outreach and education that takes place within a specified neighborhood or community. Community mobilization can take many forms, ranging from volunteer recruitment to solicitation of participation in public events, to assistance with attaining specific policy ends.

Social Marketing uses techniques adapted from commercial marketing to identify specific audiences called segments, identify their perceived needs, and then construct a program of services, support and communication to meet those perceived needs. Sometimes specific products such as condoms and condom access are identified as a need, other times the need may be for negotiation skills, social support for delaying sexual initiation, etc.

Public Events include community theater, dramatizations of real-life scenarios, "bar zaps," and interactive performance art.

Policy Interventions includes activities that are designed to reduce or eliminate barriers to HIV prevention. It may include working to change policies that may encourage high-risk patterns and behaviors. Examples include drug paraphernalia laws, policies that limit the distribution of condoms to minors, and laws that prohibit over-the-counter syringe sales.

Structural Interventions include passing laws that promote safer behavior. For example, eliminating paraphernalia laws, legalizing gay marriages.

COUNSELING, TESTING, REFERRAL and PARTNER COUNSELING AND REFERRAL SERVICES

COUNSELING, TESTING, REFERRAL (CTR)

CTR refers to voluntary HIV/AIDS counseling, referral and partner counseling and referral when accompanied by testing to inform individuals of their serostatus. Knowledge of serostatus has been correlated with an individual's willingness to change high-risk behavior, and therefore this category has received significant attention in both programming and research.

The primary goals of HIV CTR are:

- To ensure that HIV-infected persons and persons at risk for HIV:
 - have access to HIV testing to promote early knowledge of their HIV status;
 - receive high-quality HIV prevention counseling, reducing their risk for transmitting, or acquiring HIV; and
 - have access to appropriate medical, preventive, and psychosocial support services.
- To promote early knowledge of HIV status through HIV testing and ensure that all persons either recommended or receiving HIV testing are provided information regarding transmission, prevention, and the meaning of HIV test results.

To reach these goals CTR prevention providers must encourage persons to seek testing, either by educating persons at risk about the benefits of testing or by developing a campaign to decrease the stigma associated with HIV testing.

Providers need to assure HIV testing is readily available to at-risk populations. Strategies include utilizing rapid HIV tests and offering outreach testing by community based organizations, offering routine voluntary testing in high prevalence medical settings, such as emergency rooms and offering testing in correctional facilities (Gayle 2000; Janssen, Holtgrave et al. 2001).

Client-Centered HIV Prevention Counseling

Since 1993, CDC has recommended an interactive counseling model, called client-centered HIV prevention counseling, which involves face-to-face sessions with a provider or counselor. This model has traditionally used a two-step HIV testing approach in which clients are physically present at a setting for the HIV test (initial session) and then return for HIV test results (follow-up session). Each session might require 15-20 minutes (including testing and referral) for clients at increased risk for HIV, but could take only a few minutes for those at lower risk.

In the first session, a personalized risk assessment encourages clients to identify, understand, and acknowledge the behaviors and circumstances that put them at increased risk for acquiring HIV. The session explores previous attempts to reduce risk and identifies successes and challenges in these efforts. This in-depth exploration of risk allows the counselor to help the client consider ways to reduce personal risk and commit to a single, explicit step to do so. In the second session, when HIV test results are provided, the counselor discusses the test results, asks the client to describe the risk-reduction step attempted (and acknowledges positive steps made), helps the

client identify and commit to additional behavioral steps, and provides appropriate referrals (e.g., to PCRS).

Observational studies and reviews of programs in various settings have indicated that many counselors are still unfamiliar with the specific goals of the client-centered HIV prevention-counseling model. Because "client-centered" is sometimes misinterpreted as "face-to-face," providers in many HIV test sites deliver face-to-face informational messages in response to a generic checklist risk assessment. This type of counseling provides advice rather than encouraging client participation or discussion of personal risk; it seldom focuses on personal goal setting. "Client-centered" can also be misinterpreted to mean that the counselor should avoid directing the session. Although attentive listening and respect for clients' concerns are important elements of effective counseling, the primary goal of client-centered HIV prevention counseling is risk reduction. HIV prevention counseling usually requires provider training and support and ongoing quality assurance to achieve optimal benefit.

Continuum of Services

A successful CTR program provides an accessible continuum of services through which high-risk individuals, both positives and negatives, receive optimal prevention and treatment services as outlined below (Gayle 2000; Janssen, Holtgrave et al. 2001).

Population	HIV Prevention Services
Unaware of Serostatus	<ul style="list-style-type: none"> ➤ Provide current essential HIV-related information ➤ Encourage HIV CTR (via outreach, media and community-level interventions) ➤ Reduce stigma of HIV disease and services
Recently tested HIV negative No apparent behavioral risk	<ul style="list-style-type: none"> ➤ Equip to be carrier of HIV prevention messages to family, friends, children, partners
Recently test HIV negative Behavioral risk of infection	<ul style="list-style-type: none"> ➤ Intensive individual or small group counseling ➤ Community-level interventions ➤ Linkages to STD, substance abuse, mental health, hepatitis, and social services as needed ➤ Prevention case management ➤ Structural interventions (e.g. sterile syringe access)
Tested HIV Positive	<ul style="list-style-type: none"> ➤ Intensive prevention services ➤ Partner counseling and referral services ➤ Linkages to care, treatment, STD, substance abuse, mental health, hepatitis and social services as needed ➤ Prevention case management ➤ Structural interventions (e.g. avoid discrimination)

COUNSELING, TESTING, REFERRAL (CTR) <i>HIV/AIDS counseling and referral when accompanied by testing</i>	
Definition/Description	Counseling and testing is a series of personalized, client-centered encounters in which an individual can learn her/his serostatus as well as obtain tools to assess her/his own risk. CTR may include helping clients initiate and sustain behavior changes that decrease risk for HIV and giving referrals and information relevant to clients' needs.
Minimum Standards	<p><i>The CTR counselor:</i></p> <ul style="list-style-type: none"> ▪ Helps clients identify their risk(s) for acquiring or transmitting HIV and learn their HIV serostatus. ▪ Negotiates a realistic HIV risk-reduction plan with the client. ▪ Prepares a client to receive, understand, and manage the test result. ▪ Makes referral for additional medical and social services. ▪ Offers STD screening and treatment services. ▪ Offers PCRS. ▪ Must be in compliance with IDPH HIV/AIDS/Hepatitis program policies, guidelines, protocols, and performance standards.
Implementation Recommendations	<ul style="list-style-type: none"> ▪ Factors to consider for targeting CTR include timing, venue, staff representation of the community, accessibility of site, mobility of CTR.
Quality Assurance Measures	<ul style="list-style-type: none"> ▪ Staff must have been trained in Fundamentals of HIV Prevention Counseling through IDPH and have appropriate documentation on file with the employer.
Strengths	<p><i>In Iowa, CTR is:</i></p> <ul style="list-style-type: none"> ▪ Universally applicable for all populations, although different groups may be reached through different testing venues. ▪ Inclusive when a provider offers confidential, appointment-based, and drop-in services. ▪ Provided by both HIV/AIDS prevention providers and primary care facilities. ▪ Mobile, and thus can reach large numbers of people. ▪ Confidential, which expands the possibilities for follow-up and case management. ▪ A method of HIV prevention. ▪ Effective for targeting clients with low perception of risk in the venues they frequent. The use of new testing technologies makes this more attractive to clients. <i>Orasure</i> (a test of the oral mucosal transudate) and <i>urine testing</i> require no blood or needles. ▪ A means to enhance HIV prevention services for clients. Rapid tests allow the delivery of test results and counseling on the same day of testing.
Limitations	<ul style="list-style-type: none"> ▪ CTR requires referral to additional risk reduction services to maximize its effectiveness. ▪ CTR may have fewer benefits for people in an early stage of recovery from substance abuse (although CTR can become part of the recovery process). ▪ CTR may not be appropriate for communities in which there is stigma attached to HIV if offered at an HIV/AIDS service organization. ▪ CTR may have fewer benefits for people in a situation of total isolation and who lack social support. ▪ Confidentiality issues may exist in a rural environment.

Counseling and testing programs may describe not only physical settings where testing occurs, but may also differentiate between repeated post-test counseling and enhanced efforts to reduce post-test returning to high risk behaviors. These two categories emphasize the difficulties many programs have encountered with dropout. Possible sites for counseling and testing services include counseling, testing, and referral locations, local health departments, community-based organizations, substance abuse treatment centers, sexually transmitted disease clinics, family planning clinics, outreach sites, and public sex environments. Agencies are encouraged to

develop a collaborative relationship with agencies that serve individuals engaging in high risk behavior for HIV infection.

Counseling can help clients develop personal methods for behavior change that decrease risk for HIV and help in maintaining a low risk status. Clients can also receive referrals and information relevant to their needs as well as assistance in notifying partners. Prevention providers report that counseling and testing services can motivate individuals to recognize their risk, ask questions about safer sex in a safe environment, and formulate personal risk reduction plans. Counseling and testing programs allow prevention providers to identify new target populations.

Risk Assessment

Risk assessment counseling consists of a meeting between a client and a trained HIV prevention counselor. It includes the assessment of a person's risk for referral purposes and to determine appropriateness of testing. Information is provided to the client based on individual needs. Counseling and testing services are confidential. The client is guaranteed that identity and locating information will not be accessible to anyone outside of the clinic or testing site.

The **objectives** of HIV prevention counseling sessions are to

- assess actual and self-perceived HIV/STD risk
- help the participant recognize barriers to risk reduction
- negotiate an acceptable and achievable risk reduction plan to support patient-initiated behavior change.

A client's individual HIV risk can be determined through risk screening based on self-reported behavioral risk and clinical signs or symptoms. Behavioral risks include injection-drug use or unprotected intercourse with a person at increased risk for HIV. Clinical signs and symptoms include STDs, which indicate increased risk for HIV infection, or other signs or symptoms (e.g., of acute retroviral or opportunistic infections), which might suggest the presence of HIV infection. Insufficient data exist to support the efficacy of any one risk-screening approach over others (e.g., face-to-face discussion or interviews, self-administered questionnaires, computer-assisted interviews, or simple open-ended questions asked by providers)

Post-test Result Disclosure Session

Post-test disclosure sessions focus on giving clients their HIV test result. They include provision of risk reduction counseling and referrals, and assistance with accessing medical or other care. Primary purposes of post-test counseling are reinforcing a realistic perception of risk; helping those with a negative result initiate and sustain behavior change; arranging access to necessary medical, prevention, and case management services for people with positive test results; and supporting HIV positive clients in referring sexual or needle sharing partners for testing.

Referrals

Referrals provide individuals with resources appropriate to their particular needs at that time. Clients should be referred to services that are responsive to their priority needs and appropriate to their culture, language, sex, sexual orientation, age, and developmental level. Examples of these services include:

- **Comprehensive Risk Counseling and Services.** Clients with multiple and complex needs that affect their ability to adopt and sustain behaviors to reduce their risk for transmitting or acquiring HIV should receive or be referred for comprehensive risk counseling and services,

including ongoing prevention counseling. Comprehensive risk counseling and services can help coordinate diverse referral and follow-up concerns.

- **Medical evaluation, care, and treatment.** HIV-infected clients should receive or be referred to medical services that address their HIV infection (including evaluation of immune system function and screening, treatment, and prevention of opportunistic infections). Screening and prophylaxis for opportunistic infections and related HIV-conditions (e.g., cervical cancer) are important for HIV-infected persons. In addition, co-infection with HIV and communicable diseases (e.g., TB, STDs, and hepatitis) can, if untreated, pose a risk to susceptible community members. Providers must be familiar with appropriate screening tests (e.g., TB), vaccines (e.g., hepatitis A and B), STD and prophylactic TB treatment, and clinical evaluation for active TB disease to ensure that these communicable diseases are identified early and appropriate clinical referrals are made.
- **Partner counseling and referral services.** Persons with HIV-positive test results should receive or be referred to services to help them notify their sex or injection-drug-equipment--sharing partners or spouses regarding their exposure to HIV and how to access CTR.
- **Reproductive health services.** Female clients who are pregnant or of childbearing age should receive or be referred to reproductive health services. HIV-infected pregnant women should be referred to providers who can provide prevention counseling and education, initiate medical therapy to prevent perinatal transmission, and provide appropriate care based on established treatment guidelines.
- **Drug or alcohol prevention and treatment.** Clients who abuse drugs or alcohol should receive or be referred to substance or alcohol abuse prevention and treatment services.
- **Mental health services.** Clients who have mental illness, developmental disability, or difficulty coping with HIV diagnosis or HIV-related conditions should receive or be referred to appropriate mental health services.
- **Legal services.** Clients who test positive should be referred to legal services as soon as possible after learning their test result for counseling on how to prevent discrimination in employment, housing, and public accommodation.
- **STD screening and care.** Clients who are HIV-infected or at increased risk for HIV are at risk for other STDs and should receive or be referred for STD screening and treatment.
- **Screening and treatment for viral hepatitis.** Many clients who are HIV-infected or at increased risk for HIV are at increased risk for acquiring viral hepatitis (A, B, and C). Men who have sex with men and IDUs should be vaccinated for hepatitis A. All clients without a history of hepatitis B infection or vaccination should be tested for hepatitis B, and if not infected, should receive or be referred for hepatitis B vaccination. In addition, clients who inject drugs should be routinely recommended for hepatitis C testing. All clients who are infected with hepatitis viruses should be referred for appropriate treatment.
- **Other services.** Clients might have multiple needs that can be addressed through other HIV prevention and support services (e.g., assistance with housing, food, employment, transportation, childcare, domestic violence, and legal services). Addressing these needs can help clients access and accept medical services and adopt and maintain behaviors to reduce risk for HIV transmission and acquisition. Clients should receive referrals as appropriate for identified needs.

PARTNER COUNSELING AND REFERRAL SERVICES (PCRS)

The goal of PCRS is to stop the unintentional spread of HIV by providing risk reduction education to persons who are infected and those at risk of infection. It involves a confidential discussion between the infected client and a trained health professional about the patient's risk, the course of the infection, options for health care follow-up, measures to reduce the risk of disease transmission, and at risk sexual and needle sharing partners and how these partners will be notified of exposure. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services. PCRS services are integrally linked to other HIV prevention interventions that support the movement of index clients and their partners toward the practice of safer behaviors.

PARTNER COUNSELING AND REFERRAL (PCRS) <i>The range of services available to HIV-infected persons, their partners, and affected communities</i>	
Definition/Description	Once known as "partner notification," PCRS refers to "the range of services available to HIV-infected persons, their partners, and affected communities" once a person has accessed counseling and testing services. (Centers for Disease Control and Prevention, 1998b) PCRS contains an elicitation component (i.e., asking for partners' names) and a notification component (i.e., notifying partners of their risk).
Minimum Standards	<ul style="list-style-type: none"> ▪ PCRS is always an in-person service, allowing for on the spot counseling, testing, and referrals.
Strengths	<ul style="list-style-type: none"> ▪ PCRS is generally applicable for anyone wishing to inform partners of their positive HIV status and is especially valuable for clients wishing to notify a partner who is not currently in their life or who may have a violent or abusive reaction to hearing the news directly from the client. ▪ PCRS may be the only means by which some people learn of their increased risk. ▪ PCRS is especially valuable for anyone who wishes to notify a partner who is not currently in his or her life or who may have a violent or abusive reaction to hearing the news from the client. ▪ The PCRS intervention can be done by the service provider alone, or can be done jointly by the service provider and the client, depending on what is more comfortable and safe for the client.
Limitations	<ul style="list-style-type: none"> ▪ Can only reach those partners voluntarily mentioned by the testing client who wish to use this service.

Partner counseling and referral to appropriate services is essential for ensuring that sex and needle-sharing partners of HIV-infected persons are notified about their risk and offered HIV prevention counseling, testing, and referrals. Partner counseling and referral is a primary prevention service with the following objectives:

1. To confidentially inform partners of their possible exposure to HIV;
2. To provide partners with client-centered prevention counseling that assists and supports them in their efforts to reduce their risks of acquiring HIV or, if infected, of transmitting HIV infection; and
3. To minimize or delay disease progression by identifying HIV infected partners as early as possible in the course of their HIV infection and assisting them in obtaining appropriate preventive, medical, and other support services.

STD DIAGNOSIS AND TREATMENT

STD DIAGNOSIS AND TREATMENT <i>An individual receives testing and/or treatment for STDs</i>	
Definition/Description	STD detection and treatment refers to any intervention in which an individual receives testing and/or treatment for STDs, including but not limited to chlamydia, gonorrhea, syphilis, and herpes (either vaginally, anally, or orally). This is both a primary prevention strategy for HIV-positive and negative individuals (people are more susceptible to acquiring or transmitting HIV if they have an STD) and a secondary prevention strategy for HIV-positive individuals (HIV-positive people may be more susceptible to HIV reinfection when they have an STD and STDs may have more severe consequences for people with compromised immune systems).
Minimum Standards	<ul style="list-style-type: none"> ▪ Provider includes HIV counseling and testing or referrals to HIV testing. ▪ Provider includes client-centered risk assessment and risk reduction counseling.
Strengths	<p><i>STD detection and treatment can:</i></p> <ul style="list-style-type: none"> ▪ Serve as a bridge to HIV counseling and testing. ▪ Increase a person's perception of their own HIV risk if they have an STD. ▪ Be done in street-based locations. ▪ Use new screening technologies.
Limitations	<p><i>STD detection and treatment will not:</i></p> <ul style="list-style-type: none"> ▪ Ensure that all individuals will get an HIV test. ▪ Reach people who do not get regular STD screening, those who do not have access to regular medical care, or those who do not have any symptoms and therefore do not seek screening.

Recommendations of the Advisory Committee for HIV and STD Prevention include the following:

- Early detection and treatment of curable STDs should become a major, explicit component of comprehensive HIV prevention programs at national, state, and local levels;
- Screening and treatment programs for STDs that have been shown to facilitate HIV transmission should be expanded in settings where these diseases are prevalent; and
- Implementation of this strategy should be the joint responsibility of HIV and STD prevention programs.

Closely coordinating or integrating HIV prevention and STD prevention services is necessary and cost-effective and should be accomplished to reduce the transmission of HIV and other STDs, and is recommended.

Additional Information:

(1998)

<http://www.cdc.gov/std/treatment/rr5106.pdf>

<http://www.cdc.gov/std/hiv/>

HEPATITIS

HEPATITIS	
<i>An individual receives testing and/or education on hepatitis</i>	
Definition/Description	Hepatitis C screening refers to antibody testing for hepatitis C. Testing for Hepatitis A and B refer to appropriate test to determine immunity to Hepatitis A and B.
Implementation Recommendations	<ul style="list-style-type: none"> ▪ HIV care services should include Hepatitis counseling, testing for HIV positive individuals, and Hepatitis A and B vaccination. ▪ Prevention counseling should include client-centered risk assessment and risk reduction counseling for all blood-borne infections (HIV, hepatitis B, hepatitis C) based on specific risk behaviors that are presented by the client. ▪ Hepatitis C testing is usually done with the EIA antibody test. Positive results can be followed up with viral load testing. ▪ HIV positive individuals who do not have immunity to hepatitis A or B should be vaccinated for both viruses. ▪ Ideally, MSM and IDUs should be vaccinated for both Hepatitis A and B.
Strengths	<ul style="list-style-type: none"> ▪ Hepatitis services can serve as a bridge to HIV counseling and testing. ▪ Hepatitis diagnosis may increase a person's perception of their HIV risk. ▪ Hepatitis screening of HIV positive patients helps determine appropriate treatments.
Limitations	<ul style="list-style-type: none"> ▪ It is difficult to collect blood samples in street-based locations. ▪ Care providers can not use new screening technologies. ▪ Hepatitis screening will not reach people who do not get regular medical screening, those who do not have access to regular medical care, or those who do not have any symptoms and therefore do not seek screening (unless the intervention is mobile). ▪ No federal allocation for Hepatitis services.

There are two main HIV risk behavior populations that are also at high risk for hepatitis infection: MSM or other individuals who engage in high-risk sexual activity and injection drug users. It is important to consider and address all diseases that these behaviors put the individual at risk for, not just HIV.

Hepatitis A and B can both be transmitted sexually. Hepatitis C is capable of being transmitted sexually, but sexual activity appears to be an ineffective method of transmission. CDC is currently conducting studies to more fully understand sexual transmission of hepatitis C.

Both Hepatitis B and C have a much higher transmission rate through the sharing of contaminated injection drug equipment than does HIV. CDC now estimates that a 50-90 percent co-infection rate exists with HIV and HCV among HIV-infected injection drug users. Many of these individuals additionally show immunity to hepatitis B, which in most cases shows prior infection and recovery from hepatitis B as well.

HEALTH EDUCATION/RISK REDUCTION (HE/RR)

Using the taxonomy originally proposed by (Holtgrave 1994), the following interventions are included under the broad category of Health Education and Risk Reduction (HE/RR): individual-level intervention, prevention case management, group-level intervention, and outreach. HE/RR describes organized efforts to reach persons at increased risk of becoming HIV infected or, if already infected, of transmitting the virus to others. The goals of health education and risk reduction activities are to go beyond the provision of information to provide education and counseling that assists individuals in developing the skills, abilities, and self-esteem to carry out behavior change (1995). Providers can deliver health education and risk reduction interventions at an individual, group, community, or outreach level. HE/RR activities can include counseling, workshops, educational programs and materials, presentations, and outreach activities.

INDIVIDUAL-LEVEL INTERVENTION (ILI)

ILI programs seek to promote and reinforce safer behaviors among at-risk individuals through one-on-one contact. Interactions are meant to be short-term, but often involve more than one session. These programs assist individuals in assessing their own risk for getting or spreading HIV and in building the skills and abilities necessary to implement behavior change. ILI offers training in interpersonal skills needed to negotiate and sustain appropriate behavior change as well as referrals to appropriate services. This intervention also facilitates linkages to services in both clinic and community settings in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services. According to strict categorization, outreach and prevention case management also are individual-level interventions. However, for the purposes of reporting, ILI does not include outreach or prevention case management, which each constitutes their own intervention categories.

INDIVIDUAL LEVEL INTERVENTION (ILI) <i>Health Education/Risk Reduction (HE/RR) counseling conducted one-to-one</i>	
Definition/Description	A personalized, client-centered encounter between an individual and a trained counselor.
Minimum Standards	<i>Individual level interventions must:</i> <ul style="list-style-type: none"> ▪ Be of sufficient length to informally assess client needs. ▪ Include (1) HIV/STD/HCV information and dissemination, (2) documentation of discussion of risk behaviors, (3) counseling, (4) skills building, and (5) documented referral (s), if given.
Implementation Recommendations	<i>During ILI session, the provider:</i> <ul style="list-style-type: none"> ▪ Conducts a needs assessment of the client and responds to client's stated need. ▪ Establishes an opportunity for follow-up. ▪ Assists the individual in making plans for behavior changes, provides ongoing appraisals of behaviors, and supports risk reduction behaviors.
Quality Assurance Measures	<i>Providers must assure that:</i> <ul style="list-style-type: none"> ▪ Space is private and conducive to private/personal discussions. ▪ A mechanism is in place for documentation of individual educational sessions.
Strengths	<i>ILI:</i> <ul style="list-style-type: none"> • Is suitable for all populations, especially for people who are ready to deal with

	<p>health concerns, people receiving outreach services, and health center or hospital patients.</p> <ul style="list-style-type: none"> • Provides personal attention to individuals for whom confidentiality is important. • Provides opportunities to recruit clients for other prevention activities. • Can be mobile, allowing flexibility to reach many populations. • Provides linkages & referrals to social and medical services, especially CTR/PCRS. • Provides an opportunity for ongoing follow-up with clients. • Facilitates linkages to services in clinic and community settings in support of behaviors and practices that prevent transmission of HIV and help clients obtain these services.
Limitations	<ul style="list-style-type: none"> • ILI may not be appropriate for people who are not able to keep appointments.

COMPREHENSIVE RISK COUNSELING AND SERVICES (CRCS)

Individuals who need intensive individualized support may be candidates for CRCS. CRCS is an individual-level intervention directed at persons who need highly individualized support, including substantial psychosocial, interpersonal skills training, and other support, to remain seronegative or to reduce the risk of HIV transmission to others. CRCS services are not intended as a substitute for medical case management, extended social services, or long-term psychological care; nor should CRCS duplicate Ryan White CARE Act case management services for people living with HIV.

CRCS is a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage. CRCS concentrates on primary prevention (preventing HIV transmission) and secondary interventions (advocating for early medical interventions to prevent or delay the onset of symptoms in HIV infected clients). In Iowa, CRCS is intended for clients with HIV infection who engage in unsafe behaviors and who have a poor prognosis for changing behaviors without this intervention. CRCS is intended for persons who are having difficulty initiating and sustaining safer sexual and drug use behaviors and to improve client's skills in accessing community resources that support behavior change. CRCS is intended for persons at greatest risk of transmitting HIV whose needs are not being effectively served and whose behavior is not influenced by less intensive HIV prevention interventions, such as individual-level strategies, or group-level strategies.

Comprehensive Risk Counseling and Services (CRCS) <i>A client centered intervention with the goal of promoting the adoption of HIV risk reduction behaviors</i>	
Definition/Description	CRCS is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. CRCS is used with HIV-negative and HIV-positive individuals and can be provided in a face-to-face or non-face-to-face setting.
Minimum Standards	<p><i>CRCS is an intervention that:</i></p> <ul style="list-style-type: none"> ▪ Is intended for persons with multiple, complex problems and risk reduction needs, (substance abuse, financial, medical, psychological) who have difficulty initiating, or sustaining, behaviors that reduce or prevent HIV transmission. ▪ Includes the development of a client developed, written, prevention plan. ▪ Involves ongoing prevention counseling, support, monitoring, service brokerage.

	<ul style="list-style-type: none"> ▪ Lasts more than one session.
Implementation Recommendations	<p><i>The CDC Guidance, 1997, states that CRCS should include:</i></p> <ul style="list-style-type: none"> ▪ Client recruitment and engagement. ▪ Assessment of HIV and STD risks, medical and psychosocial service needs. ▪ Development of a client-centered prevention plan. ▪ Multiple-session HIV risk-reduction counseling. ▪ Active coordination of services with follow-up. ▪ Monitoring and assessment of clients needs, risks, and progress. ▪ Discharge from CRCS upon attainment and maintenance of risk-reduction goals. <p><i>For HIV positive individuals:</i></p> <ul style="list-style-type: none"> ▪ CRCS includes primary and secondary prevention in collaboration with CARE case management.
Quality Assurance Measures	<ul style="list-style-type: none"> ▪ CRCS files are updated within 24 hours of client contact and agency has an internal review policy for CRCS files. ▪ CRCS files must contain the following information: <ol style="list-style-type: none"> 1. client contact information 2. client contact notes 3. documentation of receipt by client of client rights and responsibilities 4. confidentiality statement 5. grievance procedures 6. client referrals and follow-ups ▪ Agency must assure that space for counseling is conducive to privacy. ▪ Agencies must assure that all clients have a client developed written service plan.
Strengths	<p><i>CRCS is:</i></p> <ul style="list-style-type: none"> ▪ Appropriate for HIV-positive individuals, high-risk HIV-negative individuals, and high-risk individuals who do not know their serostatus. ▪ Suitable for people seeking some stability/regularity in their lives, people who are reaching an action stage in dealing with health concerns, people receiving outreach (if the intervention is mobile), and health center or hospital patients.
Limitations	<p><i>CRCS is not:</i></p> <ul style="list-style-type: none"> ▪ Appropriate for people with low perception of their risk for HIV or for individuals who are not able to keep appointments. ▪ Sufficient for forging a relationship with the community unless accompanied by outreach or other interventions.

Priorities for CRCS services should be given to HIV seropositive persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV transmission and re-infection. For HIV seropositive persons, CRCS involves the coordination of primary and secondary prevention interventions in close collaboration with Ryan White CARE Act case management providers. Further, CRCS ensures the provision of other medical and psychosocial services affecting risk behavior, including STD and substance abuse treatment services.

HIV seronegative persons or those of unknown HIV serostatus – either (1) engaging in high-risk behavior within communities with moderate to high seroprevalence rates of HIV infection or (2) otherwise at heightened risk of infection – may also be appropriate for CRCS.

GROUP LEVEL INTERVENTION (GLI)

A group-level intervention is health education and risk-reduction counseling that shifts the delivery of service from the individual to groups of varying size. GLIs use peer and non-peer models involving a wide range of skills, information, education, and support. GLI provides small groups of individuals at high risk of acquiring or transmitting HIV infection with: educational interventions that promote and reinforce safer behaviors; interpersonal skills training and support in negotiation and maintaining safer sexual and needle-sharing behaviors; emphasis on the relationship between substance use and risky behaviors; educational materials; and referrals to appropriate services

GROUP LEVEL INTERVENTION (GLI)	
<i>A planned series of educational experiences targeted to meet the informational, social, behavioral skills building, support or referral needs of the participants</i>	
Definition/Description	A series of groups or meetings that introduce HIV issues and link them to other life issues. The same individuals attend each workshop in the series, which is different from a series of single session groups where different groups of people attend each session. Workshop topics usually build on each other from session to session. Groups may be closed or drop-in, mixed or serostatus-specific, structured, or need/issue-driven for risk reduction and psychosocial support. Groups can be held in vans, run as before/after bar groups, or be held in other community settings.
Minimum Standards	<p><i>Group level interventions:</i></p> <ul style="list-style-type: none"> ▪ Meet over a specific period of time with a scheduled beginning-end point. ▪ Use a written curriculum covering HIV/AIDS; STDs; risk/harm reduction; substance use/abuse; counseling & testing. ▪ Use a curriculum that contains a skill building component such as role-playing, safer injection techniques, negotiation skills, etc. ▪ Have a minimum participation standard (e.g., 75% of scheduled sessions). ▪ Implement a pre/post HIV/AIDS knowledge assessment with participants. ▪ Provide additional support, follow-up groups, and/or "booster" groups.
Implementation Recommendations	<p><i>Group level interventions must:</i></p> <ul style="list-style-type: none"> ▪ Have counselors available for follow-up, especially at six months, to evaluate the adoption and/or maintenance of safer behaviors. ▪ Recruit participants via other (not directly HIV-related) activities. ▪ Include ground rules created and adopted by participants. ▪ Include discussions about multiple issues that the group identifies as priorities (e.g., racism, homophobia). ▪ Have counselors available before or after the intervention to provide confidential, one-on-one referrals to other prevention services within or outside of the agency.
Quality Assurance Measure	<p><i>Group level Interventions must have a:</i></p> <ul style="list-style-type: none"> ▪ Curriculum that incorporates discussion of issues specific to the target population ▪ Group facilitator who debriefs and documents main discussion points of each session
Strengths	<p><i>Group level interventions are:</i></p> <ul style="list-style-type: none"> ▪ Able to go into greater depth about HIV risk reduction issues and strategies than single session groups, have more potential to deal with the underlying causes of unsafe behavior, and thus have a greater possibility of effecting behavior change. ▪ Able to attract MSMs who are seeking social contacts and support outside of the gay bar scene and people who are seeking connection with others who have shared experiences and interests. ▪ Frequently the first opportunity for some people to talk about sexual and drug-related behaviors with their peers. ▪ Most applicable for people with high perception of personal risk.

	<ul style="list-style-type: none"> ▪ Useful for people who are already highly motivated to attend groups. ▪ Able to provide a needed/desired structure for some populations (e.g., some homeless and/or jobless people). ▪ Able to attract people who perceive they are a part of a culture, group, or community, and are seeking connection with others who have shared experience and interests. ▪ Most fully by women, who tend to take advantage of discussion and support groups and to work well with relational models. ▪ Especially feasible and easy to integrate when conducted in institutional settings (schools, residential treatment centers, and incarcerated persons). ▪ More helpful to participants if they are interactive rather than didactic.
Limitations	<p><i>Group level interventions may not be:</i></p> <ul style="list-style-type: none"> ▪ Effective or appropriate for mentally ill populations ▪ Able to retain participants for continuing groups; providers may require a "hook" other than HIV prevention alone to motivate regular attendance (note: this is absolutely essential for youth participation). ▪ Feasible for people with limited free time.

Many providers may consider general education activities to be group-level interventions. However, GLI does not include "one-shot" educational presentations or lectures that lack a skill component. Those types of activities are included in the Health Communication/Public Information category.

OUTREACH

Outreach programs seek to change individual behavior by providing motivation, knowledge, risk reduction materials, linkage to testing, and referrals to services that support behavior change. Such programs access at-risk individuals on the street, or in malls, parks, bars, or other community settings. Outreach is directed towards a clearly defined target population of individuals at high risk for getting or spreading HIV. Such populations are further characterized by gender, age, race, ethnicity, risk behavior, physical or mental disability, and/or geographic locations. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials. Peer opinion leader models are included in this category.

STREET AND COMMUNITY OUTREACH	
<i>A face-to-face interaction with a high-risk individual in their neighborhood or area (s) where they congregate</i>	
Definition/Description	A face-to-face interaction between an outreach worker (or a team of outreach workers) and a client or a small group of clients. Takes place on the street or in venues* where the target population may congregate at appropriate times of the day, night, week, and year. The outreach activities may occur in existing settings or settings specially created for the purpose of HIV prevention. Can take a variety of forms, including community theater, dramatizations of real-life scenarios, "bar zaps," and interactive performance art, that are designed to promote HIV risk reduction behaviors among audience members. The distribution of appropriate prevention materials may also be a component of these activities. The outreach worker may establish a one-time intervention or a long-term relationship with clients in a particular community.
Minimum Standards	<p><i>Street and community outreach must:</i></p> <ul style="list-style-type: none"> ▪ Include (1) distribution and demonstration of prevention materials, such as latex barriers and bleach kits, (2) assessment of a client's needs, (3) provision of health education/risk reduction information and referrals, and (4) dialogue about a client's issues regarding HIV

	<ul style="list-style-type: none"> ▪ Be coupled with one or more of the other approved interventions. It cannot be funded as a stand-alone intervention, (i.e. as the only intervention in a program). ▪ Have a one-on-one component
Implementation Recommendations	<p><i>Street and community outreach must:</i></p> <ul style="list-style-type: none"> ▪ Address continued risk behaviors in the face of HIV knowledge. ▪ Be consistent and continuous and involve client follow-up when possible. ▪ Respect the operating conditions at, and contribute to the spirit of the venue/event. ▪ Be interactive and engaging and emphasize community unity, creating a positive environment in which participants can socialize and mingle. ▪ Encourage networking among members of different communities, through sharing of information and resources. ▪ Be held in a safe environment for both the target audience and outreach workers.
Quality Assurance Measures	<p><i>Street and community outreach agencies must have:</i></p> <ul style="list-style-type: none"> ▪ Signed Memorandums of Agreements (MOAs) with local bars, bookstores, bath houses etc. where they perform outreach activities ▪ Written field safety protocols ▪ Written outreach schedule
Data Requirements	<p><i>Providers must report:</i></p> <ul style="list-style-type: none"> ▪ Contact demographics as required by Iowa HIV Prevention & Evaluation System ▪ Referrals made and materials distributed.
Strengths	<p><i>Street and community outreach can:</i></p> <ul style="list-style-type: none"> ▪ Reach large numbers of people. ▪ Be implemented using media, video, and other interactive technology. ▪ For youth (Givertz 1993), out-of-treatment IDUs (Rahimian and Pach, 1999), populations who have a low perception of personal risk for HIV, those with lack of access to health and social services, and those in need of basic information. ▪ Serve as an opportunity to recruit clients targeted for other prevention activities. ▪ Reach people who identify with some community or a group scene/social group. ▪ Be suitable for groups with multiple issues and barriers to change, groups with a lack of access to services, people with a low perception of personal or communal risk, people needing basic information and referrals, and people that have never experienced another intervention. ▪ Provide a forum for dialogue between friends and family (community building). ▪ Encourage individuals and communities to participate in other prevention activities. ▪ Address people at various stages of behavior change. ▪ Reach people who may be in a venue less purposefully and may not be seeking HIV prevention services.
Limitations	<p><i>Street and community outreach may not be:</i></p> <ul style="list-style-type: none"> ▪ Suitable for individuals with serious mental health stressors. ▪ Appropriate or allowed in certain venues. ▪ Impactful if it is over-concentrated in a venue. ▪ Able to meet clients' needs for services due to lack of available referral resources. ▪ Appropriate for populations that are well informed but continue to show high rates of infection. ▪ As effective for reaching people who are closeted, not identified with a group/community, or not already in an institutional setting.

*Examples of venues are homes, raves, schools, churches, temples, synagogues, mosques, hospitals, sport leagues, gyms, the general assistance office, halfway houses, public housing, laundromats, crack houses, fairs and other community events, massage parlors, porn theaters, bars, night clubs, community centers, gambling parlors, and businesses.

Street outreach refers to HIV prevention education and counseling that is delivered at informal sites where persons engaged in high-risk activities congregate, such as streets, bars, parks,

shooting galleries, bathhouses, beauty parlors, etc. The strategy involves a broad range of models, from occasional condom drops to the long-term placement of highly skilled workers in the community. Street outreach programs may be highly interactive and engaging, or they may involve only a cursory risk message and delivery of referral information. Some outreach programs strive to develop long-term relationships with individuals on the street, thus the service is repeatedly delivered to an individual over time.

Street outreach involves more than the distribution of condoms and bleach. The more difficult task of the outreach worker is encouraging lifestyle changes by developing relationships through repeated outreach and a continuous presence.

Peer Education

Peer education involves services provided by individuals who are recruited from a target population. These individuals are trained in HIV/AIDS (epidemiology, prevention, resources, etc.), peer counseling, outreach, and the issues of population groups which are difficult to reach with HIV information alone. The peer model can draw on established social networks to disseminate information. Peer providers are a direct link to members of the target population who do not normally present at primary channels such as counseling and testing sites (Edelstein and Gonyer 1993).

The importance of peers as educators is based on Diffusion of Innovation Theory and the subjective norms of the Theory of Reasoned Action. Diffusion theory suggests that information and learning flows through natural social networks; people are more likely to adopt new behaviors if they are introduced by someone who is similar to them and is perceived to be a role model (Coates 1990; Dorfman, Derish et al. 1992). Peer educators may be similar to the target population by behavior, culture, race, age, ethnicity, gender, or other factors salient to the target population.

Participants in focus groups sponsored by the CPG in 1996 emphasized the importance of receiving information from peers. Peer education plays an important role in helping people perceive their own personal HIV-related risks. Perception of personal risk is an important factor in ultimately changing personal risk behavior.

PEER EDUCATION	
Definition/ Description	Services are provided to a target population by individuals recruited from that target population, which may be defined by behavior, culture, race, age, ethnicity, gender identification, or other salient factors.
Implementation Recommendations	<p><i>Agencies should:</i></p> <ul style="list-style-type: none"> ▪ Provide counseling, supervision, safety and support structures, and adequate wages or incentives for their peer educators. ▪ Establish a contract with peer educator detailing responsibilities and compensation. ▪ Incorporate comments and experiences of peer educators into program development. ▪ Ensure diversity among peer educators. ▪ Train staff on the issues of their peer educators. <p><i>Peer educators should:</i></p> <ul style="list-style-type: none"> ▪ Be perceived as credible and as true peers by the target population. ▪ Address behavior change as well as provide information.
Strengths	<i>Peer education strategies:</i>

	<ul style="list-style-type: none"> ▪ Have a theoretical foundation in diffusion of innovation theory. ▪ Draw on established social networks to disseminate information. ▪ Can be used in conjunction with individual, group, and community-level interventions. ▪ Can assist in changing the perception of norms regarding HIV and risk behaviors. ▪ Can assist in creating social networks that support self-protective behaviors. ▪ Are especially suited for populations who do not perceive themselves to be at risk. ▪ Can lead to behavior change for the peer educators themselves. ▪ Are generally applicable to all populations.
Limitations	<p><i>Peer educators:</i></p> <ul style="list-style-type: none"> ▪ May not engage in HIV preventive behaviors themselves, and thus may not always be good role models. ▪ May experience a high burnout rate. <p><i>A peer approach:</i></p> <ul style="list-style-type: none"> ▪ May not appeal as much to members of small/close communities where information travels fast and stigma may still be attached to HIV concerns. ▪ Will not be appropriate for persons that prefer to receive HIV prevention services from people they view as outside of their immediate community so that they can talk more freely. ▪ Is not appropriate for individuals desiring anonymity or fear leakage of information.

Since peer norms appear to be important influences on adolescent behavior, peer education can assist in changing the perception of norms with respect to HIV and risk behaviors (DiClemente 1993). Research has shown that successful adolescent peer educators are able to evaluate AIDS information, reconstruct it, and use their own personal experiences to filter through information. They then pass along this information and advice. Positive peer role models have been successful in helping to bring about risk-reduction changes in individual and group behavioral norms, and in serving as influential models to help young people’s attitudes toward themselves and their health. Peer-based education can also be effective in helping the young person to understand his or her own risk and to translate the significance of this realization into his or her own life and behaviors. This personalization should, however, take place only in a safe setting where self-disclosure is met with acceptance, support, and confidentiality.

Endorsements/Testimonials by Opinion Leaders

Opinion leaders are key people who are recognized as influential and charismatic members of a community. These individuals are seen as models whose opinions and behaviors are likely to influence the opinions and behaviors of a target population. An opinion leader is a member of the community who is particularly popular or respected by other members of the community. An opinion leader may be viewed as representing her/his community in the entertainment field, sports, government/politics, academia, business, popular culture, community work, etc.

NATURAL OPINION LEADERS	
Definition/Description	Key people who are recognized as influential and charismatic members of a community or communities are identified as models of opinions and behaviors with the goal of influencing the opinions and behaviors of a target population.
Implementation Recommendations	<p><i>Opinion leaders should:</i></p> <ul style="list-style-type: none"> ▪ Be identified and determined by the target population. ▪ Be individuals who have the capacity to influence social norms.
Strengths	<p><i>Opinion leader strategies are useful for:</i></p> <ul style="list-style-type: none"> ▪ Persons with group identification and who recognize community leaders.

	<ul style="list-style-type: none"> ▪ Groups such as youth, who value sports stars, movie stars, and other media heroes. ▪ Persons with perceptions of low risk either personally or for the community. ▪ Groups in which social stigma is attached to homosexuality or injection drug use.
Limitations	<p><i>Delivering prevention messages via natural opinion leaders may not:</i></p> <ul style="list-style-type: none"> ▪ Be appropriate for individuals or groups that lack community identification, it relies on the relationship between the chosen opinion leader and the group targeted. ▪ Result in behavior change, especially when they are high-profile individuals. <p><i>Opinion leaders:</i></p> <ul style="list-style-type: none"> ▪ Must engage in HIV preventive behaviors themselves to be good role models.

Condoms, Latex Barriers, Bleach Distribution

Through this strategy, health workers distribute bleach, condoms, and latex barriers, demonstrate their use, and provide referrals in areas where people at risk for HIV congregate. Limited opportunities for one-on-one health education or risk reduction are offered by this strategy that, by definition, focuses on behavioral change.

CONDOM DISTRIBUTION	
Definition/Description	Providers distribute female and male condoms to members of the target population.
Implementation Recommendations	<p><i>Condom distribution as a strategy:</i></p> <ul style="list-style-type: none"> ▪ Must be used in combination with other strategies or interventions. ▪ Be accompanied by instructions for proper use, verbal or written.
Strengths	<p><i>Condom distribution may:</i></p> <ul style="list-style-type: none"> ▪ Reduce barriers to safer sex for some populations (e.g., for those who cannot afford condoms, those who are embarrassed to buy condoms such as teens).
Limitations	<p><i>Condom distribution:</i></p> <ul style="list-style-type: none"> ▪ Has limited effectiveness unless accompanied by other interventions or strategies. ▪ May be controversial in school settings.

Access to Sterile Injection Equipment

Needle exchange programs provide sterile needles to injecting drug users. Needle exchange programs are community or street-based. Within this intervention framework, prevention workers distribute clean needles (syringes) and other supplies to individuals who use needles to inject drugs, usually in exchange for used needles. They also provide referrals to HIV-related services in areas where persons involved in high-risk behaviors congregate. A limited opportunity for one-on-one health education and/or risk reduction intervention may occur in this context, as may a chance to help link an infected person to HIV care services. Needle exchange programs focus specifically on behavior change related to needle usage and less on sexual behaviors. Needle exchange programs are designed to reach individuals on a repeated basis.

A variety of factors may limit the effectiveness of needle exchange programs, including a lack of resources and of information in target communities about existing services. Providers note that overall, only fractions of IDUs use needle exchanges. Furthermore, IDUs who would be willing to utilize needle exchange programs do not always know how to access them. Providers say IDUs fear that law enforcement officials or social service authorities will intercept them at needle exchange sites. Providers also say that some women IDUs fear their children will be taken from them if they participate in needle exchange programs.

STERILE INJECTION EQUIPMENT ACCESS AND DISPOSAL	
Definition/ Description	Needle access programs are community or street-based programs that provide sterile needles to IDUs and hormone, steroid, vitamin, and insulin users. Needle exchange can be primary (i.e., individuals exchange their own needles) or secondary (i.e., individuals exchange needles for friends or a group of people).
Implementation Recommendations	<p><i>Access to sterile injection equipment and disposal strategies must:</i></p> <ul style="list-style-type: none"> ▪ Have a designated health education and referral and resource person. ▪ Offer passes that reserve spots in drug treatment program (i.e., drug treatment vouchers) to interested clients, when possible. ▪ Have available condoms, dental dams, and information on safer sexual behavior. ▪ Meet the safety needs of clients (e.g., minimizing police presence, having a protective and vigilant staff). ▪ Consider collaborating with other HIV prevention education agencies to provide services at the needle access or disposal site.
Strengths	<p><i>Access to sterile injection equipment and disposal strategies can:</i></p> <ul style="list-style-type: none"> ▪ Be developed for a particular neighborhood. ▪ Provide a bridge to drug treatment, CTR/PCRS, hepatitis B & C screening, Hepatitis A & B vaccination, and other social and medical services. ▪ Be useful for the transgender community, and for other people who inject steroids or vitamins, as well as for IDUs. ▪ Use Pharmacies to serve as supply outlets for higher-risk populations. ▪ Reduce transmission of hepatitis B and C as well as HIV.
Limitations	<p><i>Injecting drug users:</i></p> <ul style="list-style-type: none"> ▪ Do not always know how to access needle or disposal sites because they do not know the schedule or where to go. ▪ May not always consider needle or disposal sites to be safe because they fear that law enforcement officials or social service authorities will intercept them there. ▪ Fear that their children will be taken if they participate in needle access programs. ▪ Cannot be funded with federal funds at the present time.

HEALTH COMMUNICATIONS/PUBLIC INFORMATION

Health Communications and Public Information (HC/PI) is the delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services. HC/PI programs target the general public as well as specific populations and seek to dispel myths about HIV transmission, support volunteerism for HIV prevention programs, reduce discrimination toward persons with HIV/AIDS or persons perceived to be at risk for HIV infection, promote support for strategies and interventions that contribute to HIV prevention in the community, and increase access to available services. Through the use of promotional tactics, such as hotlines and the Internet, public information programs, and one-session information programs can lead to increased knowledge of HIV/AIDS facts, offer support and referrals, and may lead to behavior change.

MINIMUM STANDARDS: HEALTH COMMUNICATIONS/PUBLIC INFORMATION

The delivery of planned HIV/AIDS messages to target audiences through electronic media, print media, hotlines, clearinghouses, and presentations/lectures, for the purpose of building support for safe behavior, support personal risk-reduction efforts, or inform persons at risk for infection how to obtain specific services.

Minimum Criteria

- Single session presentations and lectures that do not contain a skills component, belong in this category.
- Health Communication/Public Information (HC/PI) cannot be funded as a stand-alone intervention but must be coupled with one or more of the other approved interventions.

Quality Assurance Measures

- Agency has demonstrated the ability to access non-traditional communication networking, such as word of mouth through specific groups.
- Agency has demonstrated the ability to disseminate public information in the electronic, print, or other media.

Data Requirements

- The Iowa HIV Prevention & Evaluation System do not require client demographics for this intervention.
- Type of HC/PI Intervention (e.g., presentation, hotline, print media, etc.).

Electronic Media: Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, and infomercials which target a large-scale (city-, region-, statewide) audience.

Print Media: These formats reach a large-scale or nationwide audience. They include any printed materials, such as newspapers, magazines, pamphlets, and "environmental media" such as billboards and transportation signage.

Hotline: Telephone service offering up-to-date information and referral to local services, such as counseling, testing, and support groups.

Clearinghouse: Interactive electronic outreach systems using telephones, mail, and Internet/Worldwide Web to provide a responsive information service to the general public as well as high-risk populations.

MEDIA

MEDIA	
Definition/ Description	Media is a form of communication that attempts to reach a wide audience with motivational and educational messages. These messages can be designed to reach large geographically dispersed audiences, small and location-specific audiences, or audiences defined by a common culture or community identity. Examples of types of media are television (e.g., documentaries, talk shows, commercials, public service announcements [PSAs]), radio (e.g., PSAs, public talk shows), print (e.g., newspapers, magazines, newsletters), billboard advertising, computer services (e.g., Internet, bulletin boards), telephone services (e.g., hotlines, talk lines), brochures, pamphlets, fact sheets, posters, palm cards, videos, and audio tapes.
Implementation Recommendations	<p><i>Providers using media to disseminate prevention messages must:</i></p> <ul style="list-style-type: none"> ▪ Involve community members in the design, planning, and implementation of a media campaign to ensure that the effort is relevant to the target populations. ▪ Integrate HIV messages with other issues and activities of the target group. ▪ Use the social marketing theory/strategy as the foundation for media efforts. ▪ Consider the stages of change appropriate to its target audiences, and meet the readiness of the audience to receive prevention messages. <p><i>Prevention messages must:</i></p> <ul style="list-style-type: none"> ▪ Be emotionally or intellectually engaging. ▪ Be designed to target a specific group and not the general population, the messages may need to be disseminated widely to ensure that it reaches the target population. ▪ Communicate strong messages without causing desensitization. <p><i>Media campaigns must:</i></p> <ul style="list-style-type: none"> ▪ Be based on a thorough needs assessment of the target audience in order to pitch its message at the appropriate stage of change. ▪ Be appropriate for groups which are less likely to seek out or have easy access to HIV-related information (e.g., people who are homeless, IDUs, or lower literacy). ▪ Offer prevention messages without any economic investment on the part of the audience ▪ Reach persons who are unable to afford a TV or radio.
Strengths	<p><i>Media campaigns:</i></p> <ul style="list-style-type: none"> ▪ Can reach people with clearly identifiable “turf” or regular venues for hanging out. ▪ Can increase the realistic perception of personal or communal risk among people who, due to denial or demographic factors, have not seen themselves as being at risk. ▪ Are generally appropriate for all audiences and can be tailored for the target audience. ▪ Are suitable for reaching groups with little to no previous awareness or concern about HIV, groups that are less likely to seek out or have easy access to HIV related information, and people who do not perceive themselves to be at risk. ▪ Can be very affordable when they are small-scale and targeted. ▪ Can motivate people on a group/community level.
Limitations	<p><i>Media campaigns:</i></p> <ul style="list-style-type: none"> ▪ Can cause confusion when the messages are changing or inconsistent (e.g., regarding the safety of oral sex). ▪ Are more useful when combined with interpersonal interventions. ▪ May not be effective for groups facing multiple issues and barriers. ▪ Can be expensive. ▪ Mostly provide a backdrop or stage for prevention activities, and are not as useful if they are the only source of prevention information available to someone. In order for media to have an impact, personal interactions should take place in addition to media messages.

Electronic and Print Media

Media is a form of communication that can reach large numbers of people with motivational and educational messages. These messages can be designed to reach mass audiences, small and location-specific audiences, or culturally and communally specific audiences. Different types of media are listed:

- Large media can include television (documentaries, talk shows, commercials, PSAs, etc.), radio (PSAs, public talk shows, etc.), and print (newspapers, magazines, etc.).
- Small media can include materials development (brochures, pamphlets, fact sheets, posters, palm cards, videos, audiotapes, etc.).
- Internet-based HIV prevention strategies include listserves, chat rooms, electronic bulletin boards, informational web sites with links to resources, and computerized surveys and assessments.
- Other media can include billboard advertising, computer services (internet, bulletin boards, etc.), and telephone services (hotlines, talk lines, etc.).

Large media campaigns often require a substantial amount of funds and many grassroots movement-type organizations cannot afford to sponsor them. Small media, however, can be very cost-effective and affordable.

Media providers note that media messages must be strong to compete for the public's attention. Desensitization of the public from exposure to many strong messages, however, is a counterbalancing concern. Providers note that messages are most effective when they are emotionally or intellectually engaging.

HOTLINES AND CLEARINGHOUSES

Toll-free HIV hotlines provide education, risk assessment, and referral information to callers, related either to general HIV prevention, referral, and support, or for specialized AIDS-related referrals or counseling. The anonymity of hotline services fits the preferences of those who are too embarrassed, closeted, or frightened to receive services elsewhere. In most cases, hotlines serve as convenient access points to obtain needed information and referrals related to all aspects of HIV and AIDS. Hotlines can serve both as a crucial first link to other services, and as an information source for individuals who are geographically or physically isolated.

HOTLINE	
Definition/Description	A confidential telephone service functioning as an education/referral/help line for anonymous callers. Hotlines offer up-to-the-minute information on HIV and related issues, crisis intervention and counseling, and direction to other social services.
Implementation Recommendations	<p><i>Providers must:</i></p> <ul style="list-style-type: none"> ▪ Develop consistent prevention messages for hotline operators that are consistent with messages disseminated by other organizations. ▪ Promote and reinforce help-seeking behaviors. ▪ Provide brief call documentation (content and demographics).
Strengths	<p><i>Hotlines:</i></p> <ul style="list-style-type: none"> ▪ Are widely applicable to all groups at risk for HIV and are particularly appropriate for people desiring anonymity, people in crisis, people needing basic information, and people whose needs are not addressed by mass media HIV education efforts.

	<ul style="list-style-type: none"> ▪ Target a wider geographical area than most interventions. ▪ Are often first links to prevention and care services. ▪ Serve preventive as well as destigmatizing functions.
Limitations	<p><i>Hotlines:</i></p> <ul style="list-style-type: none"> ▪ May have limited usefulness in directly promoting behavior change. ▪ Can be expensive to operate. ▪ Are not appropriate for people without access to telephones. ▪ Cannot reach people who do not comfortably speak the language(s) offered.

INTERNET/COMPUTER	
Definition/Description	There are many different kinds of Internet- and computer-based HIV prevention strategies, including listserves, chat rooms, electronic bulletin boards, informational web sites with links to resources, and computerized surveys and assessments. These can be used in the context of individual interventions (e.g., email exchanges between client and provider regarding risk reduction), small group interventions (e.g., single session group workshops done in a chat room), or community-level interventions (e.g., an Internet media campaign).
Implementation Recommendations	<p><i>Agencies should:</i></p> <ul style="list-style-type: none"> ▪ Develop user-friendly, interactive approaches. ▪ Provide training (and advocate for training in schools) on how to use computers and the Internet to access HIV-related information and resources.
Strengths	<p><i>Internet strategies:</i></p> <ul style="list-style-type: none"> ▪ Can reach large numbers of people over a wide geographic area. ▪ Present opportunities for prevention using channels that people use to solicit sex partners (e.g., chat rooms). ▪ May be perceived as more anonymous and thus may be more useful for populations desiring anonymity. <p><i>Computerized surveys and assessments:</i></p> <ul style="list-style-type: none"> ▪ May be useful for groups such as adolescents who may be embarrassed or uncomfortable talking to a provider about their sexual or drug use risk behaviors.
Limitations	<p><i>Internet and computer strategies:</i></p> <ul style="list-style-type: none"> ▪ Will not reach those without Internet access or computer skills, who may be low income or marginalized groups and at high risk for HIV ▪ May compromise anonymity/confidentiality if identifying information is requested or given over the Internet.

PRESENTATIONS/LECTURES

Presentations and lectures include single session group workshops. Single session workshops consist of a one-time, intensive session or gathering focusing on information about HIV (e.g., transmission and behavior change), motivational activities, and skills building. It may also touch on other relevant issues. This intervention can take a variety of forms, such as involving impromptu groups, using vans as session sites, and before/after bar groups. The specific intervention is planned or requested, usually based on advertising or promotion of the availability of the service.

PRESENTATIONS/LECTURES	
Definition/Description	One-time sessions that focus on information about HIV (e.g., transmission and behavior change), motivational activities, and skills building. It may also touch on other relevant issues specific to the target population. This intervention may be implemented as planned

	groups, impromptu groups, or before/after bar groups.
Implementation Recommendations	<p><i>Presentations and lectures:</i></p> <ul style="list-style-type: none"> ▪ Advertise or promote the availability of prevention or care services. ▪ Recruit participants to HIV programs during other (not directly HIV-related) activities. ▪ Provide additional support, follow-up groups, and/or "booster" groups. <p><i>Providers must:</i></p> <ul style="list-style-type: none"> ▪ Include ground rules created and adopted by participants. ▪ Include discussions about multiple issues (e.g., racism, homophobia). ▪ Be available before or after the intervention to provide confidential, one-on-one referrals to other prevention services within or outside of the agency.
Strengths	<p><i>Presentations and lectures can be:</i></p> <ul style="list-style-type: none"> ▪ An initial exposure for other HIV programs. ▪ Designed specifically to educate people who might become educators or advocates themselves. ▪ Run as one-time skills-building workshops, especially for those people who have been assessed as having knowledge, attitudes, and beliefs favoring risk reduction, but have not changed behavior. ▪ Beneficial for groups that cannot commit to multiple sessions (agencies should indicate why their clients cannot commit to multiple sessions). ▪ Serve as a first step or launching pad for clients' other prevention-oriented activities, if they focus on creating linkages. ▪ Good for populations at lesser risk that have information, but want to build awareness and sensitivity (e.g., friends, family, or employers of people with HIV). ▪ Used to reduce the demands made on testing centers by people who are just worried about HIV in an unspecified way, by clarifying they do not have any actual risk.
Limitations	<p><i>Presentations and lectures are:</i></p> <ul style="list-style-type: none"> ▪ Not as effective as multiple session groups at changing HIV risk behavior. ▪ Not as helpful for people with serious mental health issues and for those most in denial about their risk. ▪ Not as beneficial and less feasible for the highest risk populations (agencies should demonstrate the acceptability/ feasibility of the single session group intervention to their target population).

SPEAKER BUREAUS	
Definition/Description	Speaker bureaus bring together individuals who have been impacted by the HIV epidemic to speak to groups of people, communities, or organizations.
Implementation Recommendations	<p><i>Speaker bureaus:</i></p> <ul style="list-style-type: none"> ▪ Presentations can be interactive and can be in single or multiple session formats. ▪ Could include, but are not limited to, PLWH, their family members, their friends, their significant others, health educators and service providers.
Strengths	<p><i>Speaker bureaus:</i></p> <ul style="list-style-type: none"> ▪ Are accessible to people at a low literacy level. ▪ Can be helpful for people needing basic information about HIV. ▪ Can have an impact on people who don't know anyone with HIV. ▪ Can serve as a denial-breaker for people with low perception of personal or communal risk. ▪ Can work well with people in institutional settings such as school, jail, etc.
Limitations	<p><i>Speaker bureaus:</i></p> <ul style="list-style-type: none"> ▪ Are not as appropriate for people with multiple issues or mental health stressors. ▪ Are generally not sufficient as the only intervention provided to a group. ▪ Should not be done in isolation from other prevention activities.

COMMUNITY-LEVEL INTERVENTIONS (CLI)

Community-level interventions are interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. CLI seeks to change the attitudes, norms, and values as well as the social and environmental context of risk behaviors of an entire community, not simply individual members of the community. CLI are based upon research among community members and incorporate community input and involvement in program design, implementation, and evaluation. Ideally, CLI programs utilize peer networks within a community as a means of increasing the effectiveness of CLI and sustaining intervention efforts after professional and service providers are gone.

Community-based approaches to behavior change provide information and skills on the community level to change behavior and encourage a supportive social environment through channels and methods that are indigenous to the community. Community-level efforts create structures and systems that assist in the maintenance of healthy behaviors. These interventions are based on several theories including Social Learning Theory, the Health Belief Model, and Diffusion Theory (Coates 1990).

CLI takes a system approach, by addressing the social networks and social norms that influence people's knowledge, attitudes, beliefs, skills, and behaviors. Changing social environments takes time; therefore the results of community-level interventions may not be immediately visible.

MINIMUM STANDARDS: COMMUNITY-LEVEL INTERVENTIONS

A systems approach that seeks to influence specific behaviors using social networks (e.g., sex-workers, IDUs, MSMs, transgender, etc.) to consistently deliver HIV risk-reduction interventions.

Minimum Criteria

- A focus on the community as a whole, rather than by intervening with individuals or small groups.
- Cannot be funded as a stand-alone intervention, must be coupled with other approved interventions.

Quality Assurance Measures

- Staff providing interventions should be recruited from the targeted population.
- Agency demonstrates the ability to access target population.
- Agency demonstrates the ability to work with the target population.

Data Requirements

- The Iowa HIV Prevention & Evaluation System does not require demographics for this intervention.

COMMUNITY ORGANIZING

Community mobilization is a strategy that involves grassroots outreach and education that takes place within a specified neighborhood or community. The goal is to increase awareness of HIV/AIDS issues. Mobilization provides a foundation for increasing participation of residents in HIV prevention and service activities. Community mobilization can take many forms, ranging from volunteer recruitment to solicitation of participation in public events or forums, to assistance with attaining specific policy ends. It generally strives to work within a community's specific value systems and norm set. Depending upon the form community mobilization takes, it

may or may not focus on HIV-related behavior change, involve interactive discussions, or be repeated over time.

Community mobilization and organizing involves community-wide efforts that bring together members of the target community to address the issue of HIV and/or other related issues (drug use, homophobia, racism, etc.). Methods used to bring members of the community together vary according to the needs and characteristics of the target population. The theoretical underpinning of community organizing for health behavior change is based in several theories including Social Cognitive Theory, the Health Belief Model, and Diffusion Theory (Coates 1990). Community organizing involves defining a community by understanding how the target population defines its community. This could be geographical, cultural, gender-related, environmental, behavior, issue-related, and many other ways. Community organizing addresses the population characteristics that create obstacles to HIV risk reduction, creates networks that can be utilized for conducting other interventions, and provides a means for creating health promoting social norms.

Community-level interventions seek to reduce risk behaviors by changing attitudes, norms, and behaviors through health communications, social (prevention) marketing, community mobilization, and community-wide events. The common denominator of these strategies is their focus on community and social group identity.

COMMUNITY ORGANIZING	
<i>A systems approach that seeks to influence specific behaviors using social networks (e.g., sex-workers, IDUs, MSMs, transgender, etc.) to consistently deliver HIV risk-reduction interventions.</i>	
Definition/Description	Community organizing involves community-wide efforts that bring together members of the targeted community to discuss problems and jointly propose solutions for HIV and/or other related issues (drug use, homophobia, racism, etc.). Community organizing strategies often have a basis in empowerment theory.
Implementation Recommendations	<p><i>Agencies should:</i></p> <ul style="list-style-type: none"> ▪ Allow the problem, the solution, and the course of action to be defined by the community. ▪ Facilitate the process, participate in dialogue regarding HIV information, and secure resources to promote community involvement and assist the community in attaining its goals. ▪ Address multiple needs of communities or collaborate with other agencies that can address those issues. <p><i>Community organizing/empowerment strategies should:</i></p> <ul style="list-style-type: none"> ▪ Seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. ▪ Cannot be funded as a stand-alone intervention but must be coupled with other approved interventions. ▪ Develop and strengthen social norms for HIV prevention. ▪ Increase communication channels for HIV prevention norms. ▪ Increase participants' self-advocacy skills and sense of personal control. ▪ Identify barriers to HIV prevention in the community. ▪ Increase community participation around issues affecting the community. ▪ Acknowledge and consider existing strategies that are working in a community.
Quality Assurance Measures	<p><i>Agencies must demonstrate an ability to:</i></p> <ul style="list-style-type: none"> ▪ Recruit staff or volunteers from the targeted population

	<ul style="list-style-type: none"> ▪ Access the target population ▪ Work with the target population
Data Requirements	<p><i>For community organizing:</i></p> <ul style="list-style-type: none"> ▪ The Iowa HIV Prevention & Evaluation System does not require client demographics. ▪ Providers must identify the type of community level or social marketing intervention.
Strengths	<p><i>Community organizing:</i></p> <ul style="list-style-type: none"> ▪ Has a strong theoretical foundation. ▪ Makes the community's own perspective and desires central. ▪ Addresses community-level obstacles to HIV risk reduction. ▪ Creates networks that can be used to conduct other interventions. ▪ Can contribute to health-promoting social norms. ▪ Is most likely to be successful in communities that have a strong identification (geographical, psychosocial, psychocultural, political, economic). ▪ Is suitable for isolated populations whose members need connection, although this is challenging. ▪ Is particularly appropriate for groups with multiple issues.
Limitations	<p><i>Community organizing:</i></p> <ul style="list-style-type: none"> ▪ Is more difficult to implement with isolated populations than with groups with a strong identity. ▪ May not be appropriate for populations that fear lack of confidentiality or those for which identification could endanger the community, such as undocumented immigrants or commercial sex workers. ▪ May not be appropriate for populations that fear lack of confidentiality and refuse to come together, such as small populations where privacy is an issue. ▪ Could be difficult with populations where identification of its members could endanger the community, such as undocumented immigrants or commercial sex workers.

SOCIAL MARKETING

Social marketing is the concept of using additional marketing tools traditionally used to sell consumer products, to "sell" healthy behaviors to target audiences. The goal is to promote behavior that is socially desirable and that contains clearly defined value for the individual (and community), such as smoking cessation, HIV prevention, or childhood immunization. A particular behavior (such as condom use) is made socially desirable by linking it to something that is valued by the targeted community (such as family values or erotic sex).

Social marketing involves the production of a message disseminated through a mode that is appropriate and effective for the target population. It includes development of a marketing plan, design of a message, use of mass media, consensus building, and packaging (Coates 1990). Social marketing is successful when it involves active participation of both the providers and the recipients of information and or services at each stage of the process. In this way, the target group will recognize the benefit(s) of the program and can adopt (or buy) the changes advocated. Social marketing in its ideal form requires thorough program planning and integration. In addition, market research, testing, and evaluation are critical components to effective social marketing.

SOCIAL MARKETING	
Definition/Description	Using traditional consumer marketing tools to promote healthy behaviors, change social norms, or recruit target audiences for participation in health promotion activities.
Implementation Recommendations	<p><i>Agencies should:</i></p> <ul style="list-style-type: none"> ▪ Conduct market research, field testing, and evaluation for their campaigns. ▪ Conduct formative evaluation to ensure the cultural and linguistic appropriateness of the campaign, the salience of the issues, the stage of behavior change, the social norms, and appropriate message channels for the target population. ▪ Involve the recipients of information or services (the "product") in planning. <p><i>Social marketing campaigns should:</i></p> <ul style="list-style-type: none"> ▪ Change behavior by demonstrating the desired behavior in a real-life context. ▪ Promote the idea that adoption of this behavior will result in lower HIV risk. ▪ Link the target population to available resources. ▪ Affirm health-promoting social norms of the target population. ▪ Be designed to increase knowledge and change attitudes about HIV/AIDS.
Strengths	<p><i>Social marketing campaigns can:</i></p> <ul style="list-style-type: none"> ▪ Be effective with those who need new information to change behavior. ▪ Motivate people to act. ▪ Reach large and diverse segments of the population. ▪ Be effective with those who want to change their behavior but have not. ▪ Be accessible to those who are difficult to reach through traditional prevention channels.
Limitations	<p><i>Social marketing campaigns may not be:</i></p> <ul style="list-style-type: none"> ▪ Appropriate for those engaging in the highest risk behavior. ▪ Successful with those who are isolated and do not see themselves in relation to the campaign. ▪ Able to pinpoint as the cause of behavior change. ▪ Cost effective.

Social marketing strategies require attention to the four "Ps": product (the behavior or idea you are trying to promote), price (the monetary or other costs/disadvantages associated with adopting the behavior or idea), promotion (which media channels you will use), and place (how and where you will disseminate the message so that it reaches the target population).

PUBLIC EVENTS

Community-level venue-based outreach involves a group of individuals who present HIV prevention activities in community settings (e.g., street corners or public forums), commercial settings (e.g., bars, sex clubs, concert houses, and theaters), or public events (e.g., street fairs and parades). The outreach activities may occur in existing settings or settings especially created for the purpose of HIV prevention. Venue-based group outreach can take a variety of forms including community theater, dramatizations of real-life scenarios, "bar zaps," and interactive performance art. This type of outreach is designed to promote HIV risk reductive behaviors among audience members. The distribution of appropriate prevention materials may also be a component of these activities.

DRAMA, THEATER, AND ROLE-PLAY	
Definition/Description	Encompasses any activities that use acting, theater, music, story telling, puppetry, role-play, or other dramatization techniques to deliver HIV prevention interventions. It may be used in individual (e.g., role-play), small group (e.g., skits) or community-level

	<p>interventions (e.g., street theater). Professional or amateur actors may perform the drama as an intervention for the audience (e.g., a formal theatrical presentation). Members of the target may perform the drama population as an intervention for themselves (e.g., participants in a group workshop doing role-plays with each other).</p>
Implementation Recommendations	<p><i>Providers using drama and theater should:</i></p> <ul style="list-style-type: none"> ▪ Assure that actors are available to answer questions and give referrals after the presentation. ▪ Assure dramatizations depict realistic scenarios. ▪ Integrate communication of accurate HIV/AIDS information into the performance. ▪ Address the target population's attitudes and beliefs about HIV transmission. <p><i>Role plays must:</i></p> <ul style="list-style-type: none"> ▪ Be grounded in realistic scenarios. ▪ Incorporate practice of skills (e.g., condom negotiation). ▪ Be followed by discussion.
Strengths	<p><i>Drama and theater can:</i></p> <ul style="list-style-type: none"> ▪ Encourage positive attitudes toward people living with HIV/AIDS. ▪ Model and encourage condom use. ▪ Be useful for individuals who do not speak or read English. ▪ Address the multiple issues people face in their lives that affect HIV risk behavior.
Limitations	<p>Theater when used alone may be limited in its ability to affect behavior.</p>

COST EFFECTIVENESS

CDC scientists have developed tools for estimating the economic impact of HIV prevention programs, taking into consideration the effective combination drug therapies now available. The economic model estimates lifetime treatment costs (based on the newest treatment scenarios) and balances these costs against the current national investment in HIV prevention to determine what level of success is needed to save the nation money.

The lifetime costs of health care associated with HIV, in light of recent advances in HIV diagnostics and therapeutics, have grown from \$55,000 to \$155,000 or more per person. This amount represents the money saved per infection averted through prevention. HIV prevention efforts can be cost-effective and even cost saving to society. Cost-effective means that the costs of the intervention compare favorably to life-saving interventions associated with other diseases, usually costing less than \$50,000 per quality-adjusted life year saved. Cost-saving means that the intervention averts health care costs in excess of the cost of the intervention. These efforts include (1) counseling, testing, referral, and partner notification services for clients at high risk for HIV infection; (2) needle and syringe exchange programs; and (3) information, education, and counseling for injecting drug users.

The cost effectiveness of interventions is an important issue in decisions about resource allocation. According to (Kelly, Murphy et al. 1994), for an HIV prevention intervention to be cost effective it must also be effective in producing behavior change. The prioritized interventions that have been approved by the CPG are based on behavior theory and have shown demonstrated effectiveness. Although the number of investigations that report cost-effectiveness is minimal, various methods have been discussed in the literature for evaluating cost-effectiveness.

Holtgrave (1994) discusses the use of cost analysis, cost-benefit analysis, and cost-effectiveness to inform policy makers. Cost-analysis can assist decision-makers in deciding whether financial resources are adequate. Cost-benefit analysis can direct decisions if the question is whether the social benefits surpass the costs. Cost-effectiveness analyses can guide the questions of whether allocating funds to HIV prevention is a better investment than allocating to other health programs. According to Holtgrave (1994), health interventions can be gauged or estimated using standard methods such as bottom-up or top-down approaches. In the former method, direct (intervention factors that utilize resources) and indirect (overhead) costs are summed. The top-down approach uses a budget approach to estimate the actual cost of a program. Both types can be useful to prevention planners when evaluating the cost-effectiveness of interventions (Holtgrave 1994).

In a later article, the authors refer to the additional cost analytic methods of cost-benefit analysis and cost-utility analysis. To be considered cost saving, the number of HIV cases that were averted by the intervention multiplied by the dollar cost of treatment must be greater than the costs of the HIV prevention program. The cost effectiveness of several HIV prevention programs led to the conclusion that behavioral interventions can be cost-effective and even cost saving (Holtgrave, Qualls et al. 1995).

In a 1993 study, Holtgrave and colleagues estimated the costs of the national Counseling, Testing, Referral and Partner Counseling and Referral programs and found them to be cost saving in terms of HIV cases averted. They concluded that the economic benefits outweigh the costs even if only one HIV infection was averted for every 100 persons tested (Holtgrave, Valdiserri et al. 1993). The evaluation of a skills training program when compared with a lecture-only intervention found that the addition of skills training was cost-effective in terms of the number of HIV infections avoided (Pinkerton, Holtgrave et al. 1998). Pinkerton et al. concluded that HIV interventions are the most cost-effective when targeted to high-risk communities and high-risk individuals. The following are examples of applying cost effectiveness to specific interventions (Pinkerton, Holtgrave et al. 1998).

Peer Leaders/Mobilization

Peer health programs are cost effective in terms of training peers to carry out health prevention programs without the expense of additional health care professionals (Sloane and Zimmer 1993). Peers are more likely to gain access to target populations by meeting with them where they live, work, and socialize. Peer educators also extend the life of intervention efforts in the community because they may remain after professionals have departed (1995).

Pinkerton et al. (1998) evaluated the cost effectiveness of a community level HIV prevention intervention that used peer leaders to endorse risk reduction among gay men. The intervention cost \$17,150, or about \$65,000 per infection averted. Assuming the lifetime medical care costs associated with HIV and AIDS range from \$71,000 to \$119,000, this was considered to be cost saving, even under very conservative modeling assumptions. In a summary of analyses of cost-effectiveness, (Kahn 1995) cites several studies that found training leaders in the gay community was a cost-effective approach to averting new HIV infections. Similarly, in an analysis of a community level peer mobilization effort among young gay men, the cost per HIV infection averted was reported to be \$11,500, a figure much lower than the medical costs associated with treating a case of HIV/AIDS.

Multiple Session HIV Prevention Intervention

One study examined the cost-effectiveness of a behavioral HIV prevention intervention for at-risk women attending urban primary health care centers. The intervention consisted of five sessions covering basic HIV related information, condom-use skills training, peer support, self-management, and assertiveness, communications, and negotiation in sexual situations. Clients receiving this intervention used condoms significantly more often than clients not receiving the intervention. Although the intervention cost approximately \$260 per client, careful analysis shows that the increases in condom use likely led to a reduction in HIV transmission and when HIV infections are avoided, medical costs of care and treatment are saved.

A paper was presented at the XI International Conference on AIDS, showing the cost-effectiveness of a 12-session behavioral HIV intervention for gay men that included HIV education, condom skills training, and self-management and communications techniques. This intervention cost approximately \$470 per client. However, the intervention led to a significant increase in condom use. Such an increase is very likely to have significantly reduced HIV transmission among intervention clients and their partners (1998). Therefore, cost-effectiveness analysis shows that multiple session interventions appear to be a cost-effective use of resources.

Perinatal Transmission

Scientific findings on the effectiveness of using prenatal, perinatal, and postnatal zidovudine therapy to prevent perinatal HIV transmission led the Public Health Service to recommend routine HIV counseling and voluntary testing for all pregnant women. In 1996 CDC research directly analyzed the cost-effectiveness of those recommendations. HIV counseling, voluntary testing, and zidovudine therapy for those infected with HIV, is a cost-savings to society (1998).

Choosing an Intervention

Cohen, Wu, and Farley (2005) recommend using cost effectiveness as one way to maximize local HIV prevention resources. The authors reviewed 26 HIV prevention interventions and recommended up to nine interventions based on local target population HIV prevalence and cost per person reached. The most cost-effective interventions are targeted to high-risk populations (e.g., men who have sex with men) or are inexpensive per person reached (e.g., condom availability programs and mass-media campaigns). They recommended reserving intensive interventions (e.g., group and individual) for high risk populations. The authors did not evaluate the benefits of prevention with people living with HIV due to the lack of evidence at the time the article was published. They did suggest that the interventions might later be shown to be cost-effective because of the high probabilities of transmission in the target population and their contacts. Multiple authors have determined that prevention with PLWH can be more effective at reducing risk behavior than interventions targeted at HIV-negative persons (Cohen 2004)

To be effective, HIV prevention efforts must optimize the number of HIV infections averted. As more interventions are developed, state health departments and community planning groups must choose among the available strategies to develop an effective plan that maximizes limited resources. Cost effectiveness should not be the sole determinant in allocating HIV prevention resources. Other critical factors include the intervention's demonstrated effectiveness, feasibility, acceptability, and replicability within the local community. Availability of staff with appropriate expertise, infrastructure support, and the quality of the relationship between providers and the target groups are additional factors to consider (Wu et al., 2004).

Evidence exists that demonstrates that HIV prevention services are both effective and cost-effective. While HIV prevention programs have reduced new infections and HIV transmission rates, the goal of reducing new HIV infections has not been achieved. A contributing factor to this failure to reduce new infections is insufficient funding, imperfect targeting strategies, and a policy that creates barriers to use of known life-saving interventions (Holtgrave 2006).

BARRIERS TO IMPLEMENTING INTERVENTIONS

Complacency

In the United States complacency about the need for HIV prevention may be among the strongest barriers communities face as they plan to meet the next century's prevention needs. The success that many people have had with new Highly Active Antiretroviral Therapies (HAART) and the resulting decline in the number of newly reported AIDS cases and deaths are good news. The underlying reality, however, is that the HIV epidemic is far from over. The success of HAART is good news for the people living longer, better lives because of it, but the availability of treatment may lull people into believing that preventing HIV infection is no longer important. This complacency about the need for prevention adds a new dimension of complexity for both program planners and individuals at risk.

- While the number of AIDS cases is declining, the number of people living with HIV infection is growing. This increased prevalence of HIV in the population means that even more prevention efforts are needed. For individuals at risk, increased prevalence means that each risk behavior carries an increased risk for infection.
- Past prevention efforts have resulted in behavior change for many individuals and helped slow the epidemic overall. However, many studies find that high-risk behaviors, especially unprotected sex, are continuing at a high rate. This is true even for some people who have been counseled and tested for HIV, including those found to be infected.
- The long-term effectiveness of HAART is unknown. Further, HIV may develop resistance to these drugs. The powerful treatments are complicated and involve taking large numbers of pills. Even the most motivated patient may forget to take all their medications or skip doses. Some patients may completely stop taking their medications for a number of days or weeks. Drug treatments are less effective when treatment schedules are not followed. Diversions from the prescribed treatment regimen increase the possibility of drug resistance developing. If the development of drug-resistance is coupled with a relaxation in preventive behaviors, resistant strains could be transmitted to others and spread widely.
- Research among gay and bisexual men suggests that some individuals are less concerned about becoming infected than in the past and may be inclined to take more risks. This may be equally true in other groups at risk who might believe they no longer need to use condoms because protease inhibitors are so effective in treating HIV disease.

Section 3: Intervention Sets for Target Populations

Prevention Interventions

Priority Sets

Evidence Based Interventions Fact Sheets

PRIORITIZED INTERVENTIONS FOR IOWA'S TARGET POPULATIONS

The Strategies for Prevention Interventions and Community Endeavors Committee presented the categorization scheme to the CPG. The committee described each intervention as specifically as possible to assure that CPG members were comfortable with how interventions or curriculums are defined. Examples of each intervention derived from Iowa's current prevention projects were given.

A set of interventions for each target population was presented and the CPG voted unanimously to accept the lists. The following criteria were used to set priorities.

- Are there indicators that the intervention is effective or might be effective in averting or reducing high-risk behavior?
- Is the intervention based on behavioral and/or social science theory?
- Is the intervention specifically designed to reach the target population?
- Does the intervention target specific behaviors, attitudes, beliefs, norms, or barriers that place people at risk for HIV infection?
- How feasible is the intervention?
- Is the intervention legal?
- Is the intervention practical given available expertise, funding, and implementation time?
- Are there resources available to assist in the delivery of the intervention?
- Is the intervention sustainable over time?
- Is the intervention acceptable to the target population?
- Is there evidence that the intervention is cost-effective?
- How accessible is the intervention to the target population?
- Can the intervention be adapted for rural communities?

The interventions recommended most frequently were group-level interventions, individual interventions, outreach, and counseling and testing. These interventions reflect the findings contained in the discussion of interventions in this chapter. The interventions most often cited tend to be those that are highly interactive, approach people where they congregate, are emphasized over time, and focus on behavior/change or changes in group/social norms. Iowa's CPG is cognizant that providers of HIV prevention programs must be aware of cultural norms and develop culturally competent programs.

Outreach

Outreach must be coupled with one or more of the other approved interventions. It cannot be funded as a stand-alone intervention, (i.e. as the only intervention in a program). Additionally, providers must incorporate an outreach component into all interventions.

Implementation

Once an intervention is adopted, its actual impact will depend on how it is implemented. It is important to achieve a balance between adapting the intervention to suit local needs and maintaining the core elements and key characteristics that made the original intervention successful. The agency that implements the intervention will require organizational support, adequate staffing, and sufficient resources for implementation.

Fact Sheets

The chapter concludes with descriptive fact sheets for each of the interventions chosen for the target populations as identified by the CPG. The fact sheets, list the type of intervention, risk behaviors addressed, behavior theory, a summary of each intervention, and core elements. Core elements are those features responsible for the effectiveness of the intervention and should not be changed without prior approval from funding agencies, e.g. IDPH. Intended outcomes, evidence of effectiveness, staffing requirements, duration and frequencies are also provided. Reference information and curriculum source are provided for those interested in further information.

Evidence Based Interventions

Evidence Based Interventions are those interventions that have been approved by the CDC for implementation. These interventions have been evaluated and replicated. The attention given to Evidence Based Interventions is not intended to minimize the role of providers' experience with their communities, their constituents, and their services. It is intended to highlight the importance of increasing the extent to which prevention funds are used for interventions with known or strongly supported effectiveness (CDC, 1999)

Developing an Intervention Plan

The target population's needs, as defined in chapter 3, should be reflected in the intervention plan. Providers must provide assurance that the intervention design and implementation address other needs such as culturally competence, accessibility, and specificity. Relevance refers to the extent to which an intervention plan addresses the needs of the affected population.

Scientific soundness considers the scientific foundation of each element covered in the intervention plan. This criterion emphasizes the need for clear and logical evidence to support the inclusion of a specific characteristic, strategy, or approach in the design and implementation of the intervention. Such an approach assumes that systematized knowledge is applied in the conception, development, and choice of intervention components. Scientific soundness also refers to the application of behavioral and social science theories developed or adapted by the provider. A theory describes the projected relationships between a problem or need, an intervention, the hypothesized effects of the intervention, and desired outcomes.

Relevance and scientific soundness are integral parts of an intervention plan. An intervention plan without relevance may lead to inappropriate allocation of resources. A relevant intervention that is not carefully specified and based on scientific evidence will not be as likely to yield positive benefits for the population it is intended to serve.

The following table provides a framework for developing an Intervention Plan.

Category	
Target population specification	<ol style="list-style-type: none"> 1) Correspondence to a priority population (chapter 4) 2) Demographics (age, race, ethnicity, sex) 3) Risk factors 4) Audience coverage (how much of the target population will be reached)
Choosing interventions	<ol style="list-style-type: none"> 1) Efficacy of the intervention 2) Behavioral or social science basis

	<ul style="list-style-type: none"> 3) Cost effectiveness 4) Scientific evidence <ul style="list-style-type: none"> a) Prior evaluation data b) Previously evaluated intervention model with a similar population c) Previously evaluated intervention model with a different population d) Applied formal theory in program development <ul style="list-style-type: none"> i) Behavioral ii) Social science iii) Logic models iv) Means by which intervention will affect outcomes 5) Intensity – dose effect
Establishing intervention goals and outcome objectives	<ul style="list-style-type: none"> 1) Process objectives <ul style="list-style-type: none"> a) Amount, frequency, duration of activities, number and characteristics of people to be served 2) Outcome objectives <ul style="list-style-type: none"> a) Intended effects of the intervention (increasing knowledge, changing behavior, affecting norms, reducing transmission)
Developing an implementation strategy and process objectives	<ul style="list-style-type: none"> 1) Where the intervention will take place 2) How the provider will serve the target population
Assessing characteristics of the implementing organization	<ul style="list-style-type: none"> Resources (human, financial, institutional) Organization’s experience Linkages Staffing (including quality assurance) Budget and resources
Describing the data system	<ul style="list-style-type: none"> Progress documentation Assessment Process evaluation Data collection Decision making

Interventions

Persons Living with HIV

Intervention Name	Intervention Level	Curriculum or DEBI	Description	Age Group	Delivery	Author, Year
OPTIONS/OPCIONES	Individual	Curriculum Medical Providers	Men Women	Adult	Physician Delivered	Fisher, 2004
Partnership for Health	Individual	Curriculum Medical Providers	Men Women	Adult	Physician Delivered	Richardson, 2004
Partner Counseling Referral Services (PCRS)	Individual	CDC Training	Men Women	Adult Youth	Iowa Department of Public Health Delivered	CDC

Persons Living with HIV

Intervention Name	Intervention Level	Curriculum or DEBI	Description	Age Group	# Sessions	Length	Author, Year
CLEAR	Individual	Curriculum Advanced CRCS	Substance Abusing	Young Adults (16-29 years)	18	27 hours	Rotherman-Borus, 2004
POWER	Individual	Curriculum	Men Women	Adult Youth			
Comprehensive Risk Counseling & Services (CRCS)	Individual	Curriculum	Men Women	Adult Youth			CDC, 2006
Learning Immune Function Enhancement (LIFE)	Individual; Group	Curriculum	Men Women	Adult Youth	16	16 hours	Shanti Institute
Healthy Relationships	Group	Curriculum	Men Women	Adult	5	10 hours	Kalichman, 2001
Holistic Health Recovery Program	Group	DEBI Curriculum	Injection Drug Users	Adult	12	24 hours	Margolin, 2003
WILLOW	Group	Curriculum DEBI	Sexually-Active Women Clinic Patients	Adult Note: Requires implementation of SISTA	4	16 hours	Wingood & DeClemente, 2004
Together Learning Choices	Group	Curriculum	Adolescents	Youth	5	10 hours	Rotherman-Borus, 2001
Community Promise	Community	DEBI Curriculum DEBI	Men Women	Adult	Continuous	Continuous	CDC AIDS Demonstration Project, 1999

Men Who Have Sex with Men

Intervention Name	Intervention Level	Curriculum or DEBI	Description	Age Group	# Sessions	Length	Author, Year
EXPLORE	Individual	Curriculum	Gay/Bisexual	Adult	10	10 hours total (+ 1-7 boosters & CT)	EXPLORE Team, 2004
Many Men, Many Voices	Group	Curriculum DEBI	Gay/Bisexual	Adult	7	2-3 hours per session	Kelly, 1989
MPowerment	Community	Curriculum DEBI	Gay/Bisexual	Youth Adult	Continuous		Kegeles, 1996
Community Promise	Community	Curriculum DEBI	Gay/Bisexual	Adult	Continuous		CDC AIDS Demonstration Project, 1999
Popular Opinion Leader	Outreach	Curriculum DEBI	Gay/Bisexual	Adult	Continuous		Kelly, 1991

Injection Drug Users

Intervention Name	Intervention Level	Curriculum or DEBI	Description	Age Group	# Sessions	Length	Author, Year
CLEAR	Individual	Curriculum	Substance Abusing	Youth	18	27 hours	Rotherman-Borus, 2004
Safety Counts	Individual, Group	Curriculum DEBI	Injection Drug Users	Adult	2 individual 2 group 2 social events 2 follow-up	10 hours	Rhodes, 1993
Turning Point	Group; Individual	Curriculum	Men Women	Adult	1 individual + 3 group	1 hour individual 4.5 hour group	Siegal, 1995
Project Smart – Enhanced	Group; Individual	Curriculum	Men Women	Adult	6 groups + 1 individual	1 hour group sessions 30 minutes individual	McCusker, 1992
Reach One Teach One	Group; Individual	Curriculum	Men	Adult			Grinstead, 1997
Holistic Health Recovery Program	Group	Curriculum DEBI	Injection Drug Users	Adult	12	24 hours	Margolin, 2003
SHIELD	Group	Curriculum	Low-income AA drug users	Adult	10	15 hours	Latkin, 2003
Community Promise	Community	Curriculum DEBI	Men Women	Adult	Continuous		CDC AIDS Demonstration Project, 1999
Real AIDS Prevention Project (RAPP)	Community	Curriculum DEBI	Women IDU	Youth Adult	Continuous		Lauby, 2000
Point for Point: Syringe & Needle Exchange	Structural	Curriculum			Ongoing		Watters, 1996

Heterosexuals

Intervention Name	Intervention Level	Curriculum or DEBI	Description	Age Group	# Sessions	Length	Author, Year
Project Start	Individual		Men	Adult	1	30 minutes	Grinstead, 1999
Love Your Man, Love Yourself	Individual	Inside/Out Video	Women	Adult	1		Comfort, 2000
Voices/Voces	Individual	Curriculum DEBI	AA and Hispanic men and Women	Adult	1	60 minutes	O'Donnell, 1998
Project Safe	Individual; Group	Curriculum	Hispanic and African American women with STD diagnosis	Adult	3 + STD C&T + HIV C&T	9-16.5 hours 9 Videos	Shain, 2004
Reach One Teach One	Individual; Group	Curriculum	Men	Adult			Grinstead, 1997
SISTA	Group	Curriculum DEBI	African American women	Adult	5	10 hours	DiClemente, 1995
WILLOW Have to be doing SISTA	Group	Curriculum DEBI	Sexually-Active women	Adult	4	16 hours	Wingood, 2004
Popular Opinion Leader	Outreach	Curriculum DEBI	Women	Adult			Kelly, 1991
Community Promise	Community	Curriculum DEBI	Men Women	Adult Youth			CDC AIDS Demonstration Project, 1999
Real AIDS Prevention Project (RAPPP)	Community	Curriculum DEBI	Women	Adult			Lauby, 2000

High Risk Youth

Intervention Name	Intervention Level	Materials	Description	Age Group	# Sessions	Length	Author, Year
CLEAR	Individual	Curriculum	HIV + Substance Abusing	Teens Adults 16-29	18	27 hours	Rotherman-Borus, 2004
Focus on Kids (FOK) + Impact	Group	Curriculum	Low income AA	Youth	8 FOK + 1 IMPACT	12 hours + 20 minutes	Wu, Stanton. 2004
SIHLE	Group	Curriculum DEBI	Sexually-active AA female adolescents	Youth 15-18 Note: Requires prior implementation of SISTA	4	16 hours	DiClemente, 2004
Making Proud Choices	Group	Curriculum		Youth	8	8 hours	Jemmott, 1999
SISTA	Group	Curriculum DEBI	African American women	Youth 15-18	5	10 hours	DiClemente, 1995
Street Smart	Group	Curriculum DEBI	Homeless and runaway youth	Youth	8	90-120 minutes/ group	Rotherman-Borus, 1993
Community Promise	Community	Curriculum DEBI	Men Women	Adult Youth	Continuous		CDC AIDS Demonstration Project, 1999

INTERVENTION FACT SHEETS

CLEAR

Choosing Life: Empowerment, Action, Results

Program Overview

CLEAR is an individual-level intervention for youth living with HIV. *CLEAR* is an adaptation of the intervention Teens Linked to Care. *CLEAR* is based on Social Action Theory that emphasizes how contextual factors influence an individual's ability to respond effectively to stressful situations, solve problems, and act to effectively reach goals. *CLEAR* is an individually delivered intervention (similar to existing protocols for *Comprehensive Risk Counseling and Services* (CRCS)) aimed at reducing sexual risk-related behaviors for young people living with HIV. *CLEAR* will be the first evidence-based approach to CRCS that will be distributed by CDC. As a result most of the core elements and key characteristics are identical to CRCS.

Core Elements (*Must do all*)

- 3 modules – Staying Healthy, Acting Safe, and Being Together.
- Each module is at least 6 sessions long
- Delivery is done in-person one-on-one format.
- Provide *Comprehensive Risk Counseling and Services* combined with case management for those clients for whom case management services are not otherwise available
- Base *Comprehensive Risk Counseling and Services* on the premise that some people may not be able to prioritize HIV prevention when faced with problems they perceive as more important
- Consider persons whose HIV status is negative or unknown to be eligible if they have a recent (past 3-6 months) history of unprotected sex with a person living with HIV, unprotected sex in exchange for money or sex, multiple or anonymous sex or needle-sharing partners, or a diagnosis of an STD
- Recruit persons who have commitment to participate in ongoing risk-reduction counseling
- Hire case managers with appropriate training and skills to complete *Comprehensive Risk Counseling and Services* activities within their job description

Online Resources~ The following resources will provide more information regarding *Choosing Life: Empowerment, Action, Results*:

- <http://chipts.ucla.edu/interventions/manuals/intervclear.html>
- http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance_crcsupvhrh.pdf
- <http://www.cdc.gov/hiv/pubs/pcmg/pcmg-doc.htm>
- <http://www.cdc.gov/hiv/pubs/pcml/pcml-toc.htm>

- Develop clear procedures and protocols for your agency's *Comprehensive Risk Counseling and Services* program

Key Characteristics (*Steps to follow*)

- Develop a client recruitment strategy
- Identify clients who are at highest risk and appropriate for *Comprehensive Risk Counseling and Services* through screening and assessment
- Develop a written, client-centered prevention plan
- Multiple HIV risk-reduction counseling sessions
- Coordinate services with follow-up
- Reassess clients' needs, risks, and progress
- Discharge clients once they have reached and maintained their risk-reduction goals
- Establish protocols to classify clients as "active," "inactive," or "discharged" and outline the minimum effort required to retain clients

Target Population

CLEAR is designed for substance-using youth living with HIV.

Program Materials

- Staff should attend a *CLEAR* PCM/CRCS training that will be taught by the 4 Prevention Training Centers starting in late summer of 2006.
- Staff who are familiar and comfortable with *Comprehensive Risk Counseling and Services* clients, have training in *Comprehensive Risk Counseling and Services*, and have worked with or a least are able to identify people with mental health needs.
- Staffing needs vary according to number of clients and availability of other services (typical caseload is 12-20 clients/full-time provider)
- Appropriate referral resources

Program Outcomes

- Youth participants significantly reduced their risk related transmission behaviors
- Youth increased overall condom use
- Youth increased condom use with HIV negative

COMMUNITY PROMISE

Peers Reaching Out and Modeling Intervention Strategies

Program Overview

Community PROMISE (Peers Reaching Out and Modeling Intervention Strategies) is a community-level intervention model for any high-risk population in which there are established peer influences. *Community PROMISE* focuses on the influencing risk factors for a specific population. *Community PROMISE* is based on theories that indicate that messages in role model stories can change behavior by influencing attitudes, beliefs, and norms through peer influence within social networks. The intent of this intervention is to increase condom use, condom carrying, bleach use, and drug-related risk-reduction behavior. *Community PROMISE* uses a community identification process; produces role model stories; recruits, screens, and trains peer advocates to distribute the stories; uses continuous formative evaluation.

Core Elements (*Must do all*)

- Conduct community identification process to identify, prioritize, access, understand populations
- Write role model stories based on personal accounts from individuals in the target population who have reduced their risk behavior
- Recruit and train peer advocates from the population to distribute role model stories and prevention materials
- Perform process evaluation and make programmatic changes as needed
- Continuous formative evaluation to capture behavior change within the target population

Key Characteristics (*Steps to follow*)

- Discuss intervention with stakeholders, other agencies, and community organizations.
- Form a Community Advisory Board
- Assess the community to determine who is at risk and what behaviors place them at risk and review epidemiologic data
- Interview staff and members of the target population, conduct community mapping, focus groups

- Identify most prevalent stages of change for various risk-reduction practices
- Choose a specific risk-reduction behavior
- Recruit and train peer advocates
- Conduct program presentations at community events to promote recognition and community buy-in
- Establish a system for retaining peer advocates
- Interview members of the target population for material for role model stories
- Write and pretest role model stories
- Have peer advocates distribute role model stories and risk-reduction supplies to 10-20 peers each week

Target Population

A particular group of people that are influenced by the risk factors that put them at higher risk for HIV. These persons or groups practice HIV risk behaviors (e.g. injection drug users and their partners, people living with HIV, sex workers, men who have sex with men but do not identify themselves as gay, youth).

Program Materials

- Outreach worker(s)
- Writing & production staff
- Volunteer peer advocates
- Computer, printer, digital cameral or scanner
- Transportation for outreach workers
- Incentives for peer advocates
- Implementation Packet
 - Manual
 - Videos: *Intervention Overview* and *How to Conduct a Role Model Story Interview*
 - Technical Assistance Guide

Program Outcomes

- Participants moved toward consistent condom use with main and non-main partners
- Participants increased condom carrying
- Participants showed positive progression in the stages-of-behavior-change for condom/bleach use

Online Resources~ The following resources will provide more information regarding *Community PROMISE*:

- www.effectiveinterventions.org
- http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance_community.pdf

CDC AIDS Community Demonstration Projects Research Group. 1999. Community-level HIV Intervention in Five Cities: Final Outcome Data from the AIDS Community Demonstration Projects. *American Journal of Public Health*, 89(3):336 B 345.

COMPREHENSIVE RISK COUNSELING AND SERVICES FOR PERSONS LIVING WITH HIV

Program Overview

Comprehensive Risk Counseling and Services for Persons Living with HIV, formerly Prevention Case Management, aims to help clients who have multiple, complex psychosocial challenges and risk-reduction needs adopt and maintain HIV risk-reduction behaviors. It provides intensive and ongoing client-centered HIV risk-reduction counseling, support, and it helps clients access other services. Priority is given to HIV-infected persons who are having, or are likely to have, difficulty initiating or sustaining practices that reduce or prevent HIV transmission and reinfection. It helps clients initiate and maintain behavior change to prevent the transmission of HIV while addressing competing needs that may make HIV prevention a lower priority. *Comprehensive Risk Counseling and Services for Persons with HIV* addresses the relationship between HIV risk and other issues; e.g. substance abuse, mental health, social and cultural factors, and physical health.

Core Elements (Must do all)

- Provide *Comprehensive Risk Counseling and Services* combined with case management for those clients for whom case management services are not otherwise available
- Base *Comprehensive Risk Counseling and Services* on the premise that some people may not be able to prioritize HIV prevention when faced with problems they perceive as more important
- Focus on persons living with HIV who have multiple, complex problems and risk-reduction needs who are having, or are likely to have, difficulty initiating or sustaining HIV-prevention practices
- Recruit persons who have some level of commitment to participating in ongoing risk-reduction counseling
- Hire case managers with appropriate training and skills to complete *Comprehensive Risk Counseling and Services* activities within their job description
- Develop clear procedures and protocols for your agency's *Comprehensive Risk Counseling and Services* program

Key Characteristics (Steps to follow)

- Develop a client recruitment and engagement strategy
- Identify clients who are at highest risk and appropriate for *Comprehensive Risk Counseling and Services* screening and assessment
- Develop a written, client-centered prevention plan, bases on on-going assessments of risk and progress toward risk reduction
- Provide multiple HIV risk-reduction counseling sessions
- Coordinate active follow-up. Work with Ryan White CARE Act case managers and other case managers serving clients
- Monitor and reassess clients' needs, risks, and progress
- Discharge clients once they have reached and maintained their risk-reduction goals
- Agencies should establish protocols to classify clients as "active," "inactive," or "discharged" and outline the minimum effort required to retain clients

Target Population

Persons living with HIV who are having difficulty reducing risk behavior and maintaining healthy behaviors due to multiple and complex psychosocial challenges.

Program Materials

- Staff who are familiar and comfortable with *Comprehensive Risk Counseling and Services* clients, have training in *Comprehensive Risk Counseling and Services*, and have worked with or a least are able to identify people with mental health needs.
- Staffing needs vary according to number of clients and availability of other services (typical caseload is 12-20 clients/full-time provider)
- Appropriate referral resources

Online Resources~ The following resources will provide more information regarding *Comprehensive Risk Counseling and Services for Persons Living with HIV*:

- http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance_crcsplwh.pdf
- <http://www.cdc.gov/hiv/pubs/pcmg/pcmg-doc.htm>
- <http://www.cdc.gov/hiv/pubs/pcml/pcml-toc.htm>

EXPLORE

Program Overview

EXPLORE, is a individual-level intervention model for HIV negative men who have sex with men. *EXPLORE* is based on multiple theories including: the information-motivation-behavioral skills model, social learning theory, and motivational enhancement. The intervention strategies based upon these theories include identifying the needs and risks of individuals being counseled, training in skills for negotiating and implementing risk reduction in the context of various partner relationships. The intervention strategies also include counseling in self-management specific to the relationship between substance use and sex, managing emotions leading to high risk sex, and maintaining risk reduction goals over time.

Study participants in the intervention treatment arm completed the same activities as those in the standard arm, but they received additional counseling in the form of multiple intensive behavioral counseling sessions (with motivational interviewing and cognitive behavior theory, for example, as key components) during the first three to four months of their study involvement period. Afterward, participants received "booster" sessions every three months (for up to, on average, 3.25 years).

Core Elements (*Must do all*)

- Provide *HIV Counseling Testing & Referral* to participants every 6 months.
- Intervention includes 10 client-centered sessions that need to be completed within the first 6-months.
- Booster sessions are offered to the individual every 3-months after the main intervention is completed.
- All intervention sessions include motivational interviewing and cognitive behavior theory as key components
- Hire staff with appropriate training and skills to complete *EXPLORE* activities within their job description
- Develop clear procedures and protocols for your agency's *EXPLORE* program

Key Characteristics (*Steps to follow*)

- Develop a client recruitment and engagement strategy
- Conduct outreach and other recruitment strategies to recruit the target population.
- Monitor and reassess clients' needs, risks, and progress
- Vary the types of HIV test used (oral fluid, blood, urine, rapid), depending on needs of the agency or client
- Match referrals to clients' priorities
- For clients whose HIV test results are positive, give high priority to referrals for medical care, partner counseling and referral services, and prevention and support services

Target Population

EXPLORE is designed for HIV negative men age 16 or older who have engaged in anal intercourse with one or more men in the previous year.

Program Materials

- Staff who are familiar and comfortable with *EXPLORE* clients, and have training in *EXPLORE*.
- *EXPLORE* Counseling Delivery Manual
- *EXPLORE* Counseling Delivery Manual Guide
- *EXPLORE* Counseling Special Topics and Worksheets
- Staffing needs vary according to number of clients
- Appropriate referral resources

Program Outcomes

- Participants showed lower rates of HIV infection
- Participants reported lower rates of receptive anal intercourse with HIV-positive and unknown status partners

Online Resources~ The following resources will provide more information on *EXPLORE*:

- http://www.hptn.org/research_studies/hivnet015.asp

FOCUS ON KIDS

African American Adolescent HIV Risk Prevention

Program Overview

Focus on Kids is a community-university linked research and intervention program. Its goal is to reduce the risk of HIV infection among urban youth. The program is built on a philosophy of education in which youth are provided both the knowledge and skills they need to protect themselves from becoming infected with HIV. Sessions emphasize value clarification and goal setting; facts about AIDS, HIV, and Human development.

Focus on Kids, which is eight sessions long, is based on Protection Motivation Theory. Each session focuses on one or more PMT concepts and also reviews concepts from the prior session. Beginning in the first session and integrated through, a family genogram was used to illustrate the application of concepts to real-life situations. Sessions emphasize value clarification and goal setting, facts about AIDS, STDs, and Human development.

Core Elements (*Must do all*)

- Gender-matched facilitators
- Uses videos, games, role-playing, acting, and arts and crafts.
- Obtaining Information
- Examining consequences
- Communication
- Trust Building and Group Cohesion
- Risks and Values
- Information about Sexual Health
- Attitudes and Skills for Sexual Health
- Review and Community Project
- Parent Session

Key Characteristics (*Steps to follow*)

- Goal setting
- Multiple delivery formats
- Community Projects
- Friendship groups
- Parental permission
- Gender matched staff
- Community setting

Target Population

High risk youth who are truant from school or who have high absenteeism rates.

Program Materials

Gender matched staff
Accessible community location
Handouts with each lesson

Program Outcomes

- Increased condom use among sexually active youth
- Stronger parental support

HEALTHY RELATIONSHIPS

A Small-Group Intervention for Men and Women Living with HIV/AIDS

Program Overview

Healthy Relationships is a five-session, small-group intervention for men and women living with HIV/AIDS. It is based on the Social Cognitive Theory and focuses on developing skills, building self-efficacy, and positive expectations about new behaviors through modeling behaviors and practicing new skills. Decision-making and problem-solving skills are developed to enable participants to make informed and safe decisions about disclosure and behavior. Sessions create a context where people can interact, examine their risks, develop skills to reduce their risks, and receive feedback from others.

Core Elements (*Must do all*)

- Define stress and reinforcing coping skills across three life areas—disclosing to family and friends, disclosing to sexual partners, and building healthier and safer relationships
- Use modeling, role-play, and feedback to teach and practice skills related to coping with stress
- Teach decision-making skills about disclosure of HIV status
- Provide personal feedback reports to motivate change of risky behaviors and continuance of protective behaviors
- To stimulate discussions and role-playing, show movie-quality video clips to set up scenarios about HIV status disclosure and risk reduction

Key Characteristics (*Steps to follow*)

- Meet in small groups (5-12 individuals) with similar backgrounds. New members cannot join once the series of sessions has begun
- Participants meet for 5 sessions, 2 hours each
- Have groups with members of the same gender and sexual orientation
- Have 2 effective facilitators per group
- Ensure the following for facilitators:
 - One facilitator is male and the other female
 - At least one group facilitator is an experienced and skilled counselor, preferably a mental health professional
 - The peer facilitator should be HIV-positive
 - At least one facilitator matches the ethnicity of the majority of the participants

Online Resources~ The following resources will provide more information regarding *Healthy Relationships*:

- www.effectiveinterventions.org
- http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance_healthy.pdf

Kalichman, S., Rompa, D., Cage, M., DiFonzo, et al. 2001. Effectiveness of an intervention to reduce HIV transmission risks in HIV-positive people. *American Journal of Preventative Medicine*, 21(2):84-92.

Target Population

The *Healthy Relationships* intervention targets men and women living with HIV/AIDS.

Program Supplies & Materials

- Group Facilitator
- Peer Facilitator
- Intervention package
 - Facilitator Manual
 - Participants Manual
 - 4 Video/Movie Clips
- 13 Video/Movie Clips
- TV & VCR or DVD player
- Easel & easel chart paper
- Markers
- Incentives (can be used but are not required)
- Forms
 - Consent Form
 - Assessment Survey
 - Personal Feedback Report (PFR)

Program Outcomes

- Participants reported greater self-efficacy for suggesting condom use with new partners.
- Participants reported intentions to consider the pros and cons of HIV status disclosure to partners.
- Participants reported intentions to engage in safer sex with partners who did not know their HIV status.
- Participants were significantly more likely to have followed through on their earlier intentions at the three-month and six-month follow-up.
- Participants reported less unprotected intercourse, more protected intercourse, and fewer sexual contacts at the six-month follow-up.
- Participants reported less sexual intercourse and less unprotected intercourse with non-HIV-positive.
- Participants were significantly more likely to refuse to engage in unsafe sex at the six-month follow-up.

HIV COUNSELING, TESTING, & REFERRAL

Program Overview

HIV Counseling, Testing, and Referral is a collection of activities designed to increase clients' knowledge of their HIV status; encourage and support risk reduction; and secure needed referrals for appropriate medical, prevention, and partner counseling and referral services. In Iowa, *HIV Counseling, Testing, and Referral* is confidential, the client provides name. Clients can refer themselves or be referred to *HIV Counseling, Testing, and Referral*, which can be accessed through clinics, dedicated sites, outreach, and other services.

Core Elements (*Must do all*)

- Obtain informed consent before delivering *HIV Counseling, Testing, and Referral*, which is a voluntary service
- Provide information and education about risk for HIV transmission and how to prevent HIV, type of test used, meaning of test result (including window period), and where to get more information
- Deliver client-centered counseling
- Set clear standards for determining when clients are not competent to give informed consent
- Use only HIV tests approved by the FDA
- Deliver test results in a supportive and understandable way
- Refer clients, as needed
- Track referrals made and completed

Key Characteristics (*Steps to follow*)

- Provide information about testing 1-on-1, in groups, or through materials
- Deliver client-centered counseling and test results face to face
- Vary the types of test used (oral fluid, blood, urine, rapid), depending on needs of the agency or client
- Match referrals to clients' priorities
- For clients whose HIV test results are positive, give high priority to referrals for medical care, partner counseling and referral services, and prevention and support services

Target Population

Persons at risk for HIV

Program Materials

- Paid or volunteer staff, trained in *HIV Counseling, Testing, and Referral* (Rapid testing has special training requirements)
- Any location that can provide confidentiality (private area or room), specimen collection according to minimal OSHA standards, flat surface, acceptable lighting, and temperature in the range recommended by the test manufacturer
- FDA approved testing materials

Online Resources~ The following resources will provide more information regarding *HIV Counseling, Testing, & Referral*:

- www.effectiveinterventions.org
- http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance_ctr.pdf
- <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm>

HOLISTIC HEALTH RECOVERY PROGRAM

A Group-level Intervention for HIV-positive and HIV-negative Injection Drug Users

Program Overview

The *Holistic Health Recovery Program* is a 12-session, manual-guided, group level program for HIV-infected and HIV-negative injection drug users. The primary goals of *Holistic Health Recovery Program* are to promote health, improve quality of life, and harm reduction. It is based on the information-motivation-behavioral skills model of HIV prevention behavioral change.

Core Elements (*Must do all*)

- Teach skills to reduce harm of injection drug use and unprotected sexual activities
- Teach negotiation skills to reduce unsafe sexual behaviors with sex partners, and teach skills to heal social relationships
- Teach decision-making and problem-solving skills using cognitive remediation strategies
- Teach goal-setting skills and develop action plans to achieve goals
- Teach skills to manage stress, including relaxation exercise, and help clients understand what aspects of stressful situation can and cannot be controlled
- Teach skills to improve health, health care participation, and adherence to medical treatments
- Teach skills to increase clients' access to their own self-defined spiritual beliefs, to increase motivation to engage in harm-reduction behaviors
- Teach skills to increase awareness of how different senses of self can affect self-efficacy and hopelessness

Key Characteristics (*Steps to follow*)

- Hold group sessions at the same time, place, with same format
- Include 3-15 clients per group
- Have 2 substance abuse counselors who have experience working with HIV-infected substance abusers and who are comfortable with the concepts of harm reduction in this population

- Have 1 male and 1 female counselor, if possible
- Have at least 1 counselor with a master's degree in a counseling discipline
- Select enrollment option: open enrollment or cohort enrollment

Target Population

- HIV-infected injection drug users
- HIV-negative injection drug users

Program Materials

- Two substance abuse counselors/session
- Facility that treats clients with substance abuse or dependence issues or agency that services HIV-infected persons who use drugs
- Confidential space
- Audiovisual set-up (slides or PowerPoint)
- TV/VCR
- Easel, paper, and markers
- Incentives
- Implementation Packet
 - Program manuals for both HIV-positive and HIV-negative injection drug users are available, which include all the materials required to implement the intervention
 - Instructional materials
 - Background materials

Program Outcomes

- Participants decreased addiction severity
- Participants decreased risk behavior
- Significant improvement in behavioral skills, motivation, and quality of life

Online Resources~ The following resources will provide more information regarding *Holistic Health Recovery Program*:

- www.effectiveinterventions.org
- http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance_holistic.pdf

Margolin, A., Avants, S.K., Warburton, L.A., Hawkins, K.A. Shi, J. 2003. A randomized clinical trial of a manual-guided risk reduction intervention for HIV-positive injection drug users. *Health Psychology, 22(2):223-228.*

LIFE

Learning Immune Function Enhancement

Program Overview

LIFE is a structured risk-reduction prevention counseling program that attracts, retains, and motivates HIV+ clients through its emphasis on health enhancement. Risk-reduction interventions are embedded into the health-counseling curriculum. For the HIV+ individual, their own health and survival becomes a powerful motivation for risk reduction.

Studies in psychology, immunology and the specialty field of psycho-neuro-immunology have shown that for people living with HIV disease and other life-threatening illnesses, certain psychological and social factors can either help or hinder the effectiveness of the immune system. By understanding these psychosocial "cofactors," and improving performance on them, people with HIV may gain significant control over their survival with HIV disease. For example, research studies show that long-term survivors of an AIDS diagnosis typically are self-assertive, a characteristic known to enhance immunity

Core Elements (*Must do all*)

- Structured, topic-driven group counseling intervention
- Standardized health education and counseling curriculum
- Meetings focus on a different psycho-social issue
- Topics include: relationship with medical provider, adherence to health routines, self-assertiveness, sustained survival stress, crisis coping skills, social support, self-disclosure, beliefs about disease progress, grief, depression, altruism, spirituality, and other cofactors.
- Includes health and risk-reduction counseling sessions
- Peer counselors

Key Characteristics (*Steps to follow*)

- Sixteen 60-minute group sessions
- Delivered by Mental health professional – psychologists, social workers, nurses, and counselors – working with and supervising trained (volunteer) peer counselors.
- Includes monthly individual health counseling sessions

Target Population

LIFE targets men and women living with HIV.

Program Materials

- Uses a structured curriculum that educates clients on the impact cofactors can have on their health, increases client awareness of their performance on each cofactor, and facilitates the formulation of improvement plans for cofactors with weak performance
- Clients are led through a psycho-educational group process that covers one cofactor per week

Original Research

LIFE participants showed reduced risk behavior, reduced alcohol/drug use, enhanced adherence to medication protocols, increased physical health functioning, and increased psychological functioning.

Online Resources~ The following resources will provide more information regarding *LIFE*:

- www.shanti.org
- <http://www.shanti.org/life/life-evaluation-report.pdf>
-

Leiphart, J.M. 1997. Psycho-neuro-immunology: A Basis for HIV Treatment. *FOCUS: A Guide to AIDS Research and Counseling*, Volume 12, Number 3, February 1997.

Leiphart, J.M. 1997. Learning to Take It Easy - A Simple Program of Stress-reduction that Can Improve your outlook - and your CD4 Count. *AIDS Care*, Volume 2, Issue 2, April 1998.

LOVE YOUR MAN, LOVE YOURSELF

The Women's Visitor's Project

Program Overview

Love Your Man, Love Yourself is a single session peer-led educational program for women with incarcerated partners. *Love Your Man, Love Yourself* provides supportive relationships between visitors and an opportunity for the provision of referrals.

The intervention includes basic HIV information and information about risks specific to having an incarcerated partner, encourages women to share this information with others, and encourages interaction and social support.

Core Elements (*Must do all*)

- Peer educators
 - Intervention topics
 - Relationships
 - Condom skills
 - Trigger management
 - Self-statements
 - Negotiation
 - Video: INSIDE/OUT
- Multi-component including
 - Community events
 - Group workshops
 - One-on-one outreach by peer educators

Key Characteristics (*Steps to follow*)

- All clinic staff attend a 3-hour training and a 1-hour booster session in which they learn how to conduct the intervention, practice intervention delivery skills, and identify agency-specific implementation strategies
- All clinic staff attend a 2-hour workshop on sexual and injection drug use behaviors and risk reduction strategies

Target Population

Women with incarcerated partners

Program Materials

- Trained clinicians
 - 3-hours didactic training & interactive practice
 - 1-hour booster session
 - 2-hour workshop on sexual and injection drug use behaviors and risk reduction strategies
- Intervention package

Program Outcomes

- Reduced high risk sexual behavior in women with incarcerated partners

Online Resources~ The following resources will provide more information regarding *HIP HOP*:

- www.caps.ucsf.edu/publications/prisonS2C.pdf

Grinstead, O., Zack, B., Faigeles, B. 1999. Collaborative research to prevent HIV among male prison prisoners and their female partners. *Health Education and Behavior* 26:225-238.

Comfort, M., Grinstead, O.A., Faigeles, B. et al. 2000. Reducing HIV risk among women visiting their incarcerated male partners. *Criminal Justice & Behavior* 27:57-71.

MAKING PROUD CHOICES

A Safer-Sex Approach to HIV/STDs and Teen Pregnancy Prevention

Program Overview

Making Proud Choices!: A Safer Sex Approach to Reducing STDs, HIV, and Pregnancy is an eight-module curriculum designed to empower adolescents to change their behavior in ways that will reduce their risk of becoming infected with HIV, other STDs and significantly decrease their chances of being involved in unintended pregnancies.

Making Proud Choices is an eight module curriculum that provides teens with the knowledge, confidence, and skills necessary to reduce their risk of sexually transmitted diseases, HIV, and pregnancy by abstaining from sex or using condoms if they choose to have sex.

Core Elements (*Must do all*)

Two co-facilitators trained in the curriculum teach:

- Getting to know you and making dreams come true
- Consequences of sex : HIV infection
- Attitudes and beliefs about HIV/AIDS and condom use
- Strategies for prevention HIV infection
- Consequences of sex: STDs and correct condom use
- Consequences of sex: pregnancy
- Developing condom use skills and negotiation skills
- Role-plays: refusal skills and negotiation skills

Key Characteristics (*Steps to follow*)

- Focus on goals and dreams and their relationship to adolescent sexual behavior
- Emphasize knowledge, including the causes, transmission, and prevention of HIV, STDs, and teenage pregnancy
- Focus on beliefs and attitudes about condoms, HIV, STDs, and pregnancy
- Stress skills and self-efficacy including negotiation-refusal and condom use skills
- Two co-facilitators trained in the curriculum
- Be flexible

- Let the group members share appropriate personal experiences
- Respect participants feelings and boundaries
- Be non-judgmental
- Can add session from Survive Outside

Target Population

The target audience is young African American, Hispanic, and white adolescents who attend middles schools or youth serving community based programs.

Program Materials

Pencils
Markers
TV
VCR
HIV Risk Continuum Signs
HIV Risk Behavior Cards
Condom
Penis Models
Index Cards

Program Outcomes

Youth who participated in the intervention showed:

- Increased knowledge about prevention of HIV, STDs and pregnancy
- More positive attitudes/beliefs about condom use
- Increased confidence in their ability to negotiate safer sex and to use condoms correctly
- Stronger intentions to use condoms if they have sex

Online Resources~ The following resources will provide more information regarding *Making Proud Choices*

Jemmott, J.B., 3rd, Jemmott, L.S., Fong, G.T., & McCaffree, K. 1999. Reducing HIV risk-associated sexual behavior among African American adolescents: testing the generality of intervention effects. *Am J Community Psychology*, 27(2):161-187.

MANY MEN, MANY VOICES

A Group-Level Intervention for Gay Men of Color

Program Overview

Many Men, Many Voices is a 7-session, group-level HIV/STD prevention intervention for black men who have sex with men. The intervention addresses factors that influence behavior specific to black MSM, including cultural, social, and religious norms; HIV/STD interactions; sexual relationship dynamics; social influences of racism and homophobia on risk behaviors.

The *Many Men, Many Voices* curriculum is designed to be facilitated by a peer in groups of 6-12 clients. The 2-3 hour sessions aim to foster positive self image; educate participant about their HIV/STD risks; and teach risk reduction and partner communication skills. Sessions are experiential, incorporating group exercises, behavioral skills practice, group discussions, and role play.

Core Elements (Must do all)

The core elements of *Many Men, Many Voices* are:

- Enhance self-esteem related to racial identity and sexual behavior
- Educate clients about HIV risk and sensitize them to personal risk
- Educate clients about interactions between HIV and other STDs and sensitize to personal risk
- Develop risk-reduction strategies
- Build a menu of behavioral options for HIV and STD risk reduction, including those that one can act on individually and those that require partner involvement
- Train in risk-reduction behavioral skills
- Enhance self-efficacy related to risk-reduction behavioral skills
- Train in partner communication and negotiation
- Provide social support and relapse prevention

Key Characteristics (Steps to follow)

- Foster positive identity
- Discuss sexual relationship roles and risks
- Address perceived personal risk and personal susceptibility for HIV/STD infection as well as perceived barriers to remaining HIV negative
- Increase skills, self-efficacy, and intentions with regard to protective behaviors

Online Resources~ The following resources will provide more information regarding *Many Men, Many Voices* :

- www.effectiveinterventions.org
- http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance_many.pdf

- Explore the dynamics of sexual relationships, including the dynamics of power
- Address the importance of peer support and social influence on maintaining healthy behaviors
- The intervention can be adapted to 12 sessions of 75-90 minutes each, or condensed into a weekend retreat, covering the 18-21 hours of intervention curriculum.

Target Population

The *Many Men, Many Voices* intervention targets gay and bisexual men of color (black men of African, Caribbean, or Latino descent). The intervention also targets men on the 'down low' with or without female partners (i.e., men of color who have sex with other men but do not identify as gay or bisexual).

Program Materials

The supplies/materials needed to implement the *Many Men, Many Voices* intervention are:

- 1-2 trained facilitators, 1 of whom must be a gay or bisexual black man
- Project staff supervise facilitators & recruit men into sessions
- Safe, comfortable, not clinical, easy to get to, appealing, quiet, private, and secure space
- TV, VCR, overhead projector
- Easels, paper, markers, poster boards, tape
- Implementation Packet
 - Educational materials for distribution which may be used to recruit persons into the group

Program Outcomes

- Participants reduced their frequency of unprotected anal intercourse
- Participants increased their use of condoms

MPOWERMENT

A Community Level HIV Prevention Intervention for Young Gay Men

Program Overview

Mpowerment is a community-level HIV prevention program that is run by a core group of gay and bisexual men from the community and paid staff coordinators. The objective of *Mpowerment* is to establish a community organizing process for diffusion of risk-reduction norms, those supportive of safer-sex behavior.

Mpowerment relies on four integrated activities:

- Formal Outreach: Teams of gay men go to locations frequented by gay men to promote safer sex
- M-groups: At these peer-led, 1-time, 3-hour meetings, groups of 8 to 10 young gay men discuss factors contributing to unsafe sex
- Informal Outreach: Men have casual conversations with their friends in an informal manner that promotes healthy community norms
- Ongoing Publicity Campaign: The campaign attracts men to the project

Core Elements (*Must do all*)

- Recruit a core group of gay and bisexual men to design and carry out project activities
- Recruit volunteers to help deliver services and make decisions
- Use project coordinators to oversee project activities
- Establish a project space
 - A safe space (away from substance use) for activities to take place, it is not necessarily a fixed place. Instead of a stationary house for implementing intervention, organizations may create a schedule designating when and where different events occur.
- Conduct formal outreach, including educational activities and social events
- Conduct informal outreach to influence behavior change
- Convening M-groups (peer-led, 1-time discussion groups)
- Conduct a publicity campaign about the project
- Convene a Community Advisory Board

Key Characteristics (*Steps to follow*)

- Social focus. Address gay/bisexual men's social needs
- Empowerment philosophy. change is most lasting when people are actively involved in creating and implementing their own problems
- Peer based. Mobilize peers to act as change agents
- Multilevel/multicomponent.
- Operate *Mpowerment* at many levels and address multiple predictors of risk. Gay/bisexual men engage in high-risk sex for a variety of reasons
- Gay-positive/sex-positive. Enrich and strengthen men's sexual identity and pride in being gay/bisexual
- Community building. Create health community; establish friendship networks; disseminate a norm of safer sex throughout the community
- Diffusion of innovations. Have gay/bisexual men talk and encourage their friends to be safe.

Target Population

- *Mpowerment* targets gay and bisexual men of diverse race, ethnicity, socioeconomic status.

Program Materials

- Core group members
- Volunteers
- M-group facilitators
- Project coordinator(s)
- Intervention package
 - Overview video of the program
 - Program implementation manual
 - M-group facilitation guide
 - Facilitator training video
- TV & VCR or DVD player
- Easel & easel chart paper & markers
- Condoms and lubricant to hand out
- Posters and handouts about safer sex
- Forms
 - Enrollment & client participation
 - Evaluation tools

Program Outcomes

- Participants decreased their rates of unprotected anal intercourse

Online Resources~ The following resources will provide more information regarding *Mpowerment*:

- www.effectiveinterventions.org
- <http://www.effectiveinterventions.org/interventions/mpowerment.cfm>

Kegeles, S.M., Hays, R.B., Coates, T.J. 1996. The *Mpowerment* Project: A Community-level HIV Prevention Intervention for Young Gay Men. *American Journal of Public Health*, 86(8), 1129-1136.

OPTIONS / OPCIONES

A Physician Delivered Intervention

Program Overview

Options/Opciones intervention is based on the Information-Motivation-Behavioral Skills Model. It is a clinician-initiated HIV risk reduction intervention for HIV+ persons in clinical care using motivational interviewing techniques. Clinicians work collaboratively with their HIV+ patients to verbally assess patient risk behaviors, evaluate patients' readiness to practice safer behaviors, strategize steps for reducing or eliminating risk behaviors, and prescribe an agreed-upon-goal to be reached at the next visit. *Options/Opciones* is implemented during every regular clinical care visit.

Core Elements (*Must do all*)

- Training the clinicians is critical
- Intervention steps
 - Clinician assessment of patient's risk behavior
 - Select a maximum of two risk behaviors to focus on further
 - Identify the conditions under which the behaviors takes place
 - Patient and clinician select one of the two previously identified risk behaviors for the patient to rate according to the importance the patient places on changing the behavior and the confidence the patient has in actually making the change
 - Patient rates self-confidence in changing behavior
 - Clinician elicits strategies from patient for changing behavior
 - Clinician and patient negotiate a plan of action to be accomplished by the following visit
 - Clinician writes goal on prescription pad and hands it to the patient

Key Characteristics (*Steps to follow*)

- All clinic staff attend a 3-hour training and a 1-hour booster session in which they learn how to conduct the intervention, practice intervention delivery skills, and identify agency-specific implementation strategies
- All clinic staff attend a 2-hour workshop on sexual and injection drug use behaviors and risk reduction strategies

Target Population

The *Options/Opciones* intervention targets men and women living with HIV/AIDS.

Program Materials

- Trained clinicians
 - 3-hours didactic training & interactive practice
 - 1-hour booster session
 - 2-hour workshop on sexual and injection drug use behaviors and risk reduction strategies
- Intervention package

Program Outcomes

- Reduced HIV positive patients' HIV sexual transmission behavior over a follow-up period of 18 months

Online Resources~ The following resources will provide more information regarding *OPTIONS/OPCIONES*:

- <http://www.chip.uconn.edu/interventions/k-options.pdf>

Fisher, J.D., Fisher, W.A., Corman, D.H., Amico, K.R., Bryan, A., Friedland, G. 2004. Clinician-initiated HIV risk reduction intervention for HIV-positive person: Formative research, acceptability, and fidelity of the Options Project. *Journal of Acquired Immune Deficiency Syndrome*. 37(supplement):s78-s87.

PARTNERSHIP FOR HEALTH

A Brief Safer-Sex Intervention for HIV Clinics

Program Overview

Partnership for Health is a brief, provider-delivered, counseling program for individual men and women living with HIV/AIDS. The program is designed to improve patient-provider communication about safer sex, disclosure of serostatus, and HIV prevention. *Partnership for Health* is based on a social cognitive model that uses message framing, repetition and reinforcement to increase the patient's knowledge, skills, and motivations to practice safer sex. The intervention specifically addresses sexual behavior and not substance use behavior.

Core Elements (*Must do all*)

- Have providers deliver the intervention to HIV-positive patients in HIV outpatient clinics
- Have the clinic adopt prevention as an essential component of patient care
- Train all clinic staff to facilitate integration of the prevention counseling intervention into standard practice
- Use waiting room posters and brochures to reinforce prevention messages delivered by the provider
- Build on the ongoing supportive relationship between the patient and the provider
- During routine visits, have the provider initiate at least 3- to 5-minute discussion with the patient or client about safer sex that focuses on self-protection, partner protection, and disclosure
- Have the provider incorporate good communication techniques and use of consequences-framed messages for patients or clients engaged in high risk sexual behavior
- Provide referrals for needs that require more extensive counseling services
- Integrate the prevention message into clinic visits so that every patient is counseled at every visit

Key Characteristics (*Steps to follow*)

- All clinic staff attend a 4-hour training and a 1-hour booster session in which they learn how to conduct the intervention, practice intervention delivery skills, and identify agency-specific implementation strategies

Target Population

The *Partnership for Health* intervention targets men and women living with HIV/AIDS.

Program Materials

- Implementation Packet
 - Manual to guide clinics through planning, implementation, and maintenance of the intervention
 - Sample brochures, chart stickers, pocket counseling outline, posters, and flyers
 - A manual for each provider
 - A training video for each clinic

Program Outcomes

- Patients who had 2 or more sex partners or at least 1 casual partner and who received consequences-framed messages were less likely to engage in unprotected anal or vaginal sex

Online Resources~ The following resources will provide more information regarding *Partnership for Health*:

- www.effectiveinterventions.org
- www.usc.edu/partnershipforhealth.pdf

Richardson, J.L., Milam, J., McCutchan, A., Stoyanoff, S., Bolan, R., et al. 2004. Effect of brief provider safer-sex counseling of HIV-1 seropositive patients: A multi-clinic assessment. *AIDS* 18:1179-1186.

POINT FOR POINT

Syringe and Needle Exchange

Program Overview

Point for Point seeks to reduce the spread of HIV among injection drug users, their partners and their families by providing sterile syringes in exchange for used and potentially infectious syringes. This needle exchange intervention operates on the premise that increased availability of sterile syringes can reduce the prevalence of needle sharing. Needle sharing is associated with high rates of HIV and other infectious disease transmission. *Point for Point* works to reduce the spread of HIV by reducing the number of previously used, potentially contaminated syringes in circulation.

Point for Point was created around harm reduction principles: it neither condemns people for their lifestyles choices nor attempts to ignore the dangers associated with illicit drug use.

The exchange protocol is designed to be as uncomplicated as possible: in return for each syringe safely disposed of under the supervision of needle exchange personnel, a program client receives one sterile syringe.

Core Elements (*Must do all*)

- Assessing what an agency needs to know about the community before implementing
- Recruiting and training persons from the targeted at-risk communities to become community advocates to their peers
- Creating role model stories based on personal accounts from individuals in the target populations who already have some risk-reduction behavior change
- Distributing role model stories and risk reduction supplies by community advocates
- Requires cooperation of law enforcement and other community agencies

Online Resources~ The following resources will provide more information regarding *Point for Point*:

- <http://www.sfaf.org/prevention/needleexchange/index.html>
- <http://www.caps.ucsf.edu/capsweb/publications/needlereport.html>

Key Characteristics (*Steps to follow*)

- Trained volunteers operate exchange sites at which sterile hypodermic syringes are exchanged for used syringes on a one-for-one basis.
- Training includes
 - One full-day classroom training session
 - On-site apprenticeship over a six-week period
- May take a year to implement

Target Population

Injection drug users.

Program Materials

- Implementation Packet (Sociometrics/HAPPA) contains instructions and guidelines on these topics:
 - Recruiting and screening volunteers
 - On-site training
 - Classroom training
 - Volunteer management
- Site logistics manual

Program Outcomes

- IDUs who reported regular use of the needle exchange were significantly less likely to engage in needle sharing than those who did not. Volunteers distribute condoms and provide exchangers with bleach, alcohol swabs, sterile cotton, and other materials associated with safer drug-injection techniques.

Implementation Note:

Federal Dollars: Not fundable with federal dollars

Richardson, J.L., Milam, J., McCutchan, A., Stoyanoff, S., Bolan, R., et al. 2004. Effect of brief provider safer-sex counseling of HIV-1 seropositive patients: A multi-clinic assessment. *AIDS* 18:1179-1186.

POPULAR OPINION LEADER

A Community AIDS/HIV Risk Reduction Program

Program Overview

Popular Opinion Leader is a community level intervention designed to identify, enlist, and train opinion leaders to encourage safer sexual norms and behaviors within their social networks of friends and acquaintances through risk reduction conversations.

Core Elements (*Must do all*)

- Direct the intervention to an identifiable target population in well-defined community venues
- Conduct community identification (formative research to identify, prioritize, access, and understand the population)
- Over the life of the program, train 15% of the target population size found in intervention venues or social networks as popular opinion leaders
- Teach opinion leaders skills for initiating HIV risk-reduction messages with friends and acquaintances
- Teach opinion leaders characteristics of effective behavior change communication messages targeting risk factors
- Popular opinion leaders endorse the benefits of safer sex and recommend steps needed to implement change
- Hold weekly sessions with opinion leaders, using different methods to help them refine their skills and gain confidence in delivering HIV prevention messages
- Have opinion leaders set goals to engage in risk-reduction conversations with friends and acquaintances
- Review, discuss, and reinforce at subsequent training sessions the outcomes of opinion leaders' conversations
- Use logos, symbols, or other devices as conversation starters

Key Characteristics (*Steps to follow*)

- Identify gatekeepers who will help identify opinion leaders
- Identify and characterize social networks with the population served
- Use key informants to identify opinion leaders
- Train opinion leaders to have a specific number of conversations with peers at risk
- Hang program posters; give leaders buttons, caps, t-shirts, key chains with program logo
- Ask opinion leaders to recruit new groups of opinion leaders
- Continue to train new groups of opinion leaders
- Hold reunion meetings with all of opinion leaders and gatekeepers

Target Population

Popular Opinion Leader can be used with various at-risk populations in a variety of venues. It has been tested with gay men in bars, African American women in low-income housing settings, and male commercial sex workers.

Program Materials

- Volunteer opinion leaders
- Front-line staff
- Volunteer gatekeepers
- Intervention implementation manual
 - Handouts / worksheet master copies
- TV & VCR or DVD player
- Incentives
- Copies of prevention materials

Program Outcomes

- Men reported a reduction in unprotected anal intercourse

Online Resources~ The following resources will provide more information regarding *Popular Opinion Leader* :

- www.effectiveinterventions.org
- http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance_POL.pdf

Kelly, J.A., St. Lawrence, J.S., Diaz, Y.E., Stevenson, L.Y. et al. 1991. HIV risk behavior reduction following intervention with key opinion leaders of population: An experimental analysis. *American Journal of Public Health*. 81(2):168-171.

POWER

Positive Wellness & Renewal

Program Overview

POWER is designed for use in one-on-one, group and workshop settings. Focus is on defining and identifying issues, assessing personal history, knowledge and skill levels, identifying barriers, challenges and successes, skills building, developing detailed risk reduction plans, providing appropriate referrals, and conducting follow-up evaluations and refinements. It uses a modular approach, allowing for flexibility as needed for varying topics or issues.

The Transtheoretical Model of Behavioral Change (Stages of Change) is used as the framework for initial assessments and evaluation. Discussions are topic-driven but loosely structured and interactive. Skills-building employs a variety of techniques including role-plays and interactive learning activities designed to reinforce knowledge and increase skill and comfort levels.

Core Elements (*Must do all*)

- All efforts follow the client-centered approach
- Modular approach
 - DEFINE – the topic or issue, overview of main points, discuss, provide background and education, receive input and feedback from participants
 - ASSESS – the personal history and experiences of participant(s) with the topic or issue, discussion of barriers, challenges, successes
 - PLAN – develop individualized, detailed risk reduction plans with clear goals/objectives
 - PRACTICE – skills building, role plays, interactive individual or group learning activities
 - EVALUATE – using verbal or written participant evaluations of each session, plus follow-up progress evaluations at set time intervals, identify barriers/successes, lessons learned, document
 - REFERRALS – to appropriate internal and community resources as needed
 - REFINE – the plan as needed using lessons learned to move closer to goals/objectives, maintain positive behavioral change

Key Characteristics (*Steps to follow*)

- Participants explore their beliefs and feelings about condoms, sex without condoms, promiscuity, and oral sex and develop skills to reduce their sexual risk behavior
- Participants learn about harm reduction techniques to take better care of overall health
- Participants are instructed on how to improve their disclosure of HIV status to sex and/or needle sharing partners
- Referral of substance users to detoxification or rehabilitation services
- Referral of participants to STD and hepatitis testing, and partner counseling referral services
- Participants develop tools to improve adherence to antiretroviral therapy as well as antidepressant and psychotropic medications
- Participants gain a better understanding of their sexual identity

Target Population

HIV+ persons who engage in sexual risk behavior, who use/abuse substances, inject drugs,

Program Materials

- Core Modules
 - Sexual Risk
 - Substance Use
 - Injection Risk
 - Harm Reduction Strategies for IDU
 - Disclosure/Negotiation/Communication\
 - Adherence/Treatment Issues
- Supplement Modules
 - Mental Health
 - Psychosocial Issues
 - Coping
 - Sex and Crystal Methamphetamine
 - Sexual Identity

Program Outcomes

- Men reported a reduction in unprotected anal intercourse

Resources~ The following resources will provide more information regarding *POWER*:

Wongvipat N, Mutchler M, Klosinski L. 2002. *POWER* (positive wellness & renewal)--A prevention for positives demonstration project. *Int Conf AIDS*. 2002 Jul 7-12; 14: abstract no. TuPeF5492.

PROJECT SAFE

Sexual Awareness for Everyone: Hispanic and African American Women

Program Overview

Project SAFE is a three session cognitive behavioral intervention designed to reduce STD infections among Hispanic and African American women. Sessions are designed to facilitate skill development to avoid infection while increasing awareness that STDs (including HIV) disproportionately affect minority women. The intervention also helps build decision-making and communication skills and encourages participants to set risk reduction goals. Participants gain mastery through role-playing, group discussion, and behavior skills exercises.

Core Elements (*Must do all*)

- Multi-component sessions led by a trained female facilitator from the same race/ethnic group as the participants
- Recognition of risk with culture and sex specific information
- Commitment to change using culture and sex specific information and interactive discussion designed to educate participants about prevention of STD: enhance communication skills: develop skills for condom use, including low self-esteem, cultural norms, and interpersonal power dynamics, and strategies for overcoming these barriers
- Acquisition of skills using culture and sex specific information and interactive discussion and role playing designed to enhance skills in eroticizing condom use: increase self-efficacy in communication about condom use, identify triggers for unsafe sex, set goals, and develop social support networks for risk reduction.

Key Characteristics (*Steps to follow*)

- Small groups
- Materials designed for low-literacy populations
- Encourage realistic risk-reduction strategies
- Lectures
- Role play
- Behavioral Skills Development
- Minority Specific
- Women

Target Population

African American and Hispanic women ages 14-45

Program Materials

The HAPPA Program Package which contains all the materials and videos for the program.

Program Outcomes

Reduced rates of STD infection among African American and Hispanic women by reducing high risk behavior

Resources~ The following resources will provide more information regarding *Project S.A.F.E.*

Shain, R.N., Piper, J.M., Newton, E.R., Perdue, S.T., Ramos, T., Champion, J.D., et al. 1999. A randomized, controlled trial of a behavioral intervention to prevent sexually transmitted disease among minority women. *N. Engl J Med*, 340(2):93-100.

PROJECT SMART

Enhanced Intervention

Program Overview

Project Smart, designed for injection drug users in treatment, uses a behavioral approach to prepare participants to reduce the harm/risk from AIDS by practicing with real-life situations. Special emphasis is given to the psychosocial aspects of behavioral change.

This intervention is a group level intervention; however it can also be used in individual settings. The enhanced intervention is conducted in six 1-hour sessions followed by a 30 minute individual health education consultation. The intervention is designed to be used in a short-term inpatient substance abuse treatment facility. The intervention utilizes a cognitive-developmental approach to engage participants in the presentations and discussions on adopting harm and risk reduction

Core Elements (*Must do all*)

- Multi-component sessions led by a trained facilitator
- Provide opportunities to practice relevant skills
- In-depth class discussions
- Homework exercises
- Tension release exercises
- Role-plays
- Trigger tape
- Peer feedback
- Hands-on needle cleaning and condom exercises

Key Characteristics (*Steps to follow*)

- Small groups
- Materials designed for low-literacy populations
- Encourage realistic risk-reduction strategies
- Lectures
- Role play
- Behavioral Skills Development
- Minority Specific
- Women

Target Population

Substance users in a short-term inpatient substance abuse treatment facility.

Program Materials

The HAPPA Program Package contains

Program Outcomes

Participants showed a reduction in risky drug-related behaviors

- Decrease works sharing in general and shooting galleries
- Increase correct cleaning of works
- Decrease high-risk practices

At follow-up intervention members reported:

- Significantly greater self-efficacy to talk themselves out of AIDS-risk behavior
- Significant reductions in risky drug use
- Significant reductions in injection frequency

Resources~ The following resources will provide more information regarding *Project SMART*:

McCusker, J., Stoddard, A.M., Zapka, J.G., Morrison, C.S., Zorn, M., Lewis, B.F. (1992). AIDS education for drug abusers: Evaluation of short-term effectiveness. *American Journal of Public Health* 82(4), 533-40.

PROJECT START

Prison Pre-Release

Program Overview

Project Start is also known as HIP HOP. It targets 18-29 year old men who are being released from prison. The intervention is based on a prevention case management model that focuses on preventing sexual and drug-related risk that could lead to HIV, STD or hepatitis infection. It uses techniques of harm reduction, motivational interviewing and problem solving.

Project Start focuses on participant's needs after release, including assessment, planning, problem-solving and facilitated referrals for housing, employment, financial problems, social relationships, substance use and mental health treatment, legal problem, and avoiding reincarceration.

Core Elements (*Must do all*)

- Base on formative research with incarcerated men and providers both inside and outside of prison
- Two sessions in prison prior to release
- Four sessions out of prison at 1, 3, 6, and 12 weeks post-release
- Focus on participant's needs after release
- Focus on sexual risk, with reincarceration as a secondary outcome
- Facilitate referral and reduce barriers to use of existing community services

Key Characteristics (*Steps to follow*)

- Develop referral lists and community resource guides
- Hire interventionists and interviewers with experience working with incarcerated populations
- Intervention staff attend two trainings prior to implementation
- Intervention staff receive follow-up trainings and regular supervisory meetings

Target Population

Project Start targets 18-29 men who are being released from prison.

Program Materials

- Interventionists and interviewers with experience working with incarcerated populations with knowledge of
 - Harm reduction
 - Problem solving
 - Motivational enhancement
 - Access to services

Program Outcomes

- Participants were less likely to report unprotected vaginal or anal sex with any partners
- Greater risk reduction occurred with main partners than with non-main partners
- *Project Start* was effective in reducing sexual risk behavior

Online Resources~ The following resources will provide more information regarding *Project Start*:

- www.caps.ucsf.edu/publications/STARTS2C.pdf
- www.cdc.gov/hiv/projects/projectSTART

Wolitski, R.J. 2004. Project START reduces HIV risk among prisoners after release. Presented at the XV International Conference on AIDS, Bangkok, Thailand. Abstract #WeOrC1296. Projects

REACH ONE TEACH ONE

Inmate Peer Educator Training

Program Overview

The *Reach One Teach One*, based on Diffusion of Innovation Theory, trains individuals in the incarcerated population to become peer health educators. Inmates are trained (5-day training) to conduct a variety of services within the prison including teaching the HIV prevention orientation class for incoming inmates, providing individual counseling for newly diagnosed inmates and providing prevention case management for releasing inmates.

Peer educator training includes HIV/AIDS basics, substance use, STDs, sexuality and HIV, public speaking introduction and practices, and diversity training. Topics include HIV/AIDS, hepatitis, other sexually transmitted diseases (STDs), and tuberculosis (TB), as well as public speaking skills, and cultural self-awareness. Goals of the peer health education include:

- Providing health education in a useful and accessible format appropriate to a specific inmate population
- Providing practical information on how individuals can protect their health while incarcerated and after they return to home.
- Encouraging early intervention that includes risk education, testing and treatment for various infectious diseases.

Core Elements

- Peer educators reflect the diversity of the prison population and include person infected with HIV/AIDS or other diseases and if appropriate, bilingual speakers.
- Peer educator have at least 6 incarceration remaining post-health educator certification
- Exclude prisoners with sexual offenses and history of disciplinary problems.
- Peer educators have minimum of GED or the equivalent in terms of communication skills and educational training level.

Online Resources~ The following resources will provide more information regarding *Reach One Teach One*:

<http://www.caps.ucsf.edu/projects/mapindex.html>

<http://www.caps.ucsf.edu/projects/mapbooster.html>

Key Characteristics (*Steps to follow*)

- Lesson plans that include presentations, discussions, and interactive activities.
- Lesson plans emphasize making decisions, defining values and ethics, improving self-esteem, discussing practical methods of health risk-reduction strategies, and developing communication and presentation skills.

Target Population

Incarcerated individuals

Program Materials

Training Kit that includes the following modules:

- Introduction to Peer Health Education
- Health and Self-Awareness
- Cultural Awareness
- Introduction to the Immune System
- HIV and AIDS
- Hepatitis
- Tuberculosis
- Sexually Transmitted Diseases
- Harm Reduction
- Presentation and Communication Skills

Program Outcomes

The primary goal of peer health education is behavioral change directed toward reducing disease risk both inside and outside of prison.

Grinstead O, Faigeles B, Zack B. 1997. The effectiveness of peer HIV education for male inmates entering state prison. *Journal of Health Education* Vol.28, p. S31-S37.

REAL AIDS PREVENTION

A Community-Level HIV Prevention Intervention

Program Overview

Real AIDS Prevention Project is a community-level HIV prevention intervention to help women and their male partners reduce their risks for HIV. Specifically, the goals are to increase consistent condom use, change community norms so that practicing safer sex is the acceptable norm, and involve as many people in the community as possible. In this intervention, women are helped to move toward consistent condom use by being given condoms and messages tailored to their stage of change. The program has two phases: 1) community assessment, which involves finding out about the community and how to talk to women and their partners about their risk for HIV infection, and 2) getting the community involved in a combination of risk reduction activities directed toward these women and their partners.

Core Elements (*Must do all*)

- Peer Network. Recruit people from the community to talk to women and men about HIV prevention and related issues
- Stage-based Encounters. Have 1-on-1 discussions with community members to find out their stage of change to begin or continue condom use
- Role Model Stories. Write and disseminate role model stories about community members' decisions to change their behavior
- Community Network. Recruit local businesses, or organizations, and agencies to support HIV prevention activities
- Small-Group Activities. Conduct small-group activities to promote safer sex, and host HIV/AIDS presentations

Key Characteristics (*Steps to follow*)

- Hire a respected community leader, who represents the target population, as an outreach specialist
- Gather community permission from key community officials to gain support and enthusiasm for the project
- Conduct a community assessment during the preimplementation phase
- Train peer volunteers to have 1-on-1 conversations with members of the target population

Online Resources~ The following resources will provide more information regarding *Real AIDS Prevention Project*:

- www.effectiveinterventions.org
- http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance_real.pdf

Lauby, J.L., Smith, P.J., Stark, M., Person, B., Adams, J. 2000. A community-level prevention intervention for inner city women: Results of the Women and Infants Demonstration Projects. *American Journal of Public Health*, 90(2):216-222.

- Write short role model stories, based on the interviews, about people in different situations and stages of change regarding condom use or abstinence
- Provide monetary incentives or stipends to peer volunteers along with appreciation events
- Debrief peer volunteers regularly and provide short refresher trainings

Target Population

The Real AIDS Prevention Project targets sexually active women of reproductive age (aged 15-44), and their male sex partners.

Program Materials

- Outreach specialist
- 10-30 peer network members
- Space near where target population lives, works, and congregates
- TV, VCR, computer, printer
- Condoms
- Incentives for focus groups
- Incentives for small-group participants
- Stipends for peer network members
- Implementation Packet
 - Overview of program
 - Training manual for agency staff and peer outreach workers from the community
 - Video introducing the program and demonstrating its components
 - Materials for reproduction, such as checklists and tracking forms

Program Outcomes

- Women living in high-risk intervention communities were more likely to have initiated condom use with steady and casual partners
- Sex workers consistently used condoms with both steady and casual partners
- African American and Latina women increased condom negotiation and use with their male partners

SAFETY COUNTS

A Cognitive-Behavioral Intervention to Reduce HIV/HCV Risks Among Drug Users

Program Overview

Safety Counts is for persons who are using illicit (non-prescribed) drugs and who are not ready or not willing to enroll in drug treatment programs or otherwise stop their drug use. Clients may be either injection drug users or drug users who do not inject. The intervention addresses the needs of both HIV-negative and HIV-positive clients.

Safety Counts consists of seven sessions held over 4 months. It incorporates social modeling, social support, and modified behavioral contracting. Clients identify the behaviors that put them at risk, identify and take ownership of personal risk reduction goals, and develop steps for achieving these goals. An important component of *Safety Counts* is recruitment, used to link clients to counseling, testing and referral, prevention and treatment services, care and other support services.

Core Elements (Must do all)

- Conduct 2 group sessions to have clients
 - Identify HIV risks and current stage of change
 - Hear risk-reduction success stories
 - Set a personal goal
 - Identify a first step to reduce HIV risk
- Conduct 1 (or more) individual counseling session to
 - Discuss and refine client's risk-reduction goal
 - Assess the client's needs
 - Refer, if needed, to HIV counseling and testing services and to medical and social services
- Hold 2 (or more) group social events to have clients
 - Share a meal and socialize
 - Participate in HIV risk-reduction activities
 - Receive reinforcement for risk reduction
- Conduct 2 (or more) follow-up contacts to
 - Review the client's progress in achieving risk-reduction goal
 - Discuss barriers encountered
 - Identify concrete next step and possible barriers and solutions
 - Refer clients to HIV counseling and testing services and to medical and social services
 - Conduct or refer to counseling and testing for HIV and hepatitis C

Key Characteristics (Steps to follow)

- Help the client identify and access sources of social support for accomplishing personal risk-reduction goal
- Use different media for risk-reduction success stories
- Provide ongoing guidance and reinforcement for each client's step-by-step progress in achieving the risk-reduction goal

Target Population

Safety Counts targets individuals who are currently using drugs, including injectors and non-injectors, and are not in drug treatment programs. Examples of specific drugs that individuals may be using are heroin, cocaine, speedball, marijuana, methadone not prescribed by a treatment program, methamphetamine, club drugs, and pharmaceutical drugs (e.g. Xanax, Vicodin, Demorol, and Percodan).

Program Materials

- Group Facilitator
- Behavioral Counselor
- Program Manual
 - Handouts / worksheet master copies
- TV & VCR or DVD player
- Video
- Easel & easel chart paper & markers
- Safer sex and needle-hygiene kits
- Incentives (for each and every core element successfully completed)
- Forms
 - Enrollment & client participation
 - Evaluation tools

Program Outcomes

- Participants were more likely to reduce their drug- and sex-related risks
- Participants reported intentions to increase condom use
- Participants reported a reduction in the number of times they inject
- Participants were more likely to test negative for opiates through urinalysis

Online Resources~ The following resources will provide more information regarding *Safety Counts*:

- www.effectiveinterventions.org
- http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance_safety.pdfv

Rhodes, F., Humfleet, G.L. 1993. Using goal-oriented counseling and peer support to reduce HIV/AIDS risk among drug users not in treatment. *Drugs & Society* (3/4):185-204.

Rhodes, F. Wood, M.S. 1999. A cognitive-behavioral intervention to reduce HIV risks among active drug users. Paper presented at the 127th Annual Meeting of the American Public Health Association, Chicago, IL.

SHIELD

Self Help in Eliminating Life-Threatening Diseases

Program Overview

SHIELD is designed to train individuals in the drug using community to become health educators and promote HIV prevention within their community. Based on a community empowerment model, individuals are trained in applying leadership skills and encourage to promote HIV prevention within their communities and to conduct community outreach. Participants are not paid for the outreach but may be provided with stipends for the training sessions. The sessions attempt to build knowledge about HIV and to build communication, decision-making, prevention, and leadership skills.

Core Elements (*Must do all*)

- Set clear standards for attendance and participation in the program
- Conduct community identification (formative research to identify, prioritize, access, and understand the population)
- Provide 10-session training to peer educators
- Teach skills for initiating HIV risk-reduction messages with friends and acquaintances
- Teach characteristics of effective behavior change communication messages targeting risk factors
- Hold weekly sessions, using different methods to help peer educators refine their skills and gain confidence in delivering HIV prevention messages
- Have peer educators set goals to engage in risk-reduction conversations with friends and acquaintances
- Review, discuss, and reinforce at subsequent training sessions the outcomes of peer educators conversations
- Use logos, symbols, or other devices as conversation starters
- Refer clients, as needed

Key Characteristics (*Steps to follow*)

- Develop a client recruitment and engagement strategy
- Conduct outreach and other recruitment strategies to recruit the peer educators.
- Identify gatekeepers who will help identify
- Train peer educators to have a specific number of conversations with peers at risk
- Ask peer educators to recruit new groups of peer educators
- Continue to train new groups

Target Population

SHIELD is designed to be used with injection drug users.

Program Materials

- Paid or volunteer staff, trained in *SHIELD*
- Volunteer peer educators
- Any location that can be used to provide peer training
- Incentives
- *SHIELD* Facilitator's Manual – provides a full description of the curriculum and required materials.
- Markers/ Tape/ newsprint

Program Outcomes

- Participants had reduced levels of risky drug behaviors

Online Resources~ The following resources will provide more information regarding *SHIELD*:

- http://www.jhsph.edu/ShipStudies/Current_Projects/shield.html

SIHLE PROJECT

A Peer-led Program to reduce sexual risk behaviors, sexually transmitted diseases, pregnancy and HIV in African American Adolescent Females

Program Overview

The SIHLE project is a social-skills training intervention for African American adolescent females, ages 14-18. The acronym stands for “**S**istering, **I**nforming, **H**ealing, **L**iving, **E**mpowering.” It is aimed at reducing sexual risk behaviors, sexually transmitted diseases including HIV and unwanted pregnancy.

Core Elements (*Must do all*)

- Ethnic/Gender Pride
- HIV Prevention Education
- Sexual Communication
- Condom Use Skills
- Healthy Relationships
- Gender Specific
- Culturally-relevant
- Include behavior skills practice
- Group discussions
- Lectures
- Role-play

Key Characteristics (*Steps to follow*)

- Comprised of four 4-hour sessions
- Delivered by peer facilitators

Target Population

The SIHLE project targets sexually active African American adolescent females, ages 14-18.

Program Materials

- Facilitator’s manual
- Activities packets
- Technical assistance guide
- Evaluation materials.

Original Research

The SIHLE project implemented between at community health centers in Alabama with 522 sexually experienced adolescents, 14—18 years of age. Participants in the social-skills intervention were recruited from 4 community health centers. Results indicated that participants in the social skills training reported using condoms more consistently.

Implementation Note

Agency must already be implementing SISTA.

Online Resources~ The following resources will provide more information regarding *SIHLE*:

DiClemente, R.J., Wingood, G.M., Harrington, K.F., Lang, D.L., Davies, S.L. Hook, E.W., Oh, M.K., Crosby, R. A., Hertzberg, V.S., Gordon, A.B., Hardin, J.W., Parker, S. & Robillard, A. (2004). Efficacy of an HIV prevention intervention for African American adolescent girls. A randomized controlled trial. *Journal of the American Medical Association*, 292 (2), 171—179.

SISTA

Sisters Informing Sisters on Topics about AIDS A Peer-led Program to Prevent HIV Infection in African American Women

Program Overview

SISTA (Sisters Informing Sisters on Topics about AIDS) is a social-skills training intervention to prevent HIV infection in African American women. Women are given the social and behavioral skills needed to adopt HIV risk-reduction strategies. *SISTA* includes discussions of self-esteem, relationships, and sexual health. This intervention is based on a theory that says that people need information, training in social and behavioral skills, and knowledge of norms to apply risk-reduction strategies.

SISTA examines a woman's willingness to adopt and maintain sexual risk-reduction strategies within heterosexual relationships according to how much power she has, her commitment to the relationship, and her role in the relationship. The information is delivered in five 2-hour sessions that are gender specific and culturally relevant and include behavioral skills practice, group discussions, lectures, role-playing, prevention video viewing, and take-home exercises.

Core Elements (*Must do all*)

- Gather small groups of women to talk about what they will learn from the program and the challenges and joys of being African American women and to learn skills
- Use a facilitator who is well trained and skilled in leading groups
- Use materials that reflect pride in being an African American woman (e.g. poetry, artwork by other African American women)
- Train women how to stand up for themselves and insist on safer sex (sexual assertion skills)
- Teach women how to use condoms
- Discuss why it is hard to talk about safer sex with partners
- Emphasize how important it is for women to get their partner's buy-in for safer sex

Key Characteristics (*Steps to follow*)

- Adapt the intervention to different populations of African American women (e.g. women who are in substance abuse treatment facilities, incarcerated women, women living in shelters, and sex workers)
- Be sure facilitators show passion in their delivery of the intervention
- Reflect African American culture
- Cover many topics (e.g. relationships, dating, and sexual health) in addition to HIV prevention

Target Population

SISTA targets heterosexually active African American women.

Program Materials

- Health educator(s)
- Quiet, accessible meeting space
- Anatomical models (male and female)
- Condoms
- Implementation Packet
 - Facilitator's manual
 - Videotape: *It's Like This*
 - Five Activity Masters packets
 - Evaluation materials (including evaluation assistance kit, original and process evaluation)
- CDC supplemental materials
 - Community Facilitator Guide
 - Technical Assistance Guide
 - Evaluation Technical Assistance Guide
 - Evaluation Plan

Program Outcomes

- Participants demonstrated increased consistent condom use, sexual behavior control, sexual communication, and sexual assertiveness skills
- Partners of participants were more likely to adopt and support consistent condom use

Online Resources~ The following resources will provide more information regarding *SISTA*:

- www.effectiveinterventions.org
- http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance_sista.pdf

DiClemente, R.J., Wingood, G.M. 1995. A randomized controlled trial of an HIV sexual risk reduction intervention for young African American women. *The Journal of the American Medical Association*, 274(16):1271-1276.

STREET SMART

Reducing HIV Risk among Runaway & Homeless Youth

Program Overview

Street Smart is an intensive HIV/AIDS and STD prevention program for homeless and runaway youth whose behaviors place them at risk of becoming infected. *Street Smart* is based on social learning theory, which links feelings, attitudes, and thoughts to behavior change.

Street Smart is a multisession, manual-guided, small-group intervention that teaches effective behavior change, problem-solving skills, and strategies for increasing safer sexual behaviors. Group sessions address improving youths' social skills, assertiveness, and coping through exercises on solving problems, identifying triggers, and reducing harmful behaviors. Staff members provide individual counseling session and a trip to a relevant community health provider.

Core Elements (*Must do all*)

- Increase clients' knowledge about HIV and its transmission, the benefits of HIV testing and knowing one's status, the role of stigma, and the changing epidemiology of the epidemic
- Have clients identify peers' and partners' social norms and expectations to increase self-efficacy
- Have clients recognize and take control of feelings and emotional responses
- Have clients identify risk, and teach personal use of HIV/AIDS risk hierarchy
- Use peer support to identify personal triggers to unsafe behavior
- Build skills in problem solving and assertiveness in social situations to reduce HIV/AIDS risk

Key Characteristics (*Steps to follow*)

- Convene small mixed-gender groups (6-10 youth)
- Conduct 8 group sessions (90-120 minutes)
- Hold 1 individual counseling session
- Hold 1 trip to a local community resource serving at-risk youth
- Have groups meet 2 to 4 times per week, with flexible scheduling
- Be sure the curriculum is highly structured with built-in flexibility to individualize to particular groups of youth

Online Resources~ The following resources will provide more information regarding *Street Smart*:

- www.effectiveinterventions.org
- http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance_street.pdf

Rotheram-Borus, M.J., Song, J., Gwadz, M., Lee, M., Van Rossem, R., Koopman, C. 1993. Reductions in HIV risk among runaway youth. *Prevention Science*, 4(3):173-187.

Target Population

Street Smart targets youth, male and female, aged 11-18, at high risk for HIV/AIDS and STDS. *Street Smart* was designed for runaway and homeless youth, but can be adapted to youth in other setting that place them at risk.

Program Materials

- 2 adult facilitators
 - 1 with youth group facilitation skills
 - 1 with a degree in counseling or behavioral science
- Large, private, comfortable meeting space for group sessions
- Implementation Packet
 - Facilitator's training manual (for program staff)
 - Orientation videotape (for program staff)
 - Workbook for participants
 - Sample social marketing and recruitment materials
 - Handouts for participants

Program Outcomes

- Participants reported lower rates of substance use
- Participants reported lower rates of unprotected sex acts
- Young women self-reported greater reductions in substance abuse and unprotected sex acts than young men
- African-American youth self-reported less substance use than youth of other ethnic groups

TOGETHER LEARNING CHOICES

A Group-Level Intervention for Young People Living with HIV

Program Overview

Together Learning Choices is an effective intervention for helping young people living with HIV identify ways to increase use of health care, decrease risky sexual behavior and drug and alcohol use, and improve quality of life. It emphasizes how contextual factors influence ability to respond effectively to stressful situations, solve problems, and act effectively to reach goals. Teens may be recruited or referred from HIV treatment programs. Delivering the *Together Learning Choices* intervention involves delivering specific content for each session, determining a routine format for all sessions, and helping clients identify behavior-changing mechanisms for solving their problems.

Core Elements (*Must do all*)

- Help clients develop awareness and identify feelings, thoughts, and actions
- Teach, model, and practice 4 core skills (emotional regulation, SMART problem solving, goal setting, assertiveness)
- Reinforce positive client behavior through the use of thanks tokens
- Help clients identify their ideal self to help motivate and personalize behavior change
- Deliver sessions in highly participatory, interactive small groups

Key Characteristics (*Steps to follow*)

- Encourage clients to attend all sessions of the intervention, but give them flexibility to drop in for particular sessions on their own schedule
- Determine whether incentives are appropriate and, if so, what type
- Modify session times and frequencies as needed
- Base group size and composition on clients' needs
- Offer snacks and use visual aids

Target Population

The *Together Learning Choices* intervention targets young people, aged 13-19 years, living with HIV.

Program Materials

- 2 trained facilitators
- Implementation Packet
 - *Together Learning Choices* Volume 1
 - i. Introduction and Overview
 - ii. Stakeholders Checklist
 - iii. Costs Worksheet
 - *Together Learning Choices* Volume 2
 - i. Staying Healthy
 - *Together Learning Choices* Volume 3
 - i. Acting Safe
 - ii. Special intervention tokens
 - iii. A “feeling” thermometer
- Condoms and models for practicing condom use
- Workbooks

Program Outcomes

- Young women reported an increase in their positive lifestyle behaviors and use of positive action coping styles
- All youth reported increased use of the social support coping style
- Youth reported fewer sexual partners, including fewer HIV-negative partners, and fewer unprotected sex behaviors
- Youth reported reductions in alcohol, marijuana, and illicit drug use
- Youth reported decreases in feelings of distress, physical symptoms of distress, and generalized and fear-based anxiety

Online Resources~ The following resources will provide more information regarding *Together Learning Choices*

- [:www.effectiveinterventions.org](http://www.effectiveinterventions.org)
- http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance_together.pdf

Rotheram-Borus, M.J., Lee, M.B., Murphy, D.A., Futterman, D., Duan, N., Birnham, J., Teens Linked to Care Consortium. 2001. Efficacy of a preventive intervention for youth living with HIV. *American Journal of Public Health*, 91:400-405.

TURNING POINT

HIV Risk Reduction for Injection Drug Users & Their Sex Partners

Program Overview

Turning Point includes four sessions a one-hour counseling session and three one and a half hour group sessions. It is based on the Health Belief Model and the AIDS Risk Reduction Model. The program aims to reduce HIV infection risk by helping IDUs recognized (1) the behaviors that make them susceptible to contracting HIV, (2) the severity of AIDS, (3) the benefits of specific HIV risk reduction behaviors, (4) the barriers to adoption of risk reduction behaviors, and (5) their personal ability to execute risk reduction behaviors. The intervention includes group discussion, lectures, role play, safer sex communication/negotiation and a video. The three group sessions address HIV/AIDS pathology, drug addiction and safer sex practices. There are also three “booster” sessions that can be used. These cover material previously presented and are designed to reinforce the HIV/AIDS prevention message. Each of the booster sessions lasts 60 to 75 minutes.

Core Elements (*Must do all*)

- Individual prevention counseling and testing session
- Video on risk reduction, condom use, and injection cleaning skills
- Groups on HIV, addiction issues, safer sex and relationship issues.
- Conducting the 3 intervention sessions order is flexible.

Key Characteristics (*Steps to follow*)

- Meet in small groups (5-12 individuals) with similar backgrounds.
- Have clients sit in a circle
- Participants meet for 3 sessions, 1.5 hours each
- Have 1 facilitator per group

Online Resources~ The following resources will provide more information regarding *Turning Point*:

- www.effectiveinterventions.org
- <http://www.socio.com/srch/summary/happa/hap06full.htm>

Siegal, H.A., Falck, R.S., Carlson, R.G., & Wang, J. (1995). Reducing HIV needle risk behaviors among injection-drug users in the Midwest: An evaluation of the efficacy of standard and enhanced interventions. *AIDS Education and Prevention*, 7(4), 308-319.

Target Population

The *Turning Point* intervention targets injection drug users and their sex partners.

Program Supplies & Materials

- Group Facilitator – trained HIV educator/counselor
- Recommended but not required that the facilitator have prior psychoeducational experience.
- Intervention curriculum available from HAPPA (link below) cost for full set of materials - \$350
 - Facilitator Manual
 - User’s Guide
 - Activity Masters packet
 - Evaluation assistance kit
 - Process evaluation instrument
 - A Slide Atlas to Differential Diagnosis in HIV Disease binder.

Program Outcomes

Implementation of *Turning Point* produced the following results:

- Increased safer needle use behaviors

VOICES / VOCES

Video Opportunities for Innovative Condom Education and Safer Sex

Program Overview

VOICES/VOCES (Video Opportunities for Innovative Condom Education and Safer Sex) is a single-session, video-based workshop, in English and Spanish, for the prevention of HIV and other STDs. The intervention was designed to reach heterosexual African American and Latino men and women at very high risk for HIV/STDs during a “teachable moment.” The goals are to encourage condom use and to improve condom negotiation skills. During *VOICES/VOCES* sessions, clients watch culturally specific videos, participate in small-group, skill-building sessions, learn about condoms, and receive condom samples.

Core Elements (*Must do all*)

- Show culturally specific videos portraying condom negotiation
- Hold small-group, skill-building sessions to practice overcoming barriers to condom use
- Educate clients about different types and features of condoms
- Distribute condom types identified by clients as best meeting their needs

Key Characteristics (*Steps to follow*)

- Introduce *VOICES/VOCES* as a routine part of clinic or agency services
- Convene 4-8 people of the same gender and race/ethnicity, to allow for open discussion of sensitive issues
- Conduct the session in a private space
- Deliver the intervention in a single 40- to 60- minute session
- Start the session by showing the 15- to 20-minute culturally specific video, included in the intervention package, which reflects up-to-date information on HIV/STDs
- Uses male and female actors of similar race/ethnicity as clients
- Depicts real-life situations
- Shows condom negotiation as a shared responsibility
- Models communication skills and prevention attitudes and behaviors
- Includes subject matter that is explicit but appropriate for viewing

Online Resources~ The following resources will provide more information regarding *VOICES/VOCES*:

- www.effectiveinterventions.org
- http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance_voices.pdf

- Use characters and situations depicted in the video to launch group discussion
- Address barriers to condom use and safer sex by
 - Increasing awareness of personal risk for HIV/STD infection
 - Providing information on safer sex to prevent infection
 - Correcting misinformation about condom use
 - Presenting the features of different types of condoms to address objections to using them
- Give each client 3 condoms of the type he or she identified as best meeting his or her needs

Target Population

The *VOICES/VOCES* intervention targets heterosexual African American and Latino adult men and women (aged 18 and older), in community agencies (e.g. STD clinics, family planning, community health, drug rehabilitation, correctional).

Program Materials

- 1-2 facilitators
- Implementation Packet
 - Preview Guide of materials for agency administrators
 - Bilingual (English/Spanish) planning and implementation manual
 - Bilingual (English/Spanish) condom poster
 - Two videos:
 - *Porque Si* (Latino men and women)
 - *Love Exchange* (African Americans)
- TV/VCR
- A variety of condoms that match the types and features on the Condom Features poster board

Program Outcomes

- Participants increased knowledge about the transmission of HIV and other STDs
- Participants had a more realistic assessment of their personal risk
- Participants had a greater likelihood of getting condoms and intending to use them regularly
- Participants presented fewer repeat STDs

O'Donnell, C.R., O'Donnell, L., San Doval, A., Duran, R., Labes, K. 1998. Reductions in STD infections subsequent to an STD clinic visit: Using video-based patient education to supplement provider interactions. *Sexually Transmitted Diseases*, 25(3):161-168.

WILLOW

A Peer-led Program to reduce HIV transmission risk behaviors and sexually transmitted diseases among women living with HIV

Program Overview

WILLOW (Women Involved in Life Learning from Other Women) is a group-level intervention designed to emphasize gender-pride, social support, HIV transmission knowledge, communication, condom use skills, and healthy relationships. Its overall goals are to reduce HIV transmission risk behaviors, sexually transmitted diseases, and to enhance HIV preventive psychosocial and structural factors among women living with HIV.

WILLOW uses 4- four hour group sessions that are implemented over consecutive weeks. Each session includes 8-10 participants, is implemented by a trained female health educator, and co-facilitated by an HIV-positive female peer educator. Session 1 focuses on gender pride by discussing the joys and challenges of being a woman and by acknowledging the accomplishments of women in society. Session 2 focuses on ways of creating new social network members, discuss ways of maintaining supportive network members, and teaches participants how to break free from network members who were not supportive of healthy behaviors. Session 3 emphasizes education in relation to HIV transmission risk behaviors and discredits common fallacies regarding HIV prevention for people living with HIV. Communication, negotiation skills for safer sex, and the benefits of using condoms consistently is emphasized during this session. Peer educators also model proper condom use skills. Session 4 teaches the impact of abusive relationships on safe sex, the difference between healthy and unhealthy relationships, and informs women of local shelters for women in abusive relationships.

Core Elements (*Must do all*)

- Gender Pride/Social Support
- Stress Management
- Sexual Communication
- Condom Use
- Healthy Relationships

Key Characteristics (*Steps to follow*)

- Comprised of four 4-hour sessions
- Delivered by peer facilitators

Target Population

WILLOW targets women living with HIV.

Program Materials

- Facilitator's manual,
- Activities packets,
- Technical assistance guide
- Evaluation materials

Original Research

The results demonstrated positive effects on condom use skill, increase in social support members, a lower incidence of bacterial infections, and greater HIV knowledge.

- Participants reported greater HIV knowledge and condom use self-efficacy
- Fewer partner-related barriers to condom use were reported
- Participants demonstrated greater skill in using condoms
- Participants reported fewer episodes of unprotected vaginal intercourse
- Participants had a lower incidence of bacterial

Online Resources~ The following resources will provide more information regarding *WILLOW*:

- www.effectiveinterventions.org
- http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance_voices.pdf

Wingood, G.M., DiClemente, R.J., Mikhail, I., Lang, D.L., McCree, D.H., Davies, S.L., Hook, E.W 3rd, Saag, M. 2004. A Randomized Controlled Trial to Reduce HIV Transmission Risk Behaviors and Sexually Transmitted Diseases Among Women Living With HIV: The WILLOW Program. *Journal of Acquired Immune Deficiency Syndrome*, 2004 Oct 1;37: S58-S67.

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Part F: Tools for Prevention and Care

Chapter 12:

Case Management Standards



CARE PLANNING

Comprehensive planning is the creation of a “road map” for the development of a system of care (HRSA, Ryan White CARE Act Title II Manual, 1998). Building upon Iowa’s epidemiological data and other needs assessment information, the planning process examines HIV care needs for Iowa and assesses the resources available to meet those needs and to overcome barriers to service provision. The comprehensive plan assists in setting long-term goals and sets guidelines for resource allocation. This section presents information on care planning in Iowa.

In 2001, the Iowa Department of Public Health (IDPH) and the Iowa HIV Community Planning Group (CPG) decided to link prevention and care planning activities. For the purposes of planning, CPG defines care as access to primary medical care. Enhanced integration of prevention and care programs with other programs that serve people who are HIV infected, or at increased risk, is a priority with the IDPH and the CPG. In Iowa, with relatively low incidence of HIV infection, the linkage of prevention and care services is critical to preventing further spread of HIV. The populations increasingly at risk for HIV infection need to be reached in creative ways, particularly in the rural parts of the state where people at risk are widely scattered. These individuals and others at continuing risk are often alienated from, or suspicious of, traditional medical, psychological, and social services. As the planning body, the HIV CPG provides recommendations to the Iowa Department of Public Health on HIV care and treatment issues. During 2002, the IDPH and CPG were involved in the development of the Statewide Coordinated Statement of Need, and assisted with Needs Assessment activities.

Long-Term Goals

The long-term goals of the Care committee are to collaborate with IDPH, the Case Management Ad Hoc Committee, and other CPG sub-committees

- in the development of Ryan White case management standards
- to create a Ryan White case management manual
- to establish guidelines so that consortia are accountable for providing non-duplicative services reflective of community needs
- to identify gaps in Ryan White CARE services
- to develop strategies to overcome identified gaps
- to develop an orientation about Ryan White Title II CARE services
- to maintain a current list of other financial and community resources available to people living with HIV disease
- to clarify allowable Ryan White Title II service categories

RYAN WHITE CARE ACT

The populations hit hardest by the AIDS epidemic are those at high risk for poverty, those who lack health insurance, and those who are disenfranchised from the health care system (Health Resources and Services Administration (HRSA), 2002). In August 1990, Congress enacted the Ryan White CARE Act to improve the availability of care for low-income and uninsured or underinsured individuals and families affected by HIV disease. Congress reauthorized the CARE Act in May 1996 and again in October 2000. Programs under the CARE Act include:

- Title I – Provides emergency assistance to Eligible Metropolitan Areas (EMAs) that are most severely affected by the HIV/AIDS epidemic.
- Title II – Provides grants to all 50 states, the District of Columbia, Puerto Rico, Guam, the US Virgin Islands, and five newly eligible US Pacific territories and associated jurisdictions. Title II also funds the AIDS Drug Assistance Program (ADAP). Title II funds may be used to provide a variety of services (see **Appendix A**). In addition, funds are used by HIV Care Consortia to assess needs and to contract for services.
- Title III – Provides comprehensive primary health care for individuals living with HIV disease.
- Title IV – Provides services to women, infants, and youth living with HIV disease. Services include primary and specialty medical care, psychosocial services, logistical support and coordination, and outreach and case management.
- AIDS Education and Training Centers (AETC) – Provides multi-disciplinary education to health care providers to counsel, diagnose, treat, and medically manage individuals with HIV disease, and to help prevent high risk behaviors that lead to HIV transmission.
- Dental Reimbursement Program (DRP) – Supports access to oral health care for individuals with HIV disease, by reimbursing dental education programs for non-reimbursed costs incurred in providing such care.

Iowa receives Title II, Title III, AETC and DRP.

Nationally, the CARE Act reaches more than 500,000 people living with HIV each year. In 2002, 650 Iowans received services through the Ryan White Title II Services and 295 received prescription drugs through the AIDS Drug Assistance Program (ADAP) (IDPH, 2002). The CARE Act serves as the payer of last resort for Persons Living With HIV (PLWH) who are uninsured or have inadequate insurance and cannot cover the costs of care on their own, or because no other source of payment for services is available.

In 2002, 18 percent of Ryan White Title II funds were spent for prescriptions, medical care, and support services for women, infants, and children. IDPH predicts that 19 percent of Title II funds will be spent on women, infants, children and youth during 2003.

Over the last few years, clinical HIV care has undergone a revolution. Highly active antiretroviral therapy (HAART) is credited with reducing mortality and improving the quality of people's lives. Enhanced management of opportunistic infections and supportive care are important elements in the HIV chronic care treatment continuum. As clients live longer, many have only partial disability and limited or no access to Medicaid or other health coverage. The complexities of treatment options are a significant factor affecting clients' ability to adhere to prescribed procedures. Social factors, adequacy of insurance, and co morbidities such as

substance abuse, mental illness, or homelessness, influence a client's ability to follow a treatment regimen.

The resources necessary to provide the appropriate medical and care services to manage HIV infection are extensive. The physical size of Iowa, coupled with a limited number of providers, has resulted in the formation of both formal and informal programs and partnerships that support HIV/AIDS care services. While issues such as adequate and affordable housing, poverty, non-medical transportation, and discrimination are not directly addressed by the CARE Act, they remain critical concerns in achieving appropriate care outcomes.

HIV CARE CONSORTIA (Title II funded)

In cooperation with designated lead agencies, the IDPH has established four HIV Care Consortia (11 providers) that encompass all 99 counties of the state. These consortia provide essential health and support services, such as case management, emergency financial assistance, food bank assistance, housing assistance, and counseling, to financially eligible clients living with HIV. In 2002, 650 clients received services. The services are widely publicized to providers of health care and HIV support services throughout Iowa. An HIV/AIDS Directory includes both prevention and care providers, and is distributed to Counseling, Testing, and Referral sites, prevention and care providers, clients, and the general public.

ADAP (Title II funded)

ADAP is administered by IDPH through the use of one contracted centralized pharmacy that distributes drugs to clients statewide. A separate advisory committee, the Ryan White AIDS Drug Assistance Program (ADAP) Advisory Committee, provides periodic review of ADAP, including the ADAP formulary. Thirty-three HIV-related medications are provided to individuals with HIV whose income does not exceed 200 percent of the federal poverty level. In 2002, 295 individuals received ADAP assistance.

TITLE III

This title supports outpatient primary medical care and Early Intervention Services (EIS) to people living with HIV disease through grants to public and private non-profit organizations. The four Title III clinics in Iowa are located in Davenport, Des Moines, Iowa City, and Sioux City.

OTHER FINANCIAL ASSISTANCE AND COMMUNITY RESOURCES

Additional financial assistance may be available to help pay medical bills, provide income if unable to work, or help in an emergency. Financial assistance programs vary from county to county and state to state. Community resources may also be available to provide home nursing care, homemaker services, support groups or volunteer support services.

HOPWA

Housing Opportunities for Persons With AIDS (HOPWA) is a program funded by the US Department of Housing and Urban Development (HUD). The program is designed to help very low-income individuals who are living with HIV/AIDS to stabilize their housing, a key to health and well-being. Each community uses HOPWA funds to best match the needs of those they serve. Examples of HOPWA services provided in Iowa include rental assistance, utilities assistance, short-term financial assistance, mortgage assistance, housing support services and case management.

MEDICAID/TITLE XIX FINANCIAL ASSISTANCE PROGRAMS

These financial assistance programs are administered through the Department of Human Services.

A. FAMILY INVESTMENT PROGRAM (FIP), replacement for AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

FIP provides cash payments and usually Medicaid health care coverage to families with dependent children and limited income and resources. The monthly cash payment is determined by the number of members in a family, current income, and resources.

B. MEDICALLY NEEDY PROGRAM

In Iowa, the Medically Needy Program is a health care program for people who a) are under 21 or over 65 years of age, pregnant, blind, and/or disabled, b) have limited resources and income, but exceed the guidelines for Social Security Income (SSI) and Family Investment Program (FIP). Medically Needy is a program designed to provide medical coverage through Medicaid.

C. MEDICAID FOR EMPLOYED PEOPLE WITH DISABILITIES (MEPD)

Many persons with disabilities may be able to work and maintain medical assistance coverage. Eligibility will be determined by a variety of qualifications. Some of these requirements include disability; under age 65; earned income from employment or self-employment; required to pay a monthly premium when monthly gross income is above 150% of the federal poverty level (currently \$1123.00). Premiums are calculated based **only** on the gross income of the disabled individual. Patients enrolled in Ryan White II may be eligible to receive premium assistance.

D. AIDS/HIV WAIVER PROGRAM

The AIDS/HIV HCBS (Home and Community-Based Services) waiver pays for services for people with acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection who would otherwise require care in a medical institution.

MEDICARE

Medicare is available for persons who are at least 65 years old and eligible to receive Social Security benefits, or have been on Social Security Disability Insurance for two years.

Medicare has two parts: Medical insurance and Hospital insurance. Hospital insurance provides 60 days of fully-covered hospital care per spell of illness, after a deductible is met. Then it

provides an additional 30 days of hospital coverage with a co-payment; 100 days of skilled nursing facility care; coverage for medically necessary hospital equipment; and in-home skilled nursing care.

There is a premium for “Part B” of Medicare. Medicaid can pay this premium if an individual meets income guidelines.

SOCIAL SECURITY DISABILITY INSURANCE (SSDI)

SSDI provides monthly cash benefits if a person is considered disabled for 12 months or longer and has earned enough work credits by paying into “FICA.” Monthly payments are based on age, years of employment, and salary. Medicare eligibility begins after the 24th month of SSDI eligibility.

SUPPLEMENTAL SECURITY INCOME (SSI)

SSI guarantees a person a minimum monthly income if over 65, blind, or disabled for 12 months or longer and determined to have limited income and resources. Iowa provides Medicaid health care coverage for persons receiving SSI.

STATE PAPERS

State papers may cover the cost of health care services and medications received from the University of Iowa Hospitals and Clinics. Transportation, meals, and lodging costs resulting from the need to receive health care services at the UIHC will also be covered. To be eligible, a person must be a legal resident of Iowa, have unpaid health care expenses from the University of Iowa Hospitals and Clinics, and meet the income and resource requirements determined by county of residence.

SUPPLEMENTAL/EMERGENCY FUNDS

Community AIDS organizations may have limited additional money from the Ryan White CARE Act federal funding, or locally-generated emergency funds. The Clinic Social Worker in each community will be aware of these services.

CARE PRINCIPLES

In 1997, the administrative agency for the Ryan White CARE Act, HRSA, released the following program principles. These principles, along with the Strategies for Prevention Interventions and Community Endeavors (SPICE) principles, presented in Chapter 4, guide care planning in Iowa.

The growing impact of the HIV/AIDS epidemic among underserved minority and hard-to-reach populations requires states to

- assess the shifting demographics of new HIV/AIDS cases; and
- Adapt care systems to the needs of emerging communities and populations; with a priority focus on PLWH who know their HIV status and are not in care.

Ensuring access to existing and emerging HIV/AIDS therapies, including new combination antiretroviral therapies and prophylaxis/treatment for opportunistic infection requires states to

- recognize the role of primary care in overcoming barriers to accessing therapies;
- recognize the role of support services in overcoming barriers to accessing therapies; and
- establish quality management programs.

Changes in the financing of HIV/AIDS care, particularly Medicaid managed care requires that CARE Act providers adapt to managed care environments and coordinate services with other Federal/State/local programs.

The increased importance of documenting outcomes from the investment of CARE Act resources requires states to

- describe the impact of Title II funds in establishing, maintaining, and expanding their continuum of care;
- establish quality assurance mechanisms; and
- establish evaluation mechanisms to assess the effect of funds on the continuum of care.

In addition, in Iowa persons living with HIV/AIDS must

- be equal and participate in the planning, implementation, and evaluation of care services;
- be complete partners in their individualized plan of care;
- be assured of confidential medical, supportive, and social services;
- have access to the most advanced quality medical and dental care available;
- have access to patient-focused and/or family-centered care;
- be provided services that facilitate and enhance independence, individual rights, and choices;
- have access to high quality, comprehensive, and supportive social services;

- have access to direct services that meet statewide minimum standards;
- receive services that are culturally and linguistically appropriate, free of discrimination based upon gender, age, sexual orientation, race, ethnicity, criminal history, substance use history, or ability to pay, with all known and perceived barriers minimized wherever possible.

BARRIERS TO CARE SERVICE DELIVERY

The following identifies Iowa's current crosscutting issues affecting PLWH, and a discussion of barriers that contribute to the difficulty faced by PLWH in accessing services (Statewide Coordinated Statement of Need [SCSN], 2002).

CHANGING NATURE OF HIV DISEASE

As a result of new drug therapies, HIV is moving closer to becoming a manageable and chronic, though still incurable, illness. Challenges and complications exist with this new long-term reality, including:

- Caseloads for Ryan White CARE Act (RWCA) grantees increasing as the number of persons living with HIV has increased.
- Financial constraints increasing the burden on already limited systems.
- An increase in hepatitis C co-infection and the complications that accompany co-infection.
- Long-term adherence to medication regimens
- Complacency about maintaining safe behaviors.

RURAL ISSUES

The rural nature of Iowa presents challenges for PLWH. Ongoing issues include having to travel long distances for regular medical care or to participate in support and planning groups. Concerns exist surrounding confidentiality when receiving testing, care, and support services in small towns. Rural PLWH do not have equal access to medical, social, or legal services as do their urban counterparts.

CHANGING NEEDS OF THOSE AFFECTED BY THE EPIDEMIC

An increasing number of people infected with HIV have a combination of complex social and health needs including homelessness, chemical dependency, mental illness, physical disabilities, poverty, and language barriers. While the reported number of people of color with HIV in Iowa is small, the rate of infection in African American and Hispanics is 12 times that of Caucasians.

SOCIOECONOMIC BARRIERS

Limited financial resources, cuts in social welfare entitlement programs, and inadequate health insurance, including prescription drug coverage and long-term maintenance, present barriers to individuals seeking to access essential HIV services. There is also a lack of consistent emergency medical coverage across the state. Fiscal barriers are compounded by the additional challenges of substance abuse, multiple HIV diagnoses in a family, and an array of mental health challenges that contribute to difficulty in accessing services. Iowa is experiencing an increase in its non-U.S. born population, both documented and undocumented who are in need of financial, medical, and social services.

RACIAL, ETHNIC, CULTURAL, & GENDER/SEXUAL ORIENTATION SPECIFIC BARRIERS

Insufficient access to a broad comprehensive health care and social service system creates barriers to service for different ethnic and racial minority groups. There continues to be a need for funding for health and social service providers to provide culturally appropriate and

competent care. Men who have sex with men, people of color, women, mentally and physically disabled individuals, and people whose first language is not English, are especially vulnerable to service barriers in Iowa.

GEOGRAPHIC BARRIERS

There is a need for more trained HIV specialists in Iowa. Primary care physicians and other health care professionals often have limited knowledge of HIV and AIDS. There is limited access to infectious disease specialists, as well as complete, coordinated and consistent services. People in rural areas struggle with the lack of adequate choices in medical care within a reasonable distance.

STIGMA, SHAME, AND FEAR OF DISCLOSURE

Stigma, shame, and fear of disclosure are barriers to accessing services for both clients and service providers. In rural areas, the small number of people infected with HIV contributes to a sense of aloneness and isolation. Fear that one's HIV status, sexual orientation, drug use history, and/or criminal history may be disclosed or not kept confidential, may prevent individuals from accessing care.

CONSUMER CONFIDENCE/EXPERIENCE AND KNOWLEDGE REGARDING THE HEALTH CARE SYSTEM

Due to the increasing number of clients born in developing third-world countries, many clients lack knowledge of current health care system. They avoid accessing health care, fearing that receipt of care will jeopardize their immigration status. Other clients have had previous negative experiences in accessing care and are reluctant to seek care services.

COMPETING NEEDS/OVERRIDING DAILY LIVING ISSUES

Competing needs such as low income, unemployment, limited disability benefits, unstable housing, homelessness, parenting and childcare issues, severely affect an individual's ability to seek care services and adhere to treatment plans.

LACK OF INSURANCE OR ABILITY TO PAY FOR SERVICES

Clients are reluctant to seek care services due to limited insurance benefits, lack of coverage, or having no financial resources to pay for the service.

LACK OF AFFORDABLE HOUSING AND TRANSPORTATION

There is a lack of affordable and available housing, transportation and other resources to meet client needs.

STRATEGIES TO OVERCOME BARRIERS TO HIV CARE SERVICES

Over the last few years, clinical HIV care has undergone a revolution. Highly active antiretroviral therapy (HAART) is credited with reducing mortality, and improving the quality of people's lives. While HAART is the most visible intervention, enhancing management of opportunistic infections and supportive care have been emphasized as important elements in the chronic care continuum of HIV treatment. As clients live longer, many have only partial disability and limited or no access to Medicaid or other health care coverage. The complexity of treatment options significantly affects clients' ability to adhere to prescribed procedures. Social factors, inadequate insurance, and co morbidity, such as substance abuse, mental illness, or homelessness, influence clients' capacity to follow treatment regimens.

CONTINUUM OF CARE

Continuum of care services and funding streams must adapt to and reflect this new reality. Increasing access to treatments and services, educating clients and service providers, and empowering persons living with HIV to advocate for themselves and for changes in the care system can accomplish this.

RESOURCES

The resources necessary to provide appropriate medical and care services to manage HIV infection are extensive. The physical size of Iowa, coupled with a limited number of providers, has resulted in the necessity to develop formal and informal programs and partnerships that support HIV care services. Issues such as adequate and affordable housing, poverty, non-medical transportation, and discrimination are critical concerns in achieving appropriate care outcomes.

CARE SYSTEMS

Current care systems must build capacity to serve rural clientele and to educate communities in which they live to help alleviate some of the social stigma surrounding HIV. They must build capacity and cultural competency to serve a diverse clientele that includes women, out-of-home and street-involved youth, those with incarceration histories, injection drug users, ethnic/racial minorities, non-English-speaking persons and undocumented clients. Alliances and partnerships must be created and maintained among HIV/AIDS and chronic disease clinics, and social service systems. These partnerships must share the primary goal to more effectively assist clients with complex needs to improve access to care services and to encourage clients to adhere to prescribed treatments.

LINKING PREVENTION AND CARE

Integration of prevention and care services is a statewide goal in Iowa. The HIV Community Planning Group has incorporated care planning into its existing infrastructure. HIV-positive persons are prioritized for prevention services. Counseling and testing, partner counseling and referral services, prevention case management, and early treatment of HIV are also linked.

IDENTIFYING PLWH NOT IN CARE

IDPH has worked with consortia to reach underserved, difficult to reach persons and link them to ADAP services. Further strategies will be developed to identify and determine the needs of

clients who know their status and are not in care. The Care Committee will develop a questionnaire to determine unmet care needs. The committee has been working with the HIV/AIDS Program Surveillance Coordinator to measure unmet need utilizing the number of People Living with AIDS (PLWA) and People Living with HIV non-AIDS/aware (PLWH non-AIDS aware) and percent of PLWA and PLWH non-AIDS/aware meeting primary care definition. This information, once gathered, will be linked to our investigations into reasons for unmet need for care. The investigations will focus on structural and individual barriers that keep people from care. They will be qualitative client interviews and focus groups.

GAPS IN SERVICES NEEDED BY PLWH

ACCESS TO HEALTHCARE

Continued expansion of the Ryan White HIV care and drug assistance programs is needed to close critical gaps that impact people's abilities to access primary and specialty care, dental care, mental health services, and medications. A significant number of people receiving services are either underinsured (limited coverage), or uninsured (no coverage). People with limited or no coverage may not seek routine HIV care because of cost. High deductibles and co-pays are barriers to non-urgent care. For the underinsured, dental, mental health, home health care, prescription services, and substance abuse treatment may not be covered. Clients accessing state programs may deal with complex spend-down rules for eligibility, or face limitations on covered drugs and mental health services.

BASIC SURVIVAL NEEDS

The overlay of poverty and service gaps for people living with HIV cannot be overstated. A significant number of people with HIV are living below the poverty level. For these individuals, the need for routine medical care is superseded by day-to-day survival needs of food, shelter, and safety. Lack of routine and preventive HIV care leads to the development of opportunistic infections, hospitalizations, and mortality. To prevent unnecessary hospitalizations and mortality, it is essential that Iowa continues to receive funding for housing assistance programs, case management and support services, and health care coverage.

EDUCATION AND INFORMATION GAPS

As increasingly complex medication regimens become the standard of HIV care, up-to-date information and education is a necessity for medical providers, social services professionals and people living with HIV. Provider awareness of current treatment regimes can directly impact the lifespan of those living with HIV. Clients of varying literacy levels, or whose primary language is not English, need access to treatment information. Bilingual and culturally-competent providers, who are knowledgeable about HIV and sensitive to cultural issues, are needed.

MENTAL HEALTH SERVICES

The need for quality, comprehensive mental health services are becoming more urgent as the numbers of patients diagnosed with both HIV and psychiatric illnesses increases. Mental health services need to be coordinated with medical and social services.

HIV treatment is complex and its affect on individuals can be unpredictable. Sexuality, multiple losses, fear, and stigma issues all impact the mental health of individuals with HIV. Professional and peer support programs are needed to help individuals and families cope with the range of psychosocial issues arising from being infected or affected by HIV. Options should include models that are creative and varied in approach to best meet the needs of the community.

SUBSTANCE ABUSE SERVICES

Lack of access to alcohol and drug treatment services severely affects the ability of people living with HIV to manage a dual diagnosis of HIV and substance abuse. Gaps in services impact providers' ability to offer high quality, consistent medical care to people with HIV who are abusing substances.

EMPLOYMENT SERVICES

As the quality of life for those living with HIV continues to improve, and as their lifespan continues to be extended, appropriate rehabilitation and employment services need to be developed. Supportive services such as job training, retraining, and rehabilitative case management must be available for those who have difficulty seeking or maintaining employment. Access to General Education Degree (GED) courses or English as Second Language (ESL) courses may also be needed.

HIV/AIDS CASE MANAGEMENT

Case management is a formal and professional service that links clients with chronic conditions and multiple service needs to a continuum of health and social service systems. Case management strives to ensure that clients with complex needs receive timely coordinated services that enhance a client's ability to function independently as long as it is practical. Case management assesses the needs of the client, the client's family, and the client's support system, and then arranges, coordinates, monitors, evaluates and advocates for a package of services to meet the client's specific needs.

During the early years of the HIV epidemic, case management was primarily concerned with coordinating support services for a terminally ill population. Case managers provided support to assist people with HIV and their families to cope with a disease that ultimately would lead to death. While some levels of nursing and medical case management were available, the focus of case management was the coordination of psychosocial support services.

Changes in the HIV epidemic have required providers in Iowa to examine how HIV services are delivered to their communities. Case management has expanded to incorporate the principles of chronic disease management. New treatments require a strong link between the provision of medical care and wrap-around services. The demographics of infected populations are changing. Providers deal with multiculturalism, women's issues, children and youth, substance abuse, mental illness, homelessness and persons living in poverty.

Title II of the Ryan White CARE Act mandates case management in rural communities. Traditional activities of case management are intake, assessment, care plan development and implementation, referral, follow up and monitoring, and discharge. In Iowa, case managers also provide services such as eligibility determination, benefits monitoring, and benefits disbursement.

Care coordination systems are being established in Iowa. Care coordination incorporates case management with access to care, outreach, information and referral, eligibility determination, benefits coordination, adherence and compliance activities, and primary care coordination. Care planning, which was merged with HIV prevention planning in 2001, takes all of these components into consideration during the planning process. Case management and care coordination activities require standardized definitions, well-defined roles and responsibilities, and the development of standards and performance outcomes.

CASE MANAGEMENT STANDARDS

Standards provide a direction to the practice of HIV case management. They provide a framework for evaluating the practice of HIV case management and define the professional case manager's accountability to the public and to the client. Case management standards can be divided into two categories: *Standards of Care* and *Standards of Performance*. *Standards of Care* delineates a competent level of services, as demonstrated by the process of delivering the service. *Standards of Performance* defines a competent level of behavior in the professional role that includes quality of care, qualifications, collaboration, legal ethics, advocacy, and resource utilization.

In 2003, the Iowa Case Management Task Force incorporated *Standards of Care* and *Standards of Performance* into one set of standards for the core activities of case management:

- Initial Client Contact
- Intake/Assessment
- Care Plan Development
- Care Plan Implementation
- Care Plan Follow-up and Monitoring
- On-going Reassessment
- Transfer and Discharge

Standards

The case management standards presented in the following section define the:

- PURPOSE of each core activity
- PROCESS, or step-by-step method to conduct the activity
- CRITERIA, or the specific activities, required to meet the Standard
- DOCUMENTATION, if required

INITIAL CLIENT CONTACT

Standard:

Each prospective client who requests or is referred for case management services meets with agency staff to provide basic demographic information.

The Initial Client Contact is necessary to determine whether the client is in a crisis situation and/or requires immediate direct service or referral. During the Initial Client Contact, agency staff will gather basic demographic information. Based on this information, agency staff can choose to 1) provide immediate assistance through the resources of the agency, 2) refer the client to another agency, or 3) continue the enrollment process by completing the client Intake/Assessment.

Process

1. Initial Client Contact is initiated by a prospective client, his or her representative, or a third-party referral (verified at least verbally by client) to the case management agency.
2. A designated individual with appropriate training and skill screens the service request or referral for basic admission criteria, and assesses the need for immediate intervention.
3. Critical demographic and case specific information is collected directly or indirectly from the client or the referral source, and the prospective client is informed of agency services and limitations.
4. The client is referred to the case manager at the agency or another agency for Intake/Assessment.

Criteria

1. The person conducting the Initial Client Contact provides prospective clients with a description of the services available from the agency, as well as services available from other agencies.
2. The person conducting the Initial Client Contact documents recommendations and referrals.

Information to be documented:

- a) Name, address (mailing if different), phone, message phone
- b) Location where client prefers/declines to be contacted
- c) Age/Date of Birth
- d) Gender
- e) Racial and/or ethnic identification
- f) Source of referral
- g) Recommendations and referrals
- h) Date of Initial Client Contact

INTAKE/ASSESSMENT

Standard:

Each prospective client who requests or is referred for case management services will be properly screened and evaluated through a face-to-face Intake/Assessment process designed to gather information for future service delivery and to assess biopsychosocial needs.

Purpose of the Intake/Assessment

An Intake/Assessment is an information gathering process which includes a face-to-face interview between a client and case manager, and acquisition of secondary data from health and human services professionals and other individuals. It is a cooperative and interactive process during which a client and case manager collect, analyze, synthesize and prioritize information that identifies client needs, resources, and strengths, for purposes of developing a *Care Plan*. The Intake/Assessment establishes the basis for development of rapport and trust, which are essential elements of successful case management. Also, it allows the client to interact with agency staff and to consider the ramifications of his or her participation in the program.

Informed Consent

Enrollment into a case management program is often the client's first encounter with the HIV services system. The client's *Informed Consent* to participate in the case management program should be obtained at this time. In the process of acquiring the client's informed consent, it is important to ensure that the client understands the *Grievance Procedure* and the right to refuse any and all services. The client may exercise this right at any time during his or her participation in the case management program.

Confidentiality

As part of enrollment into the case management program, clients are informed of the right to *Confidentiality*, and the legal limitations placed on the case manager. It is important not to assume that anyone - even the client's partner or family member - knows that the client is HIV positive. Discussion should include inquiry about how the individual prefers to be contacted (at home, work, by mail, code word on the telephone). Case managers should identify themselves only by name, never giving an organizational affiliation that would imply that an individual is living with HIV disease or receiving social services.

Release of Information

Another element of the enrollment process is the *Release of Information* form, on which the client authorizes in writing the disclosure of certain information about his/her case to another party (including family members). Included on the form are the purpose of the disclosure, the types of information to be disclosed, entities to disclose to and the expiration date of client authorization. The discussion should include a description of the *Release of Information*, its components, and ways the client can nullify it.

Client's Rights and Responsibilities

An additional document presented to the client is the *Client's Rights and Responsibilities* form. The case manager reviews all of the rights and discusses the responsibilities as part of the overall discussion of a client's participation in the case management system. A copy of the *Client's Rights and Responsibilities* form, signed by the client, should remain in the client's file, and a copy should be given to the client to keep.

Program Offerings and Limitations

The client will be provided a clear explanation of the range of services offered by the case management program, and the role of the case manager. The client or his/her support persons might have questions about the program and the case manager's involvement with the client. It is important for the case manager to make the client aware of the program's limitations as well as its offerings. This information must be provided during the Intake/Assessment to avoid client and agency problems that inappropriate expectations can cause later on. Once the Intake/Assessment is completed, both the staff and client have the information needed to determine whether further assessment is needed.

Qualifications

The Intake/Assessment should be performed by a qualified case manager who exemplifies a high degree of interpersonal skill and empathy, and in-depth knowledge of the HIV/AIDS social service system. She/he should also have the ability to assess for immediate need, with referral to the appropriate agencies/services. Local agencies will decide, based on agency and client needs, whether to allow drop-in Intake/Assessment, and whether to have multiple sessions. Intake/Assessment is directed at reaching mutual agreement between the case manager and client concerning priority needs and client strengths and limitations.

Process

1. The Intake/Assessment is conducted by case managers and is performed in accordance with the Iowa HIV Case Management Standards and any written policies and procedures established by each respective agency, especially those related to confidentiality requirements and confidential meeting location.
2. The face-to-face interview is conducted at a site mutually acceptable to the client and case management staff.
3. The process of identifying client needs and strengths should be a participatory activity that involves client self-assessment and supports client self-determination. Equally important is ongoing collaboration between the case manager and other health and human service providers and individuals involved with the client. Case conferencing and consultation with other agencies providing services to the client should be an ongoing activity of case management. Appropriate documentation of these activities should be included consistently in the client's file.

Criteria

1. The client Intake/Assessment is conducted in face-to-face meeting(s) between the client and case manager, commencing no later than ten (10) working days following the Initial Client Contact unless client's specific situation dictates otherwise and rationale is documented in the client record. The Intake/Assessment should be completed within 60 days from its initiation.
2. Client needs are systemically assessed and documented. This requires active participation of the client, assessment worker, and other individuals agreed to by the client. Following is a list of areas to be investigated. Include both the client's self-reporting and official documentation. It is important to note that not all clients will have needs in every category.
 - a. Health Status & History
 - i. date of HIV and/or AIDS Diagnosis
 - ii. current treatments
 - iii. medications
 - iv. side effects
 - v. adherence concerns
 - b. Financial
 - i. income
 - ii. benefits
 - iii. insurance
 - iv. other forms of financial assistance
 - c. Housing
 - i. quality
 - ii. accessibility
 - iii. residential support
 - d. Vocational
 - i. current employment
 - ii. work history
 - iii. accommodations
 - e. Educational
 - i. status
 - ii. literacy
 - iii. communication
 - f. Tobacco, alcohol, drug use
 - g. Mental Health
 - i. emotional
 - ii. cognitive
 - h. Cultural, ethnic, racial considerations
 - i. Communication skills, literacy, and/or translation requirements
 - j. Social relationships and support
 - i. informal care givers
 - ii. formal service providers

- iii. significant issues in relationships
- iv. social environments
- k. Accessibility of health and community resources
- l. Social activities
 - i. recreation & leisure
 - ii. social network
- m. Legal
 - i. guardianship
 - ii. power of attorney
 - iii. parole officer
 - iv. other pertinent HIV/AIDS laws
- n. Spirituality/religion
- o. Prevention needs
 - i. knowledge of HIV transmission
 - ii. risk reduction
 - iii. assess client's need to review Iowa transmission law (see **Appendix B**)
- p. Activities of daily living
- q. Transportation
- r. Other

Documentation of Elements of the Assessment

- a) Documentation of HIV status (MANDATED)-requirements are listed on the next page
- (f) iii)
- b) Primary Care Physician/clinic, address, phone
- c) Other health care providers (past and present), address, phone
- d) Release of Information
- e) Documentation of financial information/verification/proof of income
- f) Documentation of health insurance (if applicable)
- g) Photo ID (if available)
- h) Social Security Number (if available)
- i) Client Rights & Responsibilities
- j) Informed consent
- k) Client grievance procedures

To be completed as part of the Assessment

- a) Health assessment and medication adherence
- b) Psychosocial assessment (conducted face-to-face with the case manager)
- c) Other assessment data (acquired from other professionals and sources, if necessary)
- d) Problem/needs list
- e) Completed enrollment checklist
- f) Verification of HIV status
 - i. Client self-report of HIV status (documented at intake/assessment)
 - ii. **Verification of client HIV status (must be obtained Within 30 days from the date of Intake/Assessment)**
 - iii. Acceptable verification includes at least one of the following:
 1. a copy of the client's seropositive test results from the test provider
 2. a signed document from a physician or his/her designee, verifying that the client is HIV positive
 3. lab results at any time during the client's lifetime, verifying the presence of the human immunodeficiency virus

Exemption from the requirement to secure verification of HIV status is granted when a person who is affected, but not infected, is determined to be appropriate for case management services. However, per HRSA guidelines, **when case management services are provided to a client who is affected but not infected, documentation in the client file must show that the services offered will directly benefit a person living with HIV.** Specifically, rationale will address one or more of the following:

- i. How the delivery of case management services to the affected client will allow him/her to participate in the care of someone with HIV disease.
- ii. How case management of the affected client will enable an infected individual to receive needed medical, support or housing services by removing an identified barrier to care.
- iii. How case management of the affected client will promote family stability in coping with the unique challenges posed by HIV.

CARE PLAN DEVELOPMENT

Standard:

A Care Plan (the terms care plan, case plan or service plan may be used interchangeably) will be developed in an interactive process with each client of case management services. Development of the Care Plan is a translation of the information acquired during Intake/Assessment into specific measurable goals and objectives with defined activities and time frames to reach each objective.

Purpose of Assessment-Based Planning

For the most efficient use of time, and to achieve effective outcomes, a clear plan must direct the activities of the client and the case manager. This plan becomes the basis for evaluating what services were provided and whether they achieved the desired outcomes. Once the case manager has gathered sufficient information from the Intake and Assessment, this information will form the basis of the Care Plan. Within 10 working days following completion of the Intake/Assessment, a Care Plan should be developed by the designated case manager and recorded in the client record. The case manager has primary responsibility for development of the Care Plan, in conjunction with the client, other members of the support system, and other involved providers.

Elements of the Plan

The major components of the Care Plan include:

1. Identification of agreed-upon client needs and goals
2. Identification of barriers
3. Quantifiable objectives with specified action steps
4. Designated individual(s) who will perform each activity
5. Time line for each step
6. Client and case manager signatures and date

Client Involvement in Planning

The Care Plan provides the basis from which the case manager and the client work together, as partners, to access the resources and services which will enhance the client's quality of life and his/her ability to cope with the complexity of living with HIV disease. The client and members of the support system play a vital role in development of the Care Plan. This process uses the inherent supports the client brings to the case management relationship. The process supports client self-determination whenever possible, and empowers a client to actively participate in the planning and delivery of services.

In setting up a Care Plan, the client and case manager must come agree about what tasks will be done by the case manager and what the client will do. Most clients will count on the case manager to guide them through the maze of the health and human services system, and to present options and help them develop contingency plans, should the initial efforts fail to produce the

desired results. It is important to set up a time frame within which progress toward the goals will be jointly assessed and revisions of the plan can be made.

The role of the case manager is one of resource coordination. During Care Plan development, when specific knowledge or skills beyond those of the case manager are needed, consultation with other professionals is sought with appropriate releases of information.

CARE PLAN IMPLEMENTATION

Standard:

Each client will receive assistance in accessing those services critical to achieving optimal health and well-being, in accordance with the Care Plan, and advocacy assistance when barriers impede access.

Tasks in Implementing the Plan

1. Service referral/brokerage/linkage
 - Making referrals
 - Reducing barriers/facilitating access
 - Follow-up after referral
 - Advocating with referral agencies when needed
 - Emotional support
2. Designating Roles

The case manager and client will work together to decide *what* actions are necessary to accomplish each objective, and *who* will take responsibility for each task. The case manager will encourage and support clients to act on their own behalf whenever possible.
3. Referral

The act of directing a person to a service, in person or by telephone, written, or other communication channel. Referral may be made (1) from one clinical provider to another; (2) within the case management system; (3) by professional case managers; (4) by program staff; or (5) as part of an outreach program.

Referrals to outside agencies are often needed for specified services to meet the Care Plan objectives. Referral agencies should be assessed for their appropriateness to the client's situation, lifestyle and need. The referral process should include timely follow-up of all referrals to ensure that services are being received. Agency eligibility requirements should be considered a part of the referral process. Any referral made should be appropriately documented in the client record.

4. Monitoring progress of the Care Plan

Follow-up and implementation are inseparable. Through systematic follow-up the case manager and client discover whether the plan is working and when it needs revision. The Care Plan should be regularly reviewed to determine whether changes in the client's situation warrant changes in the plan, and whether the goals and objectives of the plan are being met in a timely manner and, if not, why not.

Monitoring client satisfaction is an ongoing process throughout the delivery of case management services. It determines whether the mutually agreed-upon goals of the Care Plan are truly meeting the needs of the client. At any point, this process may trigger a

need for re-evaluation of the plan and/or the client and case manager working relationship.

5. **Advocacy**

Advocacy is the act of assisting someone in obtaining needed goods, services or benefits (such as medical, social, community, legal, financial, or other services), especially when the individual has had difficulty obtaining them on his/her own. Whenever possible, advocacy should build upon, rather than fragment, agency cooperation and collaboration.

Process for Implementing the Plan

1. Implement the Care Plan incrementally, allowing for full client participation. Aim to accomplish one objective at a time, while acknowledging the next tasks to be accomplished, except in emergency or highly urgent situations where multiple objectives may need to be implemented early in the Care Plan.
2. Case conferences and other forms of care coordination can help to ensure that all providers involved in a client's care and treatment work together to achieve the best mix of services and avoid duplication.
3. Successful implementation of the plan may require the case manager to take a more active role in helping the client identify problems that could impact the client's ability to fulfill his or her obligations to the Care Plan.
4. The Care Plan should be used as an important tool for helping the client cope with his or her problems and service needs. With proper support many clients are able to increase their coping skills and stabilize their life situation to avoid the cycle of moving from one crisis to another.

Documenting Implementation

Implementation of the Care Plan includes careful documentation in the progress notes of each encounter with the client, persons in his or her support system, and other providers involved with the client's care. Dates of contact, information on who initiated contact, and any action that resulted from the contact should be included in the documentation. All documentation should be signed and dated by the case manager.

CARE PLAN FOLLOW-UP AND MONITORING

Standard

Client and case manager will reassess the Care Plan goals and objectives at least every 6 months as a way to assess progress and the need for appropriate changes. The client and case manager will agree upon and sign the revised Care Plan.

Purpose of Follow-up and Monitoring

Monitoring is an ongoing process of data collection and analysis, resulting in

- evaluation of the effectiveness and relevance of the Care Plan
- evaluation of the level of client satisfaction
- measurement of client progress toward stated goals and objectives
- determination of the need for Care Plan revision

Goals of Follow-up and Monitoring

The overall goals of follow-up and monitoring are to:

- ensure the Care Plan is being implemented and is adequate to meet client service needs
- make sure the care and treatment the client receives from different providers are coordinated to avoid needless duplication of or gaps in services
- ensure that changes in the client's condition or circumstances are adequately addressed to avoid crisis situations
- maintain regular client and case manager contact to build trust, communication and rapport

Process

1. Either the case manager or the client can initiate follow-up.
2. Clients should be encouraged to contact the case manager when changes occur in their health condition, in social factors that impact their day-to-day living, or in their practical support systems.
3. Careful planning by the client and case manager can determine how often contact is needed to minimize crisis situations and best meet the client's anticipated needs.
4. Follow-up and monitoring activities can occur through direct contact (i.e. face to face meetings, telephone communication) with the client, client and caregiver, parent or guardian. Client contact with the case manager often occurs on an ad hoc or drop-in basis. Follow-up can occur in the case manager's office, at the client's home or temporary residence, in the hospital or at other sites in the community.

5. Indirect contact with the client, client's family or caregiver, primary medical provider, service providers and other professionals also provides follow-up and monitoring information. This can happen through meetings, telephone contact, written reports and letters, review of client records, and through client and/or agency staffing.
6. To build an effective client-centered relationship, it is important that periodic follow-up and monitoring happen in face-to-face meetings with the client. This allows the case manager to offer emotional support, and assess the client's overall affect and general physical condition.
7. Identifying and contacting people previously enrolled in HIV care and treatment services, but lost to follow-up or not responding, may be a component of monitoring. This is accomplished through periodic review of client files and requests from medical providers or referral from other outreach activities. This information will be reportable, and evaluated periodically for effectiveness in re-enrolling clients with HIV in case management and primary care.

Criteria

1. The client and case manager will reassess the Care Plan goals and objectives at least every six months.
2. The client and case manager will agree upon and sign the revised Care Plan.

ON-GOING REASSESSMENT

Standard:

At least annually, clients receiving case management services will have their needs reevaluated through a comprehensive biopsychosocial reassessment.

Purpose of the Reassessment

Clients are reassessed to identify unmet and/or emerging needs, guide appropriate revisions in the Care Plan and inform them of decisions regarding discharge from case management services and/or transition to other appropriate services. Reassessment is conducted in the event of significant changes in the client's life, or as above.

Process

Reassessment is conducted by the case manager and is performed according to established standards and criteria. The process of reassessment should encourage active participation by the client and/or significant others, to include legal guardians, parents of minor children, and partner or spouse. Reassessment may involve the collaboration between case manager and other health and human services providers, individuals actively involved with the client, and client record review.

Criteria

1. Those receiving case management will be reassessed in the event of significant changes in the client's life or as defined in process.
2. Reassessment will involve the original assessment areas, and include Care Plan progress, changes, and mutually agreed-upon goals.

Documentation

1. Updated demographic data
2. Updated assessment data acquired from health care providers and other professionals and sources
3. Updated Care Plan reflecting the above input and review

TRANSFER AND DISCHARGE

Standard:

A systematic process shall be in place to guide transfer of the client to another program or case manager, and/or discharge from case management services. This process includes clear documentation of the reason(s) for discharge, notifying the client of case closure and the appeals process.

Conditions Under Which Transfer/Discharge Shall Occur:

1. Death of the client
2. Client moves out of the case manager's geographic service area
3. The client and/or client's legal guardian requests that the case be closed
4. Client makes fraudulent claims about their HIV diagnosis or falsifies documentation
5. Client enters prison

Conditions Under Which Transfer/Discharge May Occur:

1. Client is "lost to follow-up"
2. Client moves into a system of care which provides in-house case management
3. Client becomes self sufficient
4. Client is unwilling to participate in Care Plan
5. Client exhibits a pattern of abuse of agency staff, property or services
6. Client needs are more appropriately addressed by other programs

Process for Transfer/Discharge

1. Reason for discharge or transfer is discussed with the client. Other service provision options are explored and documented.
2. In instances where the case management agency initiates termination:
 - a) The case manager consults with a supervisor about the intent to discharge the client.
 - b) The client is informed of the intent to discharge, and provided information regarding appeal of that decision.
 - c) The client is informed of other available community resources that may be able to meet his/her needs.
 - d) In some circumstances, a client may be suspended from services for a specified period of time. Every effort should be made to assist the client in meeting expected program guidelines and becoming eligible for services.
3. A Discharge Summary, including careful documentation of reason(s) for discharge and a service transition plan is prepared.

Criteria

In instances where the client cannot be reached within 1 year, a letter indicating intent to discharge should be mailed to the client's last known mailing address. The letter should state that if the client has not responded within 30 days, their file will be closed.

Documentation

A Discharge Summary should be included in the Progress Notes in the client's file.

Case Management Timeline

Initial Client Contact (ICC)



Initiate Intake/Assessment within 10 Working Days



Complete Intake/Assessment within 60 Days (from ICC)



Develop Care Plan within 10 working Days (from completion of Intake/Assessment)



Reassess Care Plan at least every 6 months



Comprehensive Reassessment at least Annually

DEFINITIONS

Adherence (Treatment Regimen) -- Following the recommended course of treatment by taking all prescribed medications, keeping medical appointments and obtaining lab tests when ordered.

Case managers can help clients identify and remove barriers that prevent them from taking medications properly and consistently. Maximizing the effectiveness of treatment depends on identifying all of the elements in clients' lives which affect their ability to follow the recommended course of treatment. This assessment should include six areas of client functioning: (1) education; (2) motivation; (3) self-efficacy; (4) barriers to performance; (5) remembering; and (6) side effects.

Advocacy -- Advocacy is the act of assisting someone in obtaining needed goods, services or benefits (such as medical, social, community, legal, financial, or other services), especially when the individual has had difficulty obtaining them on his/her own. Advocacy does not involve coordination and follow-up on medical treatments. (This should not be confused with appropriate Nursing intervention.) Whenever possible, advocacy should build upon, rather than fragment, agency cooperation and collaboration.

Americans with Disabilities Act (ADA) -- The ADA is a civil rights law passed by Congress in July of 1990 to protect people with disabilities from discrimination in public and private services and accommodations. Since HIV disease is considered a disability, ADA protections apply to persons living with HIV/AIDS.

Biopsychosocial -- a comprehensive picture of a person, containing information about her/his physical (bio), psychological (psycho) and social (socio)health.

Broker -- To act as an intermediary or negotiate on behalf of a client.

Care Plan -- A written plan that directs the activities of the client and the case manager. The Care Plan delineates the case management goals and objectives that link the client to the continuum of health and support services required to manage their disease.

Client Record -- A collection of printed and/or computerized information regarding a person using services currently or in the recent past.

Confidentiality -- The process of keeping private information private. Information given by a client to a service provider will be protected and will not be released to a third party without the explicit written permission of the client or his/her representative. Information may be released only in the following circumstances: (1) When a written release of information is signed by the client; (2) When there is a clear medical emergency; (3) When there is a clear and imminent danger to the client, case manager or others; (4) When there is possible child or elder abuse; and (5) When ordered by a court of law.

Coordinated health care -- Health care services related to the treatment of HIV/AIDS infection and HIV/AIDS associated complications, as well as the maintenance of health status.

Criteria -- Definition of specific, measurable outcomes expected from a Standard.

Cultural Competency -- The ability of service providers and others can accommodate language, values, beliefs and behaviors of individuals and groups they serve.

Demographic Information -- Descriptive information about a client, including, but not limited to, age, race/ethnicity and gender. This information provides a profile of people receiving services from a specific agency.

Emotional Support, Counseling and Therapy -- While the terms emotional support, counseling and therapy are often used interchangeably, they suggest activities with somewhat different purposes in the context of HIV/AIDS case management. All, however, should have as their ultimate goal the empowerment of clients.

Emotional support -- The ability of the case manager to listen and empathize is the essence of emotional support in the case management relationship. In cultivating a trusting relationship, it is important for the case manager to strike a balance between the empathetic role--using active listening skills, developing rapport, and providing emotional support-- and the objective role which requires engaging and encouraging the client toward concrete actions to achieve a desired outcome. Because case management is often defined as a task-oriented process, we tend to focus on the “doing” of tasks with the client, and forget the importance of “being present”. Being truly available to offer emotional support is particularly important in situations where we do not have resources to meet clients’ needs.

Counseling -- Counseling is a solution-focused helping process that is outer-directed—the focus is on “here and now” problems in living--with the goal of improving the client’s ability to function in these areas. It is a strengths-based approach that enhances the client’s capacity to envision solutions and to recognize and use internal and external resources available to him or her, including resources that have worked in the past in overcoming difficulties. One of the most common examples of counseling in a case management relationship is crisis intervention.

Therapy -- Therapy refers to professional mental health interventions aimed at reducing clinical symptoms that interfere with an individual’s ability to meet the demands of daily life, and participate actively in his or her own health care. It falls outside the role of a case manager to provide mental health therapy to clients. Referring clients to appropriate mental health resources, and facilitating access to those services is the appropriate role for the case manager.

Grievance -- A verbal or written complaint or concern regarding a practice or policy of an individual or organization per the organization's policy.

Health Education/Risk Reduction - Activities which include information dissemination about methods to reduce the spread of HIV; HIV disease progression; and the benefits of medical and psychosocial support services. This activity does not include medication or treatment information, which is part of Adherence activities.

Multi-Disciplinary Team -- A team that includes professionals representing the disciplines required for a holistic approach to meeting the needs of a client, as identified through the Assessment. At a minimum, the team consists of the Medical Care Provider and the HIV Case Manager.

Process -- A step-by-step method to gather information or conduct an activity.

Quality Assurance/Improvement -- A method of program/service evaluation, which is designed to assure that the highest quality of services are provided to the client.

Ryan White CARE Act -- Passed by Congress in 1990, the purpose of this federal Act is to provide emergency assistance to communities that are most affected by the HIV epidemic and to make financial assistance available to state and other public or private nonprofit entities. This assistance provides for the development, organization, coordination and operation of more effective and cost-efficient systems for delivery of essential services to individuals and families with HIV disease.

Standard -- Authoritative statements by which a profession describes the responsibilities of its practitioners. A rule or basis of comparison in measuring or judging capacity, quantity, content, extent, value and/or quality.

Treatment Plan -- A written plan of treatment and therapy developed by a medical provider.

APPENDIX A

Glossary of HIV-Related Service Categories

Health Care Services

Ambulatory/Outpatient Medical Care: The provision of professional, diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. This includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health and nutritional issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care. *Primary Medical Care for the Treatment of HIV Infection* includes the provision of care that is consistent with the Public Health Service's Health Service guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Home Health Care: Therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home-health agency in a home/residential setting in accordance with a written, individualized plan of care established by a case-management team that includes appropriate health-care professionals. Component services include: durable medical equipment; homemaker or home-health aide services and personal care services; day treatment or other partial hospitalization services; intravenous and aerosolized drug therapy, including related prescription drugs; routine diagnostic testing administered in the home of the individual; and appropriate mental health, developmental, and rehabilitation services.

Note: Home and community based care does not include inpatient hospital services or nursing home and other long-term care facilities.

Mental Health Services: Psychological and psychiatric treatment and counseling services to an individual with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such service. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

Nutritional Counseling: Services provided by a licensed registered dietician outside of a primary care visit. Nutritional Counseling provided by other than a licensed/registered dietician should be provided under *Psychosocial support services*. Provision of food, meals, or nutritional supplements should be reported as a part of the sub-category, *Food and/Home-Delivered Meals/Nutritional Supplements*, under Support Services.

Oral Health: Includes diagnostic, prophylactic and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Rehabilitation Services: Services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low vision training.

Substance Abuse Services Outpatient: The provision of medical treatment and/or counseling to address substance abuse issues (including alcohol, legal and illegal drugs), provided in an outpatient setting rendered by a physician or under the supervision of a physician.

Substance Abuse Services Residential: The provision of treatment to address substance abuse issues (including alcohol, legal and illegal drugs), problems provided in an inpatient health services setting rendered (short term).

Treatment Adherence Services: The provision of counseling or special programs to ensure readiness for and adherence to complex HIV/AIDS treatments.

Support Services

Child Care Services: The provision of care for the children of HIV positive clients while the clients are attending medical or other appointments. Note: This does not include daycare while the client is at work.

Child Welfare Services: Assistance in placing children younger than 21 in temporary (foster care) or permanent (adoption) homes because their parents have died or are unable to care for them due to HIV-related illness.

Buddy/Companion Services: An activity provided by volunteers/peers to assist the client in performing household or personal tasks and providing mental and social support to combat the negative effects of loneliness and isolation.

Case Management: A range of client-centered services that link clients with health care, psychosocial and other services. Ensures timely, and coordinated access to medically appropriate levels of health and support services, continuity of care, through ongoing assessment of the client's and other family members' needs and personal support systems. Also includes inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities. Key activities include (1) initial assessment of the service needs, (2) development of a comprehensive, individualized service plan, (3) coordination of the services required to implement the plan as well as client monitoring to assess the efficacy of the plan, and (4) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. May include client specific advocacy and/or review of utilization of services.

Client Advocacy: The provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Advocacy does not involve coordination and follow-up on medical treatments, as case management does.

Psychosocial support services: Individual and/or group counseling, other than mental health counseling, provided to clients, family, and/or friends by non-licensed counselors. May include psychosocial providers, peer counseling/support group services, caregiver support/bereavement counseling, drop-in counseling, benefits counseling, and/or nutritional counseling, or education services that are provided to clients, families and household members, and/or other caregivers and focused on HIV-related problems.

Day or Respite Care: Home or community based non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of an adult client.

Emergency Financial Assistance: The provision of short-term payments for essential utilities and for medication assistance when other resources are not available. These short-term payments must be carefully monitored to assure limited amounts, limited use, and for limited periods of time. Expenditures must be reported under the relevant service category.

Food Bank/Home Delivered Meals/Nutritional Supplements: The provision of actual food, meals, or nutritional supplements.

Health Education/Risk Reduction: The provision of services that educate clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information, including information dissemination about medical and psychosocial support services and counseling to help clients living with HIV improve their health status.

Housing Services: The provision of short-term assistance to support temporary and/or transitional housing to enable an individual or family to gain and/or maintain medical care

Related housing services: Includes housing in medical treatment programs for chronically ill clients (e.g. assisted living facilities), specialized short-term housing, transitional housing, and non-specialized housing for HIV-affected clients. This category also includes access to short-term emergency housing for homeless people. In addition, these services include assessment, search, placement, and the fees associated with the aforementioned. Services must be linked to medical and/or health-care services or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment.

Legal Services: The provision of services to individuals with respect to Powers of Attorney, Do Not Resuscitate Orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the CARE Act. It does not include any legal services for guardianship or adoption of children after the death of their normal caregiver. See also, *Permanency Planning* and *Child Welfare Services*.

Outreach Services: Includes programs which have as their principal purpose identifying people with HIV disease so that they may become aware of and may be enrolled in care and treatment services (i.e. case finding), not HIV counseling and testing nor HIV-prevention education. Outreach services programs must be planned and delivered in coordination with local HIV-prevention outreach programs to avoid duplication of effort, be targeted to populations known through local epidemiological data to be at disproportionate risk for HIV infection, be conducted at times and in places where there is a high probability that HIV-infected individuals will be reached, and be designed with quantified program reporting that will accommodate local effectiveness evaluation. Broad marketing of the availability of health-care services for PLWH should be prioritized and funded as Planning Council or Consortium supported activities. HRSA/HAB Policy Notice 02-01 provides details on revised policy for the use of Ryan /HAB Web site, at <http://hab.hrsa.gov/history/habpolicies.htm>.

Permanency Planning: The provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.

Referral to Health care and/or Supportive Services: The act of directing a client to a service in-person or through telephone, written, or other type of communication. Referrals may be made formally from one clinical provider to another, within a case-management system by professional case managers, informally through support staff, or as part of an outreach program.

Transportation: Includes conveyance services provided, directly or through a voucher, to a client so that he or she may access health care or support services. May be provided routinely or on an emergency basis.

Other Support Services: Includes direct support services not listed above, such as translation and interpretation services.

Program Support: Activities that are not service oriented or administrative in nature, but contribute to or help to improve service delivery. Such activities may include capacity building, technical assistance, program evaluation (including outcome assessment), quality assurance, and assessment of service-delivery patterns.

APPENDIX B

709C.1 Criminal transmission of human immunodeficiency virus.

1. A person commits criminal transmission of the human immunodeficiency virus if the person, knowing that the person's human immunodeficiency virus status is positive, does any of the following:
 - a) Engages in intimate contact with another person.
 - b) Transfers, donates, or provides the person's blood, tissue, semen, organs, or other potentially infectious bodily fluids for transfusion, transplantation, insemination, or other administration to another person.
 - c) Dispenses, delivers, exchanges, sells, or in any other way transfers to another person any nonsterile intravenous or intramuscular drug paraphernalia previously used by the person infected with the human immunodeficiency virus.
2. For the purposes of this section:
 - a) "*Human immunodeficiency virus*" means the human immunodeficiency virus identified as the causative agent of acquired immune deficiency syndrome.
 - b) "*Intimate contact*" means the intentional exposure of the body of one person to a bodily fluid of another person in a manner that could result in the transmission of the human immunodeficiency virus.
 - c) "*Intravenous or intramuscular drug paraphernalia*" means any equipment, product, or material of any kind which is peculiar to and marketed for use in injecting a substance into or withdrawing a bodily fluid from the human body.
3. Criminal transmission of the human immunodeficiency virus is a class "B" felony.
4. This section shall not be construed to require that an infection with the human immunodeficiency virus has occurred for a person to have committed criminal transmission of the human immunodeficiency virus.
5. It is an affirmative defense that the person exposed to the human immunodeficiency virus knew that the infected person had a positive human immunodeficiency virus status at the time of the action of exposure, knew that the action of exposure could result in transmission of the human immunodeficiency virus, and consented to the action of exposure with that knowledge.

For all HIV applicable laws in Iowa, go to <http://www.legis.state.ia.us/IowaLaw.html>.